Coversheet: Health System Structural Change to support Reform Programme

Advising agencies	*DPMC*
Decision sought	*Agreement to public health system structural changes*
Proposing Ministers	*Hon Andrew Little, Minister of Health*

Summary: Problem and Proposed Approach

Problem Definition

What problem or opportunity does this proposal seek to address? Why is Government intervention required?

Successive reviews of the publicly-funded health system in New Zealand, most recently the independent Health and Disability System Review which was released in June 2020, have found consistently poor outcomes for some groups, in particular Māori, Pacific peoples and people with disabilities, and significant unwarranted variation in service availability, access and quality between population groups and areas of New Zealand.

The Health and Disability System Review identified that one of the root causes of this inequity and variation was the structure of the health system. It described a system that has become fragmented and complex, leading to:

- unclear roles, responsibilities and boundaries
- misalignment of strategies, plans and interventions
- a lack of a common ethos or culture
- unnecessary duplication of many tasks and activities
- underinvestment in key services, including for prevention, health promotion, primary and community care and Māori and iwi providers
- inconsistent performance and clinical data, and
- poor spread of innovation and inadequate development of digital and new care models.

Government intervention is necessary to address these longstanding issues; indeed, only Government can take the steps needed to reform the structure and operating model of the publicly-funded health system.

This analysis relates to the Government's proposals to reform the health system operating model. The wider programme of health reform is expected to encompass additional policies that will improve equity, reduce variation and tackle other issues, subject to future decisions by Cabinet. Any such policies will be subject to further assessments in due course.

Summary of Preferred Option or Conclusion (if no preferred option)

How will the agency's preferred approach work to bring about the desired change? Why is this the preferred option? Why is it feasible? Is the preferred approach likely to be reflected in the Cabinet paper?

The Government is undertaking a significant programme of reform and improvement across the health system.

The preferred option for reform of the system structure is to develop a nationally integrated health system which promotes more cohesive planning and common standards, with services tailored to the needs and values of its users, rather than service providers. The key features are:

- giving full effect to Te Tiriti o Waitangi through obligations on all health organisations, including by establishing a Māori Health Authority to oversee and monitor system performance for Māori health and commission and co-commission services to improve Māori health outcomes.
- making population health a foundational element of the system, so that planning and commissioning of health services is driven by an assessment of the long-term health needs of New Zealanders
- strengthening the coherence of the system by aligning national, regional and local planning, funding and accountability arrangements to enable national decision-making in key areas, greater central guidance, clear common expectations, and closer, more transparent clinical and financial performance management
- consolidation of hospital and specialist services into a national hospital network with consistent standards and aligned clinical leadership,
- the creation of a networked approach to primary and community services as the basis for improved integration of local services, increased access and collaboration with the social sector, and
- establishing a Public Health Agency as a business unit of the Ministry of Health to lead and coordinate national strategy for health promotion, protection and prevention of disease, and to monitor existing and emerging threats to public health; and consolidating existing operational functions into a single national public health service within Health New Zealand

This analysis considers the structural change required to support the overall reform programme, insofar as they relate to changes to the core operational functions currently undertaken by district health boards (DHBs). The form and governance of the Māori Health Authority is being designed in collaboration with Māori, and will be the subject of further impact analysis later in 2021.

The preferred option is to replace the twenty DHBs with one Crown Agent to lead the operation of the publicly-funded health system. This option has a single national entity in Health New Zealand. Local, district and regional activity is managed through internal divisions of Health New Zealand, rather than through separate statutory entities.

Under this option, Health New Zealand has an internal division with hospital and specialist services delivered through one arm, and primary and community-based services commissioned through another arm:

- Health New Zealand operates all public hospitals as part of a coordinated national approach, with decisions on allocation and distribution of services made nationally and services delivered through regional networks.
- Regional Health New Zealand commissioners are responsible for the commissioning of primary and community health services, which are organised and

delivered through locality networks of service providers, with strong community input into service design.

This proposal will support the overall reform programme by:

- supporting the Te Tiriti relationship by establishing a single entity through which Māori can establish relationships at the appropriate national, rohe, or takiwā level, without having to juggle multiple organisational relationships
- fostering a stronger "one-system" ethos, through which professionals work for Health New Zealand rather than individual local organisations and deliver common objectives and outcomes for the population as a whole
- enabling nationally consistent planning and resource allocation for health services, to optimise the use of resources for the benefit of the whole population and reduce the potential for unwarranted local variation in access
- improving efficiency and productivity by allowing a logical distribution of decision-making, including nationally where appropriate (e.g. in relation to procurement, asset management, workforce planning), and
- clarifying and simplifying accountability for delivery of health services and outcomes, to improve reporting to Ministers, Parliament and the public.

A more detailed intervention logic framework is attached as Appendix One, setting out the overall reform programme logic, and the place of structural change within it.

Section B: Summary Impacts: Benefits and costs

Who are the main expected beneficiaries and what is the nature of the expected benefit?

This proposal is the critical foundational layer which will underpin the Government's overall health reform programme. The system structure provides the basis for the operation, management and oversight of health services, and therefore is a key contributor to the environment and settings required to achieve the Government's aims for improving health and wellbeing.

While the system structure indirectly contributes to the intended benefits in terms of improved health outcomes and equity, there are also more direct benefits that are expected from a more coherent and better functioning system model.

It is not possible to quantify all such benefits in aggregate. However, we have identified the principal intended benefits from a simplified system structure, and worked through one quantifiable example of a system benefit in detail.

The quantifiable benefits associated with structural change are expected to be reflected primarily in increased consistency and efficiency. For example, more consistent financial and clinical management across the health system is expected to better identify and address variation in practice that leads to inequitable outcomes and poor use of resources:

- operating a single hospital network means common standards can be adopted and variation addressed through internal management controls, rather than requiring inter-entity negotiation. Variation in practice is thus significantly easier to identify and mitigate; and

- the use of improved and consistently-applied prioritisation frameworks and tools is expected to allocate clinical resources more effectively on a population-level, matched to health need. This will identify where resources can be freed up or redirected, for example to reduce waiting times for surgery.

Moreover, the development of single national plans and approaches to core functions and activities which can be undertaken for the health system as a whole rather than by separate DHBs will drive greater consistency. For example, a system-wide approach to procurement, management of assets and capital investment, workforce planning and deployment should be expected to optimise value for the system in the round. Adopting common systems and processes for shared functions, including administrative and financial systems, will also allow for greater interoperability, sharing of information and identification of areas that need action (e.g. outliers).

Wider, non-quantifiable benefits of a reformed system structure also include:

- Establishing a system model which supports population health approaches and encourages integration with wider social sector partners is expected to achieve a significant improvement in quality of life and deliver benefits for the wider public sector. Although the system model does not directly lead to these benefits, the intended design will improve the incentives and behaviours for entities to work in a way that is conducive with a population health approach, and will remove existing barriers that act against whole-population needs assessment, service planning and resource allocation.
- Delivering national programmes, including those for improved and new services such as the bowel screening or mental health programmes, will be faster and more efficient in a simplified system that removes organisational boundaries. The current system requires negotiation with multiple entities to deliver national priorities, with oversight and monitoring further complicated by complex reporting lines. The new system model will provide for a single chain of accountability to support more effective delivery of shared requirements. Although not easily quantifiable, this will ensure that the benefits of such programmes are delivered more rapidly and more equitably to populations.

Benefits associated with the reforms will accrue to the publicly-funded health system, and in turn therefore to Government (in terms of managing demand and cost pressures) and to the public (in terms of improved access and health outcomes).

A significant expected benefit from a nationally commissioned and managed hospital system is reduced variability in hospital admissions and length of stay. The benefit takes the form of reduced pressure on hospital services, meaning over the long term, hospital planners can reallocate resources to areas of need, rather than realisable savings. We estimate the resources available for reallocation could amount to nearly 1 percent of Vote Health or approximately $4 billion over ten years. This figure is based on current variation data, and is more fully explained in Appendix Two.

Where do the costs fall?

The quantifiable costs of change fall on the government. The current estimate of the costs of making the structural changes is approximately $180 million over four years. These estimates are early, and may change as more detailed design is undertaken.

These costs do not include wider non-structural costs of health reform. For example, to address longstanding health disparities and to shift costs away from hospital settings, changes to primary and community care will be need to expand services and address access barriers. In particular, current primary care funding arrangements are not adequately adjusted for need. Additional costs will be expected subject to future Cabinet decisions on such issues.

What are the likely risks and unintended impacts? How significant are they and how will they be minimised or mitigated?

Key risks which have been identified include:

- That the transition may impact on the existing workforce and on delivery of existing services. This risk will be mitigated by transferring all DHB staff, assets and contracts into Health New Zealand using a 'lift and shift' approach. Other transitional risks will be mitigated by early establishment of the proposed entities in interim form, and through a comprehensive change management plan.
- There is a risk that the disruption of structural change undermines the cultural shift in mind-set and behaviour, particularly in the sector leadership, that is essential for long-term success. This will be mitigated by early work on the Health Charter recommended by the Health and Disability System Review and involving system leaders in the next stage of design.
- A further risk in the short term is the potential for district health boards to act in a manner that is incompatible with the direction of reform, which will be mitigated through use of the existing ministerial levers applying to Crown Agents.
- It is proposed that Health New Zealand be established as a Crown Agent, as with DHBs. This implies a risk that Health New Zealand will make decisions that do not reflect government policy, as has sometimes been the case with DHBs. This risk is not as acute is in the current system as it is not proposed to have elected members who may make decisions based on electoral considerations rather than government policy. Moreover, this risk will be mitigated by the use of the standard Crown entity intervention powers, including the power of direction. In addition, it is proposed that the Minister have wider intervention powers, including the ability to require improvement plans.

Section C: Evidence certainty and quality assurance

Agency rating of evidence certainty?

We are confident of the evidence supporting the problem definition, which is taken from official statistics and health system performance data.

There is also substantial information in the reports of the Health and Disability System Review Panel, particularly the interim report, and the sector feedback on that report. There is some uncertainty about the totality of expected benefits, but examples for which there is good information and a strong intervention logic have been identified and analysed, and clearly outweigh the costs of change.

To be completed by quality assurers:

Quality Assurance Reviewing Agency
Treasury

Quality Assurance Assessment
Meets

Reviewer Comments and Recommendations
Treasury's Regulatory Impact Analysis Team has reviewed the Supplementary Analysis Report (SAR) "Health System Structural Change to Support Reform Programme" produced by the Department of the Prime Minister and Cabinet. The review panel considers that it **meets** the Quality Assurance criteria. The SAR provides a clear problem definition and intervention logic. It acknowledges that not all costs and benefits of the proposed change have been estimated, and provides informed estimates where these are possible. The analysis within this SAR is on the first regulatory proposal decided as part of the wider health reform process. Subsequent regulatory decisions will be accompanied by separate regulatory impact analysis

Summary Analysis Report: Health System Structural Change to support Reform Programme

Section 1: General information

1.1 Purpose

The Department of the Prime Minister and Cabinet has prepared this Supplementary Analysis report and is solely responsible for the analysis and advice set out in it.

The scope of analysis has been agreed between the Health Transition Unit within DPMC and the Treasury.

1.2 Key Limitations or Constraints on Analysis

Issues out of scope

This analysis relates to structural reform options for the core operational functions of health services currently held by DHBs and the Ministry of Health. It does not include:

- Options relating to the form and governance of the Māori Health Authority. Cabinet has agreed that the Māori Health Authority will be designed in collaboration with Māori, per the government's manifesto commitment. Decisions are expected to be brought to Cabinet later in 2021, and be the subject of impact analysis at that time.
- Options relating to disability support services. The Ministry of Health and Ministry of Social Development are undertaking separate work on the future arrangements for disability support services, which will be the subject of separate analysis if required.
- Options relating to the Public Health Agency. Cabinet has determined to deliver the manifesto commitment through the establishment of a business unit within the Ministry of Health.

What are the assumptions underpinning the impact analysis?

The cost of operating Health New Zealand once fully established is assumed to be the same or less than the cost of operating the existing DHBs (excluding costs of providing care).

While there are expected to be savings from reducing duplication and reallocation of decision rights across the system in areas such as capital planning, digital investment and procurement there is expected to be increased resource devoted to strengthening community-based delivery and services for Māori, improved use of data, intelligence and

digital enablers, commissioning and planning, quality improvement and community engagement, so overall costs may not reduce.

This assumption is distinct from the direct costs of change, and the savings from reduced variation in performance, which are estimated in this analysis.

It is assumed that any option will be supported by:

- changes in monitoring and intervention practice – more robust monitoring and intervention is essential to improve oversight and accountability
- strengthened Iwi/Māori Partnership Boards that will be the primary vehicle for giving effect to the Te Tiriti partnership and jointly identifying priorities, and co-designing services and plans at the locality level. These will be iwi and Māori boards, rather than government entities, and
- a stronger population health approach to needs analysis and service design, with more robust data collection and analysis.

What is the quality of data used for impact analysis?

The quality of data used for impact analysis is high, where data are available. Specific figures have been taken from health system reporting, or from cost estimates based on robust analysis supporting Budget bids.

There is however, limited access to consistent performance data, and limited analytical capability under existing settings. One of the benefits of the preferred option will be improved access to data, and consolidated and therefore stronger analytical capability.

1.3 Responsible Manager

Stephen McKernan

Director

Health Transition Unit

Department of the Prime Minister and Cabinet

[Date]

Section 2: Problem definition and objectives

2.1 What is the current state within which action is proposed?

The vast majority of health and disability services in New Zealand are publicly funded. About 80 percent of total expenditure on health services is government-funded[1]. Publicly-funded hospital services are almost all provided through publicly-owned hospitals, with some very few carried out in private settings. For primary and community care, most providers are private individuals or organisations.

Publicly-funded health services are largely delivered through twenty district health boards (DHBs). DHBs are Crown Agents, responsible for improving, promoting, and protecting the health of their district's population. They own public hospitals and clinical equipment and employ staff across hospital service delivery, strategy, planning, corporate and other functions. DHBs generally work autonomously of each other, but do collaborate in four regional groups (Northern, Midlands, Central and Southern) for particular services and initiatives. Regional working is supported by a variety of shared services agencies.

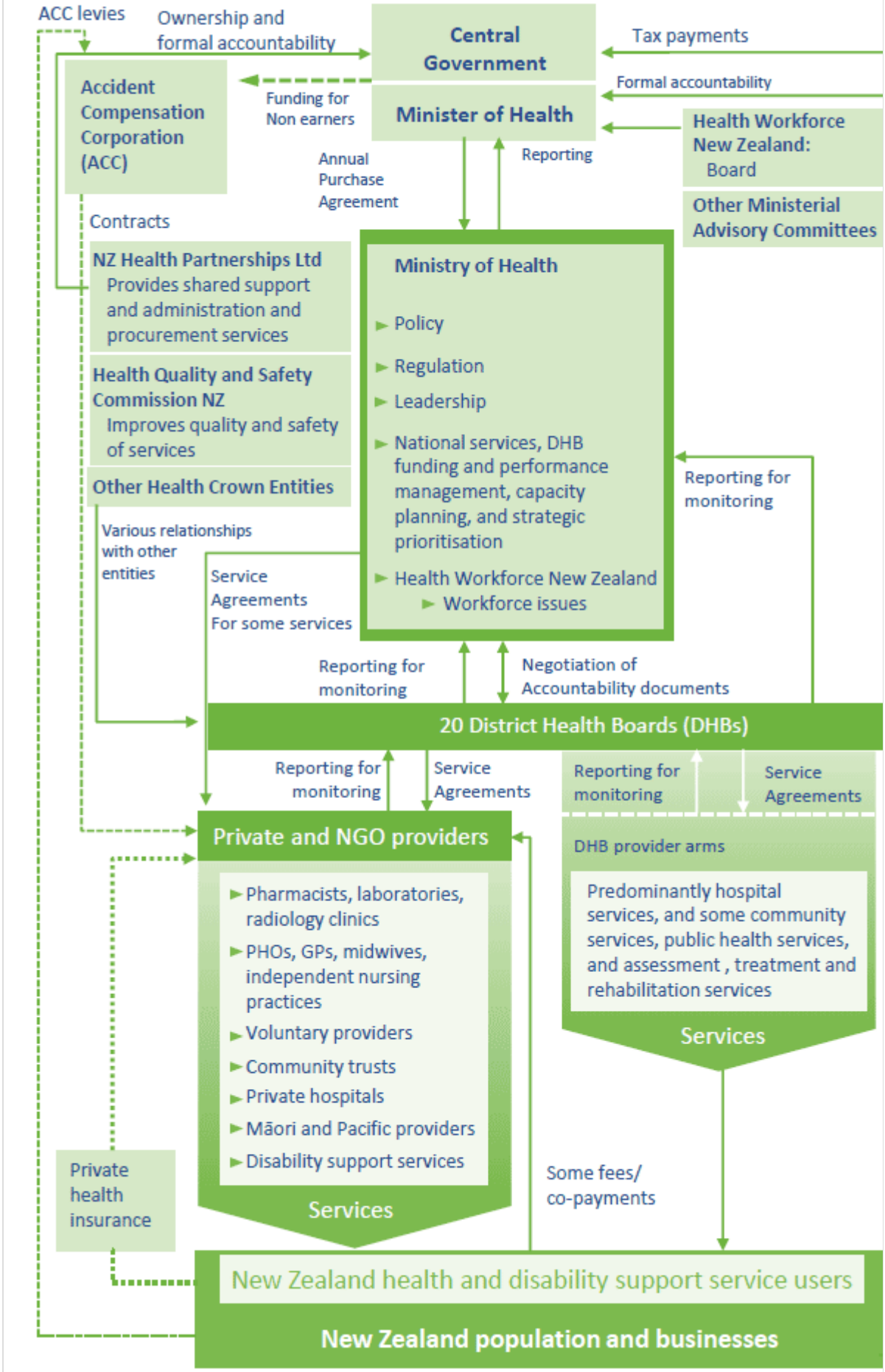
DHBs fund a range of other primary and community-based services, which are delivered by a wide variety of disparate providers under a range of funding models and payment mechanisms. DHBs fund primary care through Primary Health Organisations, and directly to other entities such as community pharmacies and kaupapa Māori providers. Primary Health Organisations are non-government organisations contracted to provide general practice-based primary care and health promotion services. DHBs are required by their Crown Funding Agreement to fund general practice care through PHOs unless given a specific exemption – for example, South Canterbury DHB funds primary care directly, acting as if it were a PHO for that purpose.

The Ministry of Health directly funds some services, in particular disability support services for those under 65 and national contracts for some primary and community-based services, such as Plunket. The Ministry of Health holds approximately $4 billion of non-departmental expenditure.

The Ministry of Health has a Māori policy unit, and funds some Māori provider and workforce development.

[1] OECD, retrieved from https://data.oecd.org/healthres/health-spending.htm 15/2/2021

The structure of the New Zealand health and disability sector



Previous decisions

The Government's election manifesto commits to a long-term programme of reform to build a stronger health and disability system, drawing on the recommendations from the Health and Disability System Review. Some specific commitments include:

1. working with tangata whenua to establish a Māori Health Authority
2. establishing a Public Health Agency to provide national leadership and consistency around core aspects of public health
3. adopting a networked approach to primary and community services
4. reducing the number of district health boards, maintaining the current level of service while reducing administrative costs and duplication.

Cabinet has accepted the case for change and general direction of travel outlined in the final report of the Health and Disability System Review. The full report is available from the Review website, but the case in summary is:

1. The public health system has become complex and fragmented, with unclear roles, responsibilities and boundaries, which can lead to organisations and individuals operating within the system pulling in different directions.
2. Services are too often built around the interests of certain providers, and not around what consumers value and need.
3. Outcomes for some, particularly Māori, Pacific peoples, and people with disabilities, are significantly worse than other groups. Outcomes for Māori represent systemic challenges, as outlined in the WAI 2575 Inquiry.
4. Funding has not kept pace with increasing costs and rising demand, and funding arrangements have not incentivised innovation or a longer term focus. However, funding arrangements are not the sole cause of the large sector deficits, or the major contributor to inequitable outcomes.

In response to this, the Review sets out a vision of a nationally integrated system where services are tailored to the needs and values of its users, rather than service providers. The key features are:

- Making population health a foundational element of the system, including the creation of a networked approach to primary and community services.
- Strengthening the coherence of the system by aligning long-term national, regional and local planning, funding and accountability arrangements to provide for decisions being made at the right level of the system, closer clinical and financial performance management, and greater transparency of performance.
- Cultural change in leadership and the mind-set of the system toward a collaborative, person focused system

The Review recommended structural change to support clearer lines of accountability and greater national coherence. The Review outlines a public health and disability sector that has:

- The Ministry of Health as chief steward with responsibility for policy, strategy, legislation, long-term system outcomes and monitoring, building population health capacity and leading the Budget process.
- A new organisation, provisionally called Health New Zealand, to provide national leadership of health service delivery, both clinical and financial.
- A Māori Health Authority to provide policy and strategy advice on Māori health and a limited commissioning role with respect to Māori provider and workforce development, and some kaupapa Māori services, and to support Health New Zealand and DHBs with the commissioning of Māori health services.
- Strengthening DHBs' accountability for improving equitable health outcomes in their own populations and contributing to the efficiency and effectiveness of the

nationwide health and disability system. This would include more regional collaboration, under the guidance of Health New Zealand. The Review proposed a reduction in the number of DHBs from 20 to between 8 and 12, over a five-year period, as regional collaboration increased.

- A much greater focus on Māori health, updating relevant clauses in legislation, strengthening DHB-Iwi partnerships, requiring DHBs to improve equity of Māori health outcomes in their strategic and locality plans, and ensuring funding formulas better reflect unmet need.
- Localities and locality networks to deliver tailored, integrated primary and community services to geographically defined populations.

Ministers have agreed to the high-level direction identified, specifically: in order to improve equity of access and outcomes for all New Zealanders, to make changes to the health and disability system that:

- prioritise equity and improved performance for Māori health
- reduce fragmentation
- strengthen leadership and accountability
- increase the focus on population health, and
- tailor services to the way that people live their lives.

The impact analysis considers the structural changes to operational functions in the health system to support the government's overall objectives, for which legislation will be required.

Structural change is necessary to clarify roles and accountabilities, to ensure clear lines of control in the system, and to lay the foundation for more efficient planning and service provision that will lead to improved outcomes. This type of change alone will not be sufficient to achieve the policy goals of improved equity and an efficient system that provides person and whānau-centred care. Those goals are the focus of the wider reform programme.

2.2 What regulatory system(s) are already in place?

The proposals in this analysis affect the Health Systems and Institutions regulatory system. The purpose of that system is to ensure that health and disability services are effectively and efficiently provided to the public. It includes the governing legislation for the publicly-funded health and disability system and the institutions within it. Legislation is required to restructure the publicly-owned health system.

The regulatory system is narrowly focused on establishing the publicly-owned institutions, and does not intersect with other regulatory systems, except insofar as the institutions are bound by the administrative statutes, such as the Crown Entities Act. Other health regulatory systems, such as those governing the workforce and health products and markets will not be altered as part of the proposals in this analysis.

The wider government, local government and NGOs have a substantial interest in the operations of the publicly-owned health system. This is especially true in the case of public health, where local government has a large role, but the health system affects all of society. They have no role in the Systems and Institutions regulatory system per se, although local government members will often also be DHB board members.

2.3 What is the policy problem or opportunity?

Health system presenting problems

- Increasing demand for health services

New Zealand has an ageing population, with increasing morbidity from long-term conditions. Around a quarter of New Zealanders have multiple long-term conditions. Over the next 15 years, the New Zealand health system will face increasing demand from an aging population, continued growth in chronic conditions, greater health needs for Māori, Pacific and low socio-economic communities, workforce challenges and cost pressures. These and other factors will bring increased pressure on the already struggling health system, so it is important to act now and use the next 2-3 years to get the system operating in a more optimal state.

- Inequity for Māori

Māori life expectancy at birth is 7.2 years lower than that for non-Māori and non-Pacific. More than half of those premature deaths are potentially avoidable, compared with just under a quarter for non-Māori[2]. Māori have worse rates of access to services and poorer quality of care. They are less likely to be referred to specialist services, or prescribed effective medicines[3].

- Inequity for other groups

For Pacific people, life expectancy is 6.3 years lower. More than half of those premature deaths are potentially avoidable, compared with just under a quarter for non-Māori and non-Pacific. Disabled people also have inequitable outcomes, with only 50 percent rating their health as good, compared to 89 percent of the nondisabled population[4]. The Health and Disability System Review identified that physically disabled adults experience a higher prevalence of chronic diseases including arthritis, asthma, cardiovascular disease, diabetes, high blood pressure, high cholesterol and stroke'[5]

- Unwarranted variation in service availability and performance

This is particularly acute for Māori, who are more likely to wait longer than 3 months for a specialist appointment and more likely to not attend an appointment they do have[6]. Rates of unplanned admission, and unplanned readmission vary considerably across hospitals. Based on standardised intervention rates (that is, adjusted for ethnicity, age, sex, and deprivation) for the 2018/19 financial year, there is significant variation across key interventions, for example:

- There is a 3-fold variation in cataract intervention rates across DHBs, ranging between 17.4 and 51.5 per 10,000 people
- There is a 1.6-fold variation in Cardiac Surgery intervention rates across DHBs, ranging between 13.4 and 21.4 per 10,000 people

[2] HDSR final report, p 20

[3] See for example this 2019 systematic: review https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1057-4

[4] New Zealand General Social Survey self-rated general health status, 2016 , referenced in HDSR Interim report p 31

[5] HDSR Interim report p 130

[6] HDSR interim report p 185

- There is a 1.8-fold variation in major joints intervention rates across DHBs, ranging between 17.4 and 30.9 per 10,000 people
- There is a 6-fold variation in median waiting time for orthopaedics - the longest median waiting time is 133 days, and the shortest is 22 days.

- The system is not consumer-focused

Prioritisation, planning and service design does not account sufficiently for the needs and aspirations of people who use services and their whānau.

For example, technology has long been available allowing remote consultations, but they have been uncommon in spite of significant consumer interest and potential benefits. During 2020, in response to COVID-19 restrictions, remote and virtual primary care consultations became significantly more common, by necessity. Consumers expressed very high levels of satisfaction with remote consultations, only slightly lower than an in-person visit. Eighty-percent of people wanted telephone and 69 percent wanted video consultation in future.

- Lack of strategic planning and partnership

The health system operates in many respects as 20 discrete district-level systems, with duplication in many functions and limited collaboration. Collective approaches to planning and allocation of resources are the exception, not the norm, leading to a lack of whole-population focus and inefficiencies in procurement and commissioning.

- Persistent deficits

DHBs have persistent and increasing deficits. The overall DHB deficit was $120 million at the end of 2016/17 and, even after adjusting to remove one-off effects, $500 million at the end of 2019/20[7].

Underlying causes

- Māori are not involved in decision-making.

The Health and Disability System Review Panel undertook extensive engagement with Māori in preparing its report. A lack of Māori involvement in decision-making at all levels, from governance to clinical, to consumer was highlighted.

- The public are not meaningfully involved in decision-making.

Similarly, the Review found that public engagement was variable and has not led to improvements in services.

- The system emphasises services, rather than population health

Contracts are framed in terms of outputs rather than outcomes. Organisations will be funded according to the number of people seen, vaccinations given, and so forth. There are some services funded on an outcomes basis, notably Whānau Ora contracts, but they are not the norm, and inhibit flexibility and responsiveness to consumer needs.

[7] DHB financial reports, Ministry of Health https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/summary-financial-reports

- Multiple organisations, with varying capability and poor alignment.

There are 20 DHBs who differ considerably in size, and thus capability. They do not routinely plan services together or learn from each other's experience.

- Limited effective power to direct system activity from the centre

The complexity of the system means it has been difficult to make changes. In order to make a system wide service change, there is a need to negotiate with 20 DHBs and perhaps 30 PHOs. This means national programmes and priorities that can make a real difference to health outcomes are slow to implement, including bowel screening, mental health service improvements, and reduced cancer waiting times. Improving this variability is the key outcome of structural reform.

While there are extensive ministerial powers of direction, including through conditions on Crown Funding Agreements, they are either so detailed they are of limited usefulness, as with the Operational Policy Framework and Crown Funding Agreement, or Ministers have been reluctant to use them – there has only been one ministerial direction to an individual DHB.

2.4 What do stakeholders think about the problem?

We have relied on the consultation undertaken by the Health System Review, outlined in the Summary of Submissions available at https://systemreview.health.govt.nz/assets/HDSR-interim-report/31c03743ab/Summary-of-Submissions-Report-for-the-NZ-Health-and-Disability-System-Review.pdf

There were 646 submissions, 477 from individuals and 169 from organisations. About three-quarters of the individual submitters work in the health and disability systems, across a broad range of different occupations. Of the organisational submitters, about three-quarters were from an NGO or non-profit.

We have also relied on the analysis undertaken by the Waitangi Tribunal in its Hauora Inquiry, WAI 2575. The Inquiry, while ongoing, has provided much useful information to inform decisions. In particular, the outline of principles, which has already been adopted by the Ministry of Health for its primary care planning, and is proposed to be included in legislation, and the recommendation that a separate Māori Health Authority be established with commissioning, monitoring, and policy functions, have informed the options considered.

There is broad agreement with the problems as outlined above.

There has been engagement with selected sector and Māori stakeholders on the options considered in this Impact Assessment and key features of the health and disability system which will be required in any system operating model option, such as a greater population health needs assessments underpinning planning. The selected stakeholders include:

- Primary and community-based services representatives including the National Nursing Leadership Group, NZ College of Midwives, General Practice, community pharmacists, home care support providers, Platform Trust (representing

community mental health service providers), St John NZ, Federation of Primary Health, Home and Community Health Association, Plunket.
- Sector leaders including DHB Chief Executives and Chairs, GMs funding and planning, Chief Medical Officers, Health Quality and Safety Commission Board, Health and Disability Commissioner
- Medical specialists including orthopaedic and the Association of Salaried Medical Specialists, NZ Medical Association
- Māori stakeholders, including WAI2575 claimants, members from the Māori Expert Advisory Group to the Health and Disability System Review, Te Rōpū Whakakaupapa Urutā, Māori DHB Board Chairs, Tumu Whakarae (DHB Māori General Managers network), Tai Tokerau Māori Providers/Ngāti Hine.
- Other health entities, including the Ministry of Health, Health Quality and Safety Commission, Health Promotion Agency, Pharmac, ACC, Cancer Control Agency, Office of the Children's Commissioner.

2.5 What are the objectives sought in relation to the identified problem?

The policy objectives for the overall reform programme agreed by Cabinet are:

- to meaningfully give effect to the Te Tiriti relationship
- to improve equity of access and outcomes for all New Zealanders
- to increase the focus on population health
- to better tailor services to the way people live their lives
- to reduce fragmentation and improve cohesion, and
- to strengthen leadership and accountability

There are some tensions between the objectives, but not unresolvable ones. In particular, reducing fragmentation may imply greater national consistency. This has the potential to impede equity improvement and tailoring services – tailored services are by their nature not nationally consistent. However, these tensions can be managed through careful objective setting and monitoring. A focus on consistent outcomes, rather than services as such, will tend to promote equity, as in order to achieve the objective services will need to be tailored to particular populations' needs.

The objectives have different weight in different service settings. In primary and community care, tailoring of services is more important than consistency in order to increase access to and the impact of these services on maintaining wellbeing, and preventing ill health and managing chronic conditions. In the hospital setting, there is less need to tailor the services as such, although the patient experience should be tailored to particular needs.

For the structural reform, the key objectives are reducing fragmentation, strengthening leadership and accountability

Section 3: Option identification

3.1 What options are available to address the problem?

Opportunity for change

The problems identified above are not amenable to a simple solution. It will require the concerted effort of all system participants, over many years, to reach the goal of an integrated, responsive, efficient, and equitable health system. While this impact statement is focused on structural changes, the wider reform programme will also include changes to ways of working, planning cycles, funding models and other policies.

The intention of legislative reform is not to solve all these problems, but to establish a clear framework in which they can be, and are more likely to be, resolved. The system operating model – the way that system functions and roles are allocated – is the critical foundational layer for improvement. Choices about functions and organisations set the context in which all publicly-funded health services operate. They can impair the achievement of our goals for the system, or support them. At present, the system arrangements impair our ability to achieve those goals.

A redesigned system, with clear allocation of functions, is necessary to achieve the government's overall goals for the health system. A clearer, shared understanding of the specific responsibilities and accountabilities of each organisation is the essential prerequisite for working collectively to achieve better and more equitable health outcomes.

Structural change is an intermediate step that will support the overall reform programme. Appendix One sets out the intervention logic for structural reform, within the overall reform programme. In brief, the structural setup of the health system contributes to poor outcomes and variability

The identification of options for structural reform began with an assessment of the current functions in the health system, how these are discharged, and the effectiveness of each.

Core functions in the health system

The health system requires numerous functions to be fulfilled simultaneously. At a high-level, these include:

- policy and strategy functions (including legislation), to set direction for the system and provide ongoing policy development and support for Government priorities;
- regulatory (such as medicines regulation) and quasi-regulatory (such as commissioning guidelines) functions, through which a clear set of rules is enshrined in law and described in guidance to ensure the health system provides equitable access to safe and effective services and treatments, delivers value for money, protects public health, and supports system actors to innovate;
- funding functions, including securing and managing appropriations through the Budget process, determining the allocation of funding to health organisations, and setting the financial framework through which investment may be targeted and incentivised to particular ends;
- planning and commissioning functions, which provide a formal methodology to the planning, design, contracting and review of health services and technologies at all levels of the system, translating priorities and policy direction into the right mix and design of services to meet the needs of populations;

- service delivery functions, through which contracted services are provided to consumers and whānau;
- monitoring and oversight functions, including system-wide oversight and population health outcomes (stewardship), organisational oversight and performance (governance), service oversight and monitoring of delivery (including as part of commissioning), and how accountability works coherently;
- improvement and innovation functions, including approaches to improving existing services and functions by identifying issues with equity, access and quality; ensuring appropriate oversight and putting in place support and targeted interventions; and investing in research and development to test new models, harness new technologies and support rapid adoption and dissemination.
-

These functions can all be identified in the current health system. However, as the Review argued, these functions are not always allocated to organisations in a strategic or logical manner. Some overlap or duplicate; others are split across multiple entities. Over time, a complex mix of national, regional and local constructs have further complicated the model. The objective of reform is to develop a simpler, more cohesive and more coherent allocation of functions across organisations in the future.

An analysis of these functions identified a number of critical design choices that would drive the different options for the system structure.

Key design choices

There are four key choices to make about system structure and the design of core operational functions. These choices reflect greater or lesser central control, creating a trade-off between consistency, quality, local control and responsiveness.

The key choices are:

Sub-national organisations: are there sub-national health organisations, and if so, what degree of independence do they have from a national body? There are likely to be elements of the health system which are practically best managed on a regional or local basis, but there is choice regarding the status and accountability of sub-national bodies who discharge these functions.

Planning and commissioning hospital services: at what level should planning and commissioning of hospital and specialist health services take place? While the terms are used in various ways, it is helpful to distinguish between planning as the overall decision-making about required outcomes and services, and commissioning as the process of procuring services. Commissioning is distinct from simple purchasing and implies an ongoing relationship, including service design and development. Planning and commissioning may be undertaken by the same organisation, or by separate entities.

Providing hospital services: Is the provision of hospital services centrally managed, or are individual hospitals operated relatively independently? The government has ruled out a move away from public provision of hospitals.

Planning and commissioning primary and community care: Is primary and community care commissioned by the same organisation/at the same level as hospital care, or by separate organisations?

An assessment of the different potential approaches under these key choices has led to the development of four overarching models which form the basis of the core structural options in this analysis.

Option One – A national system

This option has a single national operational entity: Health New Zealand. Local, district and regional activity is managed through Health New Zealand internal divisions, rather than through separate entities. This is the preferred option.

Under this option, Health New Zealand has an internal structural separation with hospital and specialist services delivered through one arm, and primary and community-based services commissioned through another arm:

- Health New Zealand operates all public hospitals as part of a coordinated national approach, with decisions on allocation and distribution of services made nationally and services delivered through regional networks.
- Regional Health New Zealand commissioners are responsible for the commissioning of primary and community health services, which are organised and delivered through district and locality networks of service providers, with strong community input into service design.

This option strongly supports national consistency and improved service quality. There is a risk that some local flexibility may be lost, especially in primary and community care. This effect is mitigated by organising primary and community care into localities, with strong requirements for community involvement. Locality arrangements will allow for tailoring services to meet local needs and preferences.

Option Two – National hospital network, independent primary and community care

This option has Health New Zealand as the single operational entity for hospital and specialist services, which operates nationally, through regional offices. Hospitals are planned, managed and delivered through Health New Zealand, as with option one.

Primary and community health services are commissioned by 8-12 separate and autonomous sub-national organisations, which would have a similar legal status to current DHBs but operate under the guidance of Health New Zealand.

The key difference between this option and the first is the separate organisations for planning and commissioning primary and community care.

This option strongly supports consistency and improved service quality in hospitals. For primary and community care, it supports local solutions and service design to meet the needs and preferences of the local population, but would lose some consistency and quality improvement benefits.

Option Three – Reformed DHBs

This is the Health and Disability System Review recommendation.

Health New Zealand leads the operational aspects of the health system. There are 8-12 reformed DHBs that plan and deliver hospital services and commission primary and community services within their districts. The DHBs operate under the oversight of

Health New Zealand and have fully appointed boards. They are funded by Health New Zealand and performance is monitored against those funding agreements.

This option supports local decision-making and consolidates some current DHB functions into a smaller number of entities. However, it retains the underlying

weaknesses of the current system with respect to fragmentation and variability, although mitigated to some extent by Health New Zealand oversight.

Option Four – Regional health organisations

Under this option there are four autonomous regional health organisations that plan and commission both hospital and primary and community services within their regions. Health New Zealand is the overall operational lead.

While similar to option three, the regional health organisations under this option cover a wider span of the population and would be more independent – Health New Zealand monitors their performance, and provides system-wide services, such as IT services, but does not fund them.

This option is a balance between aggregation and local decision-making. It has some benefits, but also some drawbacks, of either approach.

Key choices as described through four options:

Key choice	Status quo	National system	National hospital network	Reformed DHBs	Regional health organisations
Sub-national organisations	District Health Boards	Part of Health NZ	8-12 Separate organisations, but responsible to Health NZ	8-12 Separate organisations, but responsible to Health NZ	Four Regional organisations, work with Health NZ, responsible to Minister
Planning and commissioning hospital services	District Health Boards	Health NZ plans and commission	Health NZ plans and commissions	Health NZ plans, sub-national organisation commissions	Health NZ plans, sub-national organisation commissions
Provision of hospital services	District Health Boards	Health NZ	Health NZ	Sub-national organisations	Sub-national organisations
Planning and commissioning primary and community care	District Health Boards, via PHOs	Health NZ, through locality commissioners	Sub-national organisations	Sub-national organisations	Sub-national organisations

3.2 What criteria, in addition to monetary costs and benefits have been used to assess the likely impacts of the options under consideration?

The assessment criteria have been developed from the identified problems of fragmentation, unwarranted variation in performance, and unclear accountability. They are focused on what structural change can achieve in particular, rather than on the overall reform goals for which wider policies may also be employed.

- Enhances Te Tiriti relationship

  To what extent does the option support genuine Māori partnership and control over design and delivery of health services for Māori?

- Nationally consistent decision-making, with resources allocated on a whole-system basis

  To what extent does the option support service planning on a national basis, avoiding regional variability in service availability and access?

- Ability to make changes in services rapidly

  To what extent does the option support rapid changes in services, for example rolling out new services such as the bowel screening programme, or enhancements to existing services, such as reducing cancer wait times, or responding to significant public health emergencies, such as a pandemic

- Consistent measurement and reporting

  To what extent does the option support consistent data standards and collection, and comparable reporting, allowing differences in performance to be assessed?

- Local flexibility

  To what extent does the option support local preferences and needs being accommodated in service design?

- Clear accountability, including Ministerial intervention ability

  To what extent does the option provide for clear accountabilities, avoid mixed accountability and respond to direction?

- Practicality – implementation issues, time, cost

  How practical is the option to implement, What are the likely time and financial costs?

There is a potential tension between national consistency and local flexibility. However, these criteria do not require a trade-off as such. They have different weights at the hospital and at the primary and community level. For hospital level services, consistency is likely to be more important than tailored services, while for primary and community services, tailoring of services (but not outcomes) is likely to be more important than consistency of services.

3.3 What other options have been ruled out of scope, or not considered, and why?

The parameters set by Ministers have ruled out consideration of a change in overall model, for example moving to an insurance-based system or moving away from public provision.

Similarly, the Government's manifesto commits to:

- a reduction in the number of DHBs, hence excluding options which would increase the number of separate sub-national organisations, and
- establishing a Māori Health Authority, in consultation with Māori, and a Public Health Agency (although not within the scope of this analysis).

Cabinet has in addition noted the Minister's intention to establish Health New Zealand as the operational leader of the system.

Section 4: Impact Analysis

Marginal impact: How does each of the options identified in section 3.1 compare with taking no action under each of the criteria set out in section 3.2?

	No action	Option One: National system, with separate branches for hospital services and primary/community care	Option Two: National Hospital network, with independent primary and community care organisations	Option Three: Reformed DHBs, with oversight from Health NZ	Option Four: Regional Health Organisations with oversight from Health NZ
Enhances Te Tiriti relationship Do structures support effective relationships?	**0**	+ Clear national level relationship for discussions to happen at the appropriate level of authority – for mana to talk to mana	+ Clear national level relationship for hospital services; local relationships for primary and community services	- Multiple relationships with addition of new national organisation and potential conflicts between national and local.	+ Fewer organisations means fewer relationships to maintain.
Nationally consistent decision-making Do structures support national planning and resource allocation?	**0**	++ Single organisation means consistency can be managed through internal controls	+ Clear for hospital services. Potential for variation in primary and community care	+ Improved by Health NZ guidance, but multiple organisations likely to mean significant variation	+ Improved by Health NZ guidance, and variation reduced as smaller number of agencies and potential approaches.
Consistent reporting Do structures support consistent data standards and collection?	**0**	++ Single organisation means consistency can be managed through internal controls	+ Clear for hospital services. Potential for variation in primary and community care	**0** Possible marginal improvement, due to smaller number of possible different approaches.	+ Improved by Health NZ guidance, but multiple organisations likely to mean significant variation
Clear accountability Do structures support clear and unmixed accountability?	**0**	++ Single agency standard	+ Clear for hospital services, some risk of mixed accountability for primary and community.	**0** Many agencies to monitor complicates accountability. Risk of mixed accountabilities.	+ Fewer agencies simplifies accountability. Risk of mixed accountabilities

Local flexibility Do structures support local preferences	**0**	**0** National system tends to act against local flexibility.	**+** Local organisations positioned to take best advantage of local opportunities.	**0**	**+** Regional agencies are large enough to be able to create efficiencies and exploit opportunities.
Implementation issues	**0**	**--** Larger degree of change – every organisation changes, but functions incorporated into one	**-** Smaller degree of structural change – amalgamation	**-** Smaller degree of structural change – amalgamation	**--** Largest degree of change – every organisation changes and five new established
Overall assessment	0	**++ preferred**	**+ second best**	**-**	**+**

Key:

++ much better than doing nothing/the status quo

+ better than doing nothing/the status quo

0 about the same as doing nothing/the status quo

- worse than doing nothing/the status quo

- - much worse than doing nothing/the status quo

Section 5: Conclusions

5.1 What option, or combination of options is likely to best address the problem, meet the policy objectives and deliver the highest net benefits?

The preferred option for Health New Zealand is Option One: a single operational entity which owns and operates public hospitals, and commissions primary and community care, organised into locality networks of service providers.

With regard to the formal assessment criteria:

- This is the most effective option for **enhancing the Te Tiriti relationship** – it establishes a single entity for Māori to engage with and allows for consistent expectations on partnership to be embedded and monitored through all internal divisions.

- This option most strongly supports **nationally consistent decision-making** – there is only one organisation formally making decisions, albeit with delegation of decisions to the appropriate level within Health New Zealand, so greater consistency is to be expected. Option 2 is likely to be second-best on this criterion, as Health New Zealand would directly manage the national hospital network, assuring consistency, with variation occurring at the local level, where some variation is desirable.

- This option strongly supports **consistent reporting** by allowing clear and transparent measurement, using consistently collected and analysed data, managed by internal business processes. Options 2 and 4 would likely also be an improvement on the status quo as structures are simpler, making it easier to implement consistent data standards and performance reporting, but because the sub-national organisations are independent, data variation is still likely.

- This option provides **clear accountability** through establishing a single organisation with clear control over, and accountability for, clinical and financial management. Because reporting will be nationally consistent, monitoring will be more effective, with consistent data and analysis.

- A national system could have a tendency to reduce **local flexibility.** However, the design of Health New Zealand will be focused on distributing authority and ensuring appropriate internal delegations so that decisions are taken as close as possible to communities. This will be further managed in implementation through the locality approach, with mandatory consumer involvement in planning of primary and community services. Other options could also support local flexibility, but this benefit is outweighed by the poorer performance against the other criteria.

- This option will be challenging to **implement.** It involves a large amount of change to the system structures. Options 2 and 3 are likely to be relatively easier to implement, as the required modifications are likely to be achievable through amalgamating existing DHBs, rather than wholesale change. However, there is no simple or easily achievable approach that delivers the Government's objectives.

Benefits

It is difficult to estimate the total expected benefit of the changes, as they are expected to improve performance across the entire system. We have worked through an example of how the preferred option could be expected to lead to improvements, based on New Zealand data.

Reduction in variation through single operational entity

At present, there are twenty DHBs with differing capability and priorities. There is unacceptable variation in waiting times and intervention rates. The rollout of new programmes, or national improvements, requires negotiation with individual DHBs, and often primary health organisations: new services such as bowel screening take a long time to establish and are inconsistent across the country.

It is expected that these issues will be addressed with the simplification of the system. A nationally-managed hospital network will enable variation to be rapidly identified and addressed.

Reduction in variation for unplanned admissions and length of stay

There is significant variation across hospitals with respect to unplanned admissions, unplanned readmissions, and lengths of stay. If this variation could be reduced, there would be significant benefits in terms of cost growth reduction from reduction in growth of bed days and staffing requirements.

At present, unplanned admissions range from just under 100 per 1,000 population at the lowest, to 150 per 1,000 at the highest, after standardising for age and ethnicity. The variation in unplanned readmissions, standardised for age and ethnicity, range from 6.7 of discharges to 9.4 percent. Average length of stay also varies considerably between hospitals, ranging, for planned care, from 1 day to 2.5 days, and for unplanned care from 1.5 to 2.75 days.

There are two large factors influencing this variation: clinical and administrative practice within the hospitals, and the effectiveness of primary and community care. The situation is complex, and there are multiple risk factors, but it is most likely that an unplanned readmission within seven days is the result of a treatment complication, while an admission between 8-and 28 days after discharge is more likely to be for a co-morbidity or potentially manageable in primary care[8].

At present, there is limited national control over clinical and administrative practice in hospitals, with each DHB making its own decisions, albeit with national guidance for some elements through the professional colleges and the Health Quality and Safety Commission. The effectiveness of primary and community care, and the relationships between primary and community care and secondary care also have considerable influence over rates of hospital admission and duration of stay. For example, infection is a

[8] See for example, a case study from 2018 of a Sydney hospital https://bmcmedinformdecismak.biomedcentral.com/articles/10.1186/s12911-017-0580-8

frequent cause of readmission, but can often be managed in primary care, or even in home care.

If this variation can be reduced to the current lower quartile, we estimate the cost growth reduction at $3.865 billion over ten years. That estimate is based on extrapolation from 2018/19 (the last full year not impacted by COVID-19). The figure should not be treated as a prediction, but rather an indicative estimate for the purpose of illustrating a potential benefit. This would represent a potential reduction in cost pressure on hospital services, rather than a realisable or cashable saving.

There is a medium degree of confidence in the estimate of cost growth reduction. It is a conservative estimate, based on bringing performance up to 75 percent of the top performer, rather than every hospital performing at the level of the highest performer. There is a clear intervention logic flowing from the ability to impose internal management controls to make change rather than inter-agency negotiation. There are multiple factors influencing the figures, so the full potential benefit may not be achieved. However, even if only a quarter of the gain is realised, that represents a considerable saving that outweighs the estimated costs of change.

That estimate only accounts for hospital costs. There is of course a significant potential benefit to patients if unplanned hospital admissions can be reduced, but such benefits (e.g. QALY gain) have not been estimated.

Component	21/22	22/23	23/24	24/25	Total
Transition Unit	25.960	10.434	0	0	36.394
Health New Zealand establishment entity	18.530	42.779	45.975	37.264	144.548
TOTAL ($m)	44.490	53.213	45.975	37.264	180.942

Costs of change

The total cost of making the system changes proposed is currently estimated at $180 million over four years: about 0.25 percent of Vote Health over that period. That cost is for the establishment entities, including the Transition Unit, and the establishment unit for Health New Zealand. It does not include cost estimates for the Māori Health Authority.

After the initial design phase, the cost peaks in 2022/23, which is the high point of Health New Zealand establishment costs. After 2024/25, the permanent structures are expected to be in place. The ongoing cost of operating Health New Zealand is not included in this analysis, as it will replace existing structures and is assumed the costs will be met within the existing amount for DHB administration and Ministry of Health operational functions.

5.2 Summary table of costs and benefits of the preferred approach			
Affected parties *(identify)*	**Comment**: *nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, compliance rates), risks*	**Impact** *$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts*	**Evidence certainty** *(High, medium or low)*
Additional costs of proposed approach compared to taking no action			
Regulated parties	Costs of establishing and operating new organisations. One-off costs of establishment, system design, and capability building. Ongoing costs of operation for Māori Health Authority, Iwi Māori Partnership Boards. Based on figures developed by Health Transition Unit for Budget 2021.	$180 million over four years	Medium. Further detailed design work may identify some additional investments to enhance functions or capabilities
Regulators			
Wider government			
Other parties			
Total Monetised Cost		$180 million	High
Non-monetised costs	Impact on workforce of change process – no immediate reduction in numbers anticipated	*Low*	
Expected benefits of proposed approach compared to taking no action			
Regulated parties	Reduction in cost pressure on hospitals through reduction in unwarranted variation in unplanned admissions, unplanned readmissions, and length of stay. Based on extrapolation from current figures. Assumes performance of all hospitals can be brought to current upper quartile, through internal management controls, reaching a peak in the third year. Analysis detailed in Appendix Two	$3,865 million over 10 years	Medium

Regulators			
Wider government			
Other parties			
Total Monetised Benefit			
Non-monetised benefits	Reduction in unnecessary duplication of administrative and clinical functions	*Medium*	

5.3 What other impacts is this approach likely to have?

There are likely impacts on improved quality of care through the networked hospital approach allowing variation of all kinds to be identified and addressed. This will likely have impacts on life expectancy and health expectancy. These impacts have not been quantified.

Section 6: Implementation and operation

6.1 How will the new arrangements work in practice?

The structural change proposed will require legislation. It is intended to introduce a Health Reform Bill into the House in September 2021 and have it passed by April 2022, coming into force on 1 July 2022, to align with the government financial year.

The legislation will establish Health New Zealand as a Crown entity, disestablish DHBs and transfer DHB assets, liabilities and employees, to Health New Zealand.

Once established, the new structure will be operated according to the standard Crown Entity operating arrangements, with the Ministry of Health as the monitoring department.

There will be three months lead time once legislation is passed, before it comes into effect. While the legislation will make a substantial change to the structure of the publicly-owned health sector, the only immediate effect for staff will be a change of organisation – their job, and conditions, will initially remain the same.

In the interim, following Cabinet decisions on structural reform, it is intended to set up interim entities to plan and prepare for transition. These would be departmental agencies, established by Order in Council. There would be a committee for each interim entity, established using the powers in section 11 of the New Zealand Public Health and Disability Act, to undertake governance functions.

The interim entities are intended to be established in August 2021, following Cabinet decisions in March 2021. This will allow sufficient time to recruit members to the governance boards, following usual government processes.

6.2 What are the implementation risks?

The implementation risks are primarily related to disestablishment of DHBs. There will be impacts on the workforce, and existing entities, that will present a risk to system performance in the transition period.

With any change programme, there is a significant potential impact on the existing workforce. While no reduction in numbers is planned, and the existing workforce is expected to continue in their existing roles initially, people do respond to change in different ways and uncertainty may lead to higher absenteeism. This may have an impact on the public if it leads to delayed appointments. We do not anticipate a significant public impact – the health workforce is dedicated and we have received extremely positive feedback from early engagement, so we anticipate a high level of support will mitigate adverse effects of a change programme. Moreover, the potential adverse effects will be mitigated through a comprehensive change management programme, currently in development. This will be supported by a sector communications plan that will make clear the aims and timeframes of work. Engagement with sector stakeholders and unions is planned.

During the interim period between announcements and statutory change, district health boards will remain the legal entities responsible for planning and funding health services for their districts. There is a risk they could make decisions that do not align with the reform

proposals. We propose to mitigate the risk by using the existing ministerial levers, and by establishing interim versions of the new entities.

We intend to encourage and assist district health boards to align decision-making with new national priorities. The interim entities will work with district health boards to help align their activity with the reform goals.

The existing ministerial levers will also be used to align DHB performance with reform aims. Initially, we anticipate a supplementary letter of expectation, but there is potential to issue ministerial directions. If necessary, members can be removed from boards for misconduct or neglect of duties, or a board can be replaced with commissioners, where the minister is seriously dissatisfied with their performance.

Section 7: Monitoring, evaluation and review

7.1 How will the impact of the new arrangements be monitored?

The actual impacts of the change proposed will be measured through:

- the monitoring and accountability arrangements, which will be clearer and simpler in the reformed system, with clear lines of sight and intervention mechanisms available, and
- clinical and administrative data, which will be consistently collected and analysed, with outputs being made available routinely to system agencies.

Extensive clinical and financial performance data is already routinely collected, and have informed this impact assessment. The data are at present not routinely analysed or made available to decision-makers in a useful way. With the establishment of Health New Zealand as the primary service delivery and commissioning organisation, we anticipate more consistent and useful data and analytics being routinely available to the Ministry, and Health New Zealand itself. This will enable better identification of service gaps and improved planning and provision of services. It will also be an important tool to identify inequity and improve equity through robust population data.

With the establishment of Health New Zealand as a Crown Entity, it will be subject to the standard monitoring and accountability arrangements, such as statements of intent, statements of performance expectations, etc. The Māori Health Authority will, in addition, monitor other system entities, including the Ministry, with respect to Māori health performance. This will provide clear and public information to judge and direct performance.

Monitoring arrangements will function as follows:

- At system-level, the Ministry will monitor and report to the Minister of Health on agreed national health outcomes and system objectives, including clinical and financial performance. It will monitor the overall health of the system, with a particular focus on equity, with the aim of identifying emerging issues and facilitating the appropriate response through other organisations. The Ministry will also be responsible for monitoring the performance of Health New Zealand and other Crown health entities.

- The Māori Health Authority is expected to have both system-level and service-level monitoring roles. At the aggregate system level, it will be accountable directly to the Minister of Health for the oversight of national population health outcomes for Māori and for the delivery of national policy objectives relating to Māori, partnering with the Ministry where relevant to ensure alignment. This will entail monitoring the performance of Health NZ nationally in respect of Māori health outcomes.

- Health New Zealand will monitor the operational performance of the publicly-funded health system. It will be accountable to the Minister via the Ministry for the aggregate operational and financial performance of the health system, and for the delivery of quality and equitable health and enabling services as mandated by the NZ Health Plan. It will be accountable to the Minister, via the Māori Health Authority for delivering on improved population health outcomes for Māori. Health

NZ will be responsible for monitoring all system commissioning and service delivery by regional and locality entities.

- The Health Quality and Safety Commission will continue to monitor quality of care, including an enhanced focus on patient-reported outcomes and experience of care, providing analysis and insight to support other national organisations to conduct their functions. The Health Quality and Safety Commission will also convene cross-system sharing of intelligence to help identify and respond to issues with quality. It will also have an enhanced role as the centre of expertise for consumer engagement.

7.2 When and how will the new arrangements be reviewed?

The Ministry of Health will be responsible for reviewing the arrangements. This will be a routine part of the Ministry's stewardship function, in partnership with the Māori Health Authority for hauora Māori. The establishment of Health New Zealand as a single operational entity allows the precise configuration of services and administrative arrangements to be modified relatively easily if evidence of a problem emerges.

In addition to the routine stewardship, it is intended that legislation require a formal review of the legislation after five years, in accordance with usual practice. Early results should be available within that time, in particular figures on changes in unwarranted variation, such as the admission and length of stay figures. The review will provide an opportunity to ensure system arrangements are working as intended and amend planning and accountability documents or legislation, if required.