Regulatory Impact Statement

Improving the Health System: Legislative amendments to support more collaborative planning and purchasing of administration and support services by District Health Boards.

Agency Disclosure Statement

This Regulatory Impact Statement (RIS) has been prepared by the Ministry of Health (the Ministry) and accompanies 'Improving the Health System: Legislative amendments to support more collaborative planning and purchasing of administration and support services by District Health Boards'.

The RIS provides the Ministry's analysis of the legislative options considered to give effect to Cabinet's recent decisions relating to: a) collaborative planning of health and disability services;[1] b) faster movement towards DHBs sharing administration, support and procurement.[2]

The Ministerial Review Group (MRG) report highlighted the ongoing challenge facing the health and disability system of providing high quality care and disability support services that are affordable in a tight funding environment. The Ministerial Review Group (MRG) report recommended that changes are needed to address the lack of collaboration across the health system, and to speed up the process of removing barriers and strengthening incentives for DHBs to make collective decisions that better support the long-term clinical and financial sustainability of the health and disability system in New Zealand.

In response to the MRG report, Cabinet agreed [CAB Min (09) 37/13-15 refers] to pursue appropriate legislative arrangements to support:

- "a requirement for DHBs to develop regional service plans, which are fully costed and conform to planning parameters set by the Minister of Health, and for district annual plans (DAPs) to be consistent with regional plans";
- "implementation of an arbitration power over DHB disputes in relation to regional planning, and possibly an approval power over regional service plans".

Cabinet also noted that:

- "it is likely that legislative change, through an appropriate amendment to the New Zealand Public Health and Disability Act 2000, would be required to mandate a national approach to administration and support services (and collective procurement)".

[1] **"Health and disability services"** refers to all publicly-funded personal and public health and disability support services, including (but not limited to) primary care services, acute and elective services, disability support services, public health services, and specialist mental health services.

[2] **"Administration, support and procurement services"** relate to services that are not directly involved in the delivery of patient care or support of people with disabilities. They are functions that are vital to care and support, but are not the core roles of Health and Disability Support planners, funders, and service providers. The functions include, but are not limited to:

- Procurement of non-clinical supplies (cars, equipment, stationery, etc) and clinical supplies (medical devices may be included to some extent depending on Cabinet decisions). May include part or all of the entire supply chain, from price negotiation to warehousing and distribution.
- Finance (including management of payment to, and on behalf of, the sector)
- Human resources (including payroll)
- Clerical
- Facilities management, engineering, and maintenance
- Information systems and technology.

In addition, Cabinet agreed "that steps should be taken to make the District Health Board (DHB) model work better in the first instance, rather than undertaking wider structural reform at this time". This decision has been a key parameter limiting the options covered in this RIS.

The options in the Cabinet paper propose amendments to existing legislation and will not impose additional costs on businesses, impair private property rights, market competition, or incentives for innovation, nor override fundamental common law principles.

Options have been considered against the following criteria:

- Appropriateness of legal clauses to give effect to Government objectives (guided by Ministry of Health and central agency lawyers; Crown Law advice obtained during the MRG process; and independent legal advice).
- Consistency with relevant law (e.g. the Crown Entities Act 2004, Public Finance Act 1989, Commerce Act 1986).
- Sufficient ability and flexibility to adopt appropriate policy mechanisms to support Government objectives and to ensure legislative options do not result in unintended consequences or limit the Government's ability to develop solutions to address the identified non-legislative barriers.
- The ability to change DHB and Ministry practices in order to secure the clinical and financial sustainability of the health sector and to ensure the best use of resources (physical, financial and human) across district, regional and national boundaries.

The net impact of improved collective decision-making in terms of the population as a whole is expected to be positive due to improved sustainability and value for money, and enabling resources to be invested in improving the quality of front-line services.

The legislative options in the Cabinet paper are part of a suite of measures to improve the financial and clinical sustainability of the health system. Three of the four papers under the heading 'Improving the Health System: Further Elements' have already been considered by Cabinet.

In line with the Minister of Health's expectations on timeframes for legislative and policy change, further work on funding and accountability arrangements is being conducted in parallel. This is a key dependency for the success of this work and will help to address the non-legislative barriers to more effective decision-making at national, regional and district levels. Further work is also being undertaken to provide advice on appropriate planning, funding and accountability arrangements for services at a national level.

Margie Apa

Transition Director **20 January 2010**

Status quo and problem definition

1. The New Zealand Public Health and Disability Act 2000 (the NZPHD Act) has created a semi-devolved system where most health and disability services are planned, funded and delivered at a district level. In addition, most administration, support and procurement services are also planned and provided or purchased at a district level.
2. Given the challenges facing the sustainability of the health system (as outlined in the MRG report and subsequent Cabinet decisions [CAB Min (09) 37/13-15 refers]), many important decisions will need to be made across DHB boundaries in the future to ensure the best use of scarce physical, financial and human resources.
3. When the current DHB model was introduced in 2000, the intention was that DHBs would collaborate and the Minister of Health would be able to use accountability arrangements and policy settings to reinforce the importance of collaboration. DHBs have, in some circumstances, begun cooperating at a regional level on specific aspects of: a) health and disability service planning and delivery; and b) administration, support and procurement services. For example, Canterbury and West Coast DHBs have moved to shared clinical rosters for some specialties. Such cooperation can improve quality of care, reduce service vulnerability and improve cost-effectiveness (by reducing the transaction costs of DHBs conducting their own individual processes).
4. However, it has become increasingly clear that there are barriers preventing DHBs from making genuinely collective decisions, consistently and in a timely manner, including a set of legislative barriers. In addition, there are legislative barriers limiting the ability of the Minister to require and direct collaboration by DHBs. As a result, there can be a lack of coordination in service planning, purchasing and delivery across the system, which can create variability in access to services between districts and within regions. In addition, decision-making processes and structures are often unclear, and do not always provide for a system-wide, cross-DHB view. This can create inefficiencies and fragmentation of services in the short-term as well as jeopardising the long-term clinical and financial sustainability of the health and disability system.
5. It is the Ministry's view that the Act encourages an emphasis on local accountability and that this is consistent with the intention of the previous reforms. As such, amendments to the NZPHD Act are required to help ensure that DHBs collaborate to give effect to a better balance of district, regional and national priorities in decision-making processes.

Overview of legislative barriers to greater collaboration

Legislative Barriers	Explanation
1. DHBs' objectives and functions (as defined in the NZPHD Act) do not adequately emphasise collaboration.	The NZPHD Act, as it currently stands, does not include, as an explicit objective (Section 22) or function (Section 23) of DHBs, either: a) the collaborative planning and delivery of health and disability services; or b) the collaborative sharing of administration, support and procurement services.
2. Lack of legal requirement for DHBs to: a) collaboratively plan and deliver health and disability services; and b) to share	There is no clear legal obligation within the NZPHD Act for DHBs to collaborate in respect of service planning or to share administration, support and procurement services to ensure the optimal use of resources across district, regional and national levels. DHBs have, in some circumstances, begun cooperating with the development of regional plans for some specific services. However,

administration, support and procurement services.	this has been ad hoc and is wholly reliant on the willing participation of the parties; progress can be (and has been) obstructed when there are complex issues to resolve that adversely affect one DHB, its staff or local population (even if the proposed outcome is in the interests of the broader population and results in the best outcome for resource utilisation).
3. Absence of Ministerial authority to direct DHBs on how administration and support and procurement services should be purchased.	In establishing DHBs as autonomous bodies, and in focusing their responsibilities predominantly on local priorities, the NZPHD Act has led to DHBs operating as largely independent, inward-looking corporate entities. As described in the MRG report, this has led to the widespread duplication of functions and a lack of coordination across the system.
4. Weak powers of Ministerial arbitration to resolve disputes between DHBs	As noted above, recent attempts at collaboration by DHBs have been inhibited by tensions between district and regional priorities. The Minister of Health currently has only a limited mandate to intervene in disputes to resolve matters thwarting closer collaboration between DHBs. The NZPHD Act currently allows for regulations to be made to prescribe rules by which differences or disputes can be mediated or arbitrated. The rules can provide for the selection of persons to undertake the mediation or arbitration function. However, they currently allow for DHBs and others to **voluntarily opt out** from participating in a dispute resolution process (in effect, maintaining service arrangements that are not in the broader interests of the population).
5. Absence of governance structures to support regional collaboration	The NZPHD Act constrains the ability of the Minister to appoint elected members of one DHB Board to other DHB Boards. The NZPHD Act also constrains the ability of the Minister to approve the establishment of new Board Committees. These may present potential barriers to DHBs adopting a collaborative perspective.

Non-legislative barriers to regional collaboration

6. Although non-legislative barriers are not the focus of this RIS, there are a number of non-legislative factors which currently do not provide adequate incentives for DHBs to act in the broader interests of the health and disability system, most notably the way that the funding and accountability mechanisms can reinforce a focus on district priorities at the expense of regional or national priorities.

7. In addition to the legislative options set out in this RIS, officials are developing advice on potential funding and accountability mechanisms which would provide appropriate incentives to achieve the Government’s objectives. Therefore, the legislative options outlined in this RIS are sufficiently permissive to enable a range of specific policy changes to be implemented in order to support and incentivise both better planning of services and greater sharing of administration, support and procurement services. Further work is also being undertaken to provide advice on appropriate planning, funding and accountability arrangements for services at a national level.

8. Legislative and non-legislative changes are necessary, and undertaking legislative change without addressing the non-legislative barriers (and vice-versa) would not be sufficient to achieve the objectives outlined in CAB Min (09) 37/13-15.

Objectives

9. The intent of the proposals discussed in this paper is to amend the NZPHD Act to be more permissive and provide the legislative environment that will enable DHBs to collaborate more effectively. These changes are necessary, but not sufficient, to achieve Government's objectives.
10. The proposed amendments aim to remove legislative barriers to DHBs progressing further and faster in order to make better use of scarce resources and ensure improved sustainability over time. Where the Cabinet paper proposes a preferred option, this has been noted in the RIS.

Regulatory impact analysis

11. The following sections present an analysis of the legislative options to establish:
    1. A clear requirement for DHBs to collaborate on:
        a. Health and disability service planning and delivery; and
        b. Shared administration, support and procurement services.
    2. Ministerial authority to require DHBs to act collaboratively in health and disability service planning.
    3. Ministerial authority to:
        a. direct DHBs to share administration, support and procurement services and
        b. direct DHBs as to *how* to obtain administration, support and procurement services.
    4. Enhanced Ministerial authority to resolve disputes between DHBs.
    5. Ministerial authority to establish more efficient governance structures to support collaboration and approve the establishment of new Board Committees.

Proposal 1: Legislative requirement for collaboration to be an explicit objective and function of DHBs

12. DHBs' objectives and functions, as currently defined in the NZPHD Act, do not explicitly require collaborative planning and delivery of health services or explicitly require collaborative provision of administration, support and procurement services. Amending Sections 22 (Objectives of DHBs) and 23 (Functions of DHBs) of the NZPHD Act to more explicitly include collaborative planning and provision (with respect to both health and disability services and administration, support and procurement services) will establish acting collaboratively as a core component of DHBs' "business as usual" activities.
13. As sections 22 and 23 already exist to define DHB objectives and functions, amending these sections is the best option to establish collaboration as an objective and function of DHBs. As such, no other legislative options have been assessed; these have been presented as recommendations 3 and 4 in the Cabinet paper.

Proposal 2: Requirement for DHBs to plan appropriately at district, regional or national levels

14. Sections 38 and 39 of the NZPHD Act require DHBs to produce District Strategic Plans (DSPs) and District Annual Plans (DAPs), respectively. DHBs are then held accountable for the implementation of these plans. These requirements have established an inward-looking (i.e. district-focused) approach to planning and accountability. There is no requirement for DHBs to collaborate on, or contribute to, plans for services that are most effectively and efficiently planned, funded and delivered through collaboration with other DHBs (including administration, support and procurement services). That is, there is no explicit legislative imperative to ensure that DHBs' planning and purchasing decisions are driven by a view that balances national, regional and district priorities. Combined with the consequent district-focused accountability, this means that collaboration remains vulnerable to the interests of individual DHBs.

15. Cabinet's decision to 'pursue appropriate legislative arrangements to support a requirement for DHBs to develop regional service plans, which are fully costed and conform to planning parameters set by the Minister of Health, and for district annual plans to be consistent with regional plans' could be realised by either:

    - **Option one:** amending the NZPHD Act to require DHBs to collaborate in producing Regional Service Plans (RSPs)[3] in addition to District Annual Plans and District Strategic Plans
    - **Option two:** amending the NZPHD Act to describe the **functions** of an effective planning, decision-making and accountability framework, and to enable the appropriate **form** of that framework to be determined by the Minister through regulation (that is, specify requirements relating to the form, content and process of planning and accountability documents in secondary, rather than primary, legislation).

16. Under both options, the plans would be subject to Ministerial approval, in the same way that the Minister currently approves DAPs and DSPs, to ensure national consistency and prudent use of public resources. This approval acts as the key accountability mechanism as DHBs would then be held accountable for delivering on the plans.

17. The new NZPHD Act will set out the basic framework for planning requirements, saying that:

    - Each DHB must prepare or contribute to a plan or plans that consider the national, regional and district needs of the community.
    - In preparing the plan or plans, DHBs must comply with any regulations or written notice by the Minister setting out the required format and/or content of the plans and/or process requirements (including consultation with public or other DHBs) required in preparing the plans, etc.
    - Functions and objectives that DHB planning documents need to achieve, including to support DHBs to give effect to the purposes of the NZPHD Act, including to promote the organisation of services at the district, regional or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services; and to support DHBs to operate in a financially responsible manner.

[3] Regional service plans (RSPs) are service plans that span DHB boundaries and could include plans for the sharing of administration, support and procurement services.

- Where DHBs cannot agree on a plan the Minister may refer the dispute(s) to an expert advisory body who would offer expert advice relating to the desired outcome and the Minister would then make a decision based on that advice and would publish the decision. The Minister may also make regulations setting out the process that would be followed in such circumstances.
- A requirement on DHBs for an annual output plan as the key accountability document.
- Plans must be approved by the Minister.
- Other requirements relating to amending plans, making plans publicly available, consistency with national standards, etc.

18. With regard to the form component of option two, the Ministry would prepare regulations to provide additional detail as necessary to support the planning framework in primary legislation. This could include, for example, further specifications on content, format, and processes.
19. Under both options, officials would develop further advice on the appropriate content of the planning and accountability framework to guide the translation of the Government's objectives into robust national, regional and district service planning processes. The advice will propose options that minimise the overall transaction costs of service planning and funding (including the burden of bureaucratic compliance imposed by the planning framework).

Costs and Benefits

Proposal 2: Requirement for DHBs to plan appropriately at district, regional or national levels		
Options	**Benefits/Opportunities**	**Costs/Risks**
Option A: Amend the NZPHD Act to require DHBs to collaborate in the production of RSPs (in addition to DSPs and DAPs)	• Immediate clarity for DHBs regarding which accountability documents they are required to produce • Would clearly indicate importance of (and requirement for) regional service planning and funding – and would clearly establish the planning and accountability process for it • Simple legislative amendment that would broadly maintain current processes for accountability to the public and Parliament.	• Adds an immediate additional reporting/compliance requirement to accountability framework, which is already onerous for DHBs. • Current framework viewed as prescriptive by DHBs. DSPs, in particular, are seen as a compliance exercise, with DHBs lacking a sense of ownership over them. • May limit ability to reduce duplication of content and compliance activity across documents. • May create instability in DHBs and may not address the actual causes of tension between district and other priorities (especially with respect to priorities of local constituencies). • Limits the ability of the Minister to revise the planning framework to meet changing needs. • Unlikely to resolve tension between the different planning and accountability requirements at district and regional levels.

Option B: (Cabinet paper recs 5, 6, 7, 8 & 9) Amend the NZPHD Act (repealing sections 38 and 39) to describe the **functions and objectives** that DHB planning and accountability documents need to achieve and enable the **form** of the planning framework to be determined by the Minister through regulation under Section 92 (that is, do not include a requirement in primary legislation for any specific planning documents).	• Flexibility to define accountability framework as and when circumstances change • Enables priorities to be defined and adapted in a more timely way through regulation • Development of regulation would require consultation with DHBs on the form of accountability framework, thereby creating opportunity for streamlining of accountability requirements and reduction of compliance burden on DHBs • Provides an opportunity to form a framework over which DHBs have a sense of ownership • Greater opportunity to reduce duplication and coordinate content across multiple documents • Does not impact on the requirement to produce Statements of Intent, Financial Statements and Annual Reports under the Crown Entities Act 2004.	• In addition to those noted above, this option has the following potential costs/risks: • Lack of medium/long term certainty regarding requirements and content (and longevity) of accountability framework • May be open to priorities and influences of electoral cycles (i.e. may become increasingly "politicised") • May be seen as elevating accountability to Minister over accountability to the public (and to Parliament) • Attempts to reduce compliance burden and respond to specific priorities may lead to inadequate focus on some service areas • Possible weakening of DHB accountability if specific requirements are removed from primary legislation.

20. Both options have been developed within the overarching parameter agreed by Cabinet that there will be no major structural change or fundamental reform of the DHB model at this time. Both options have an inherent potential risk that the accountability framework for DHBs is weakened, or that tensions will be introduced, by the introduction of regional planning requirements.

Proposal 3: Establish ability for Minister to direct DHBs to give effect to Government policy for greater collaboration; and ability to direct DHBs as to how to provide shared administration, support and procurement services

21. While the amendments outlined above would require DHBs to collaborate, they may not be sufficient for achieving accelerated progression toward the sharing of administration, support and procurement services. Further amendments could require this acceleration by enabling the Minister to:

    3a direct DHBs as to Government policy for greater collaboration; and

    3b direct DHBs as to how to (jointly) obtain administration, support and procurement services.

Proposal 3a Ministerial authority to direct DHBs as to Government policy for greater collaboration

22. In practice, despite the potential financial benefits of collaboration, incentives for DHBs to share services are lacking and progress is often subject to the pace of the slowest participant: some collaboration arrangements have taken years to plan.

23. Currently the Minister of Health can make clear to DHBs his or her expectation that they will collaborate in respect of planning or to obtain administration, support, and procurement services collectively, and that those plans are to be reflected in their planning documents.

24. If the Minister is not satisfied with how that approach is progressing or wishes to give more strength to the communication of his or her expectations, the Minister could then issue a direction (in accordance with Section 103 of the Crown Entities Act 2004) relating to a government policy. A direction power to give effect to government policy on collaboration and/or shared administration, support and procurement services would mean that the DHBs would need to ensure that, at a minimum, their planning and accountability documents (currently the district strategic plan, district annual plan, and statement of intent), do not conflict with government policy.

25. Issuing a direction under Section 103 of the Crown Entities Act 2004 would require the direction to be issued 21 times (i.e. to each DHB). To establish an administratively stream-lined process, the NZPHD Act could be amended to enable the Minister to issue a single direction that applies to each DHB equally. This could be achieved by establishing a new Section in the NZPHD Act, based on Section 107 of the Crown Entities Act 2004. Section 107 enables a blanket "whole of government" direction to be issued to all Crown Entities of a particular type requiring the implementation of government policy. The NZPHD Act could be amended to enable the Minister of Health to issue an "all DHBs" direction relating to government policy on collaboration and/or shared administration, support and procurement services.

Costs and Benefits

Proposal 3a: Ministerial authority to direct DHBs as to Government policy for greater collaboration		
Options	**Benefits/Opportunities**	**Costs/Risks**
Option A: Amend Act by adapting Section 103 of the Crown Entities Act to allow the Minister of Health to direct DHBs to give effect to government policy on collaboration and/or sharing services.	• This is a power the Minister can already use. Under this power he can make clear to DHBs his expectations around shared administration, support and procurement services (eg the types of services and some expectations around timeframes, quality, and cost). • DHBs can determine how they will meet those expectations in the planning and accountability arrangements. • These plans are agreed by the Minister but the Minister is protected from individual commercial decisions. • Low risk for the Minister.	• Requires consultation with affected parties (as per section 115 of the Crown Entities Act). • Requires a direction to be sent to every DHB, increasing administrative burden. • Risk that DHB action does not as far or as fast as desirable for a sustainable health system.
Option B: (Cabinet Paper recs 10 & 11) Create a new direction making power in the NZPHD Act based on section 107 of the Crown	• Achieves objective in that the Minister could direct DHBs to give effect to Government policy. • Covers the same scope of direction as in option A but is more administratively efficient, eg one whole-of-DHB direction • DHBs will remain accountable for how they give effect to the government's policy.	• Risk that DHB action does not go as far or as fast as desirable for a sustainable health system.

Entities Act to enable the Minister to direct all DHBs as to government policy on collaboration and/or sharing services.	• Low risk for the Minister	

Proposal 3b Ministerial authority to direct DHBs as to how to obtain administration, support and procurement services

26. Cabinet has noted that 'an improved national approach to shared services in the health and disability sector could yield significant cost savings, reduced personnel, more efficient systems, and better health services' [CAB Min (09) 37/13-15 refers].

27. If the Minister is not satisfied with the pace at which DHBs progress toward sharing services, a "last resort" ability to direct DHBs as to ***how*** to obtain administration, support and procurement services could be established in the NZPHD Act.

28. Firstly, DHBs could be directed as to the process they should use, perhaps including an organisation that will run that process, to determine optimal solutions for obtaining specific administration, support, and procurement services. DHBs would remain accountable for how well they follow that process and the outcome of it. If the power was exercised in such a way, the Minister of Health would be appropriately distanced from the actual commercial decisions on those optimal solutions. Officials would advise this approach is adopted, in most situations, as it will best balance effectiveness and risk.

29. Secondly, this power could also enable the Minister to direct DHBs as to who should provide particular administration, support, or procurement services. The use of such a power involves the Minister of Health more directly in commercial decisions and presents a higher degree of risk, including the potential for real or perceived conflicts of interest. Specifying the action DHBs must take at this level of detail also removes their choice and correspondingly risks diminishing their accountability. In some extraordinary situations the Minister of Health may wish to resolve an impasse by this style of use of the power. It is envisaged that he would only do so having clearly taken advice on the course of action he was directing.

30. However, Section 33 of the NZPHD currently prevents the Minister of Health from directing DHBs to contract with specified persons/organisations; thus the Minister would not be able to direct one or more DHBs to contract with a "preferred provider" for any administration, support and procurement services. Therefore, in order to establish an ability for the Minister to be specific in respect of shared services, it is necessary to amend Section 33 the NZPHD Act.

31. If Ministers wish to establish a legislative mandate for the Minister of Health to direct DHBs to contract with a designated shared administration, support and procurement agency, a new Section 33a could be added to the NZPHD Act to enable the Minister to:

    - distinguish between "health and disability support services" and administration, support and procurement services";
    - direct DHBs as to the process to be used for obtaining certain common administration, support and procurement services; and

- require DHBs to collectively obtain common administration, support and procurement services from a designated organisation (or organisations).

32. To ensure that the Minister understands DHB perspectives and has all relevant information to hand when exercising this power it is proposed that there is a requirement to consult DHBs before exercising the power. It should be noted also that directions under this power would be subject to judicial review. In addition, officials can design further legislative safeguards if desired by Cabinet. These might include some or all of, for example:
    - Tabling of a notice in Parliament.
    - Limiting the power to direct the use of a particular organisation to organisations that are wholly or majority Crown-owned.
    - Restricting the scope of the services that could be subject to such a direction. For instance a restriction to determining optimal solutions rather than providing outsourced administration, support or procurement services).
33. An alternative option of amending Section 24 of the NZPHD Act was also considered, but was considered to be insufficient to solve achieve the outcomes sought. Section 24 relates to activities that DHBs "may" undertake; it may have been possible to amend this section to place a stronger emphasis on shared services. However, if a power to expressly direct DHBs in respect of shared services, establishing a Section 33a presents a much more appropriate, and effective, avenue.

Costs and Benefits

Proposal 3b: Ministerial authority to direct DHBs on how administration, support and procurement services should be obtained		
Options	**Benefits/Opportunities**	**Costs/Risks**
Option A: (Cabinet Paper recs 12, 13, 14 & 15) Creating a Section 33a in the NZPHD Act to enable the Minister to direct DHBs to provide or arrange for the provision of certain services.	• Requires DHBs to collectively obtain administration, support and procurement services, thus reducing duplication. • Would provide a strong incentive for collaboration – would encourage DHBs to collaborate and avoid Ministerial involvement. • Administratively simpler (i.e. no schedule). • Enables the Minister to define what administration, support and procurement services DHBs would be required to collectively obtain, as well as how those services would be obtained. • Greater potential to achieve efficiency gains and value-for-money assurance. • Legal advice from central agencies confirms that this can be drafting and implementing either of the options would be done in a way that avoids conflicting with the	• Would establish a strong mechanism for the Minister to direct DHBs' activities, arguably with little protection around its use, leaving it open to potential abuse in the future (such as requiring the use of a shared service organisation where there are clear conflicts of interest or the perception thereof). • This power potentially undermines DHB accountability arrangements. • Potential for real and/or perceived conflicts of interest if a Minister opted to direct DHBs to contract with a particular organisation. • Potential for resistance from DHBs. • Potential for much greater Ministerial involvement in commercial decisions than under status quo which risks judicial review.

	Crown Entities Act. • Would send a very clear signal to DHBs	

Proposal 4: Dispute Resolution

34. Attempts at collaboration by DHBs on planning and funding of health services and administration, support and procurement services have often been inhibited by tensions between district and broader regional and/or national priorities. Although the amendments proposed above would create a statutory requirement to collaborate to produce and then enact collaborative plans, disagreements on decisions regarding the planning, funding and delivery of services may still emerge.

35. Section 92(2) of the NZPHD Act allows for regulations to be made 'prescribing rules by which disputes or differences between any one or more publicly-owned health and disability organisations or providers of services or other persons may be mediated or arbitrated with the agreement of the persons concerned.' As such, the legislation allows for persons involved in a disagreement to choose to not be part of a dispute resolution process.

36. Therefore, for instances where "all else fails" in dispute resolution processes, an amendment could be made to section 92(2) to remove the words 'with the agreement of the persons concerned'. This would establish a clear incentive to resolve disagreements without Ministerial involvement, but would also enable effective resolution of situations where DHBs are unable to make difficult and necessary collective decisions to safeguard the sustainability of the health system.

37. As noted in the Cabinet paper, this option has inherent legal and political risks and requires considerable work by officials on designing the direction, the guidelines and the regulations, and work on aligning funding and the accountability documents with the policy. Key to this will be the development of a clear and transparent framework that sets out the circumstances under which intervention in disputes should take place. This framework would be based on the principle that intervention should only take place when the consequence of not intervening is a material risk to the clinical and financial sustainability of the health and disability system at an aggregate (regional or national) level.

38. The framework would also include specific safeguards that decisions to intervene are fair, impartial and free from perceived or actual conflicts of interest, and could include, for example, a role for the National Health Board (NHB) to provide the Minister with advice on dispute resolution. The dispute resolution rules supporting this framework could also be referenced in agreements with DHBs as well as funding and accountability documents in order to give effect to those rules.

39. Developing the framework is not constrained by the legislation deadlines associated with these health system changes and can occur while the drafting and passage of the legislation occurs.

Costs and Benefits

Proposal 4: Dispute resolution		
Options	**Benefits/Opportunities**	**Costs/Risks**
Option A: (Cabinet Paper recs 19, 20, 21	• Prevents DHBs from opting out of dispute resolution, which has proved	• Reduces autonomy of DHBs by removing their individual power of

& 22) Amend Section 92(2) of the NZPHD Act to allow regulations to determine rules governing dispute resolution processes without needing the agreement of the persons concerned	to be a major barrier to regional co-ordination. • Enables faster resolution of disputes, which historically have hindered collective action and solutions. • Provides greater clarity around dispute resolution processes through establishment of clear processes for intervening in disputes that preserve Ministerial distance from specific commercial decisions, for example through use of independent parties.	veto over decisions. • Over-turning a DHB's decisions would be likely to result in dissent from that DHB, or from more than one DHB. • Potential for conflicts of interest. The Cabinet paper proposes that this will be mitigated by requiring the Ministry to develop at transparent framework and process for escalation and resolution of disputes and an appeals process. • Requires consultation with any parties who could reasonably be expected to be affected, in this case the DHBs. There is also a period of 28 days between the Gazetting of the regulations and their coming into force.

Proposal 5a: Ministerial authority to establish more efficient governance structures to support collaboration

40. In order to establish more effective governance structures to support greater collaboration across the health and disability system, the MRG report proposed that regional planning and funding by DHBs be governed by collectives of DHB Chief Executives and Chairs.

41. After considering the recommendations of the MRG, Cabinet:
    - Agreed that steps should be taken to make the DHB model work better in the first instance, rather than undertaking wider structural reform at this time.
    - Agreed to a further review of the DHB model within the next three years to assess whether more fundamental reform will be needed to create strong enough incentives for efficiency and to enable the sector to lift its performance within a more sustainable growth track.
    - Noted the MRG proposal that DHBs be required to delegate responsibility for developing and implementing regional service plans to regional bodies made up of DHB Chairs and CEOs [CAB Min (09) 37/13-15 refers].

42. Consideration has not been given to establishing formal regional governance bodies as it would amount to a major structural change to the DHB model, which would be contrary to Cabinet's decision to not pursue structural reform at this time.

43. The Cabinet paper accompanying this RIS notes that regional decision-making can be facilitated by members of the Board of one DHB also being members of the Board of one or more other DHBs. Currently, Schedule 3, Clause 2(1)(c) allows for appointed Board members of one DHB to be an appointed Board member of one or more other DHBs. However, Clause 3(b) prevents an *elected* member of a Board being appointed (or elected) to the Board of any other DHB. Option one would involve amending the legislation to allow elected members of Boards to also be cross-appointed would further facilitate collaboration across DHBs and incentivise those Board members to take a broader regional perspective.

Costs and Benefits

Proposal 5a: Ministerial authority to establish more efficient governance structures to support collaboration		
Options	**Benefits/Opportunities**	**Costs/Risks**
Option A: (Cabinet paper recs 23 & 24) Amend Act to enable members elected to one DHB Board to be appointed to another.	• Boards more likely to consider regional issues • Fairness – elected and appointed members both able to be appointed to other DHBs • Enables more than one DHB to benefit from contributions of highly skilled people • Builds on current practice while mandating processes to which DHBs currently 'opt in' • Minimal change to DHB planning structures	• Conflicts of interest and competing priorities • Potential for expertise to be spread too thinly • No formal regional entity that can be held to account by the Minister • Requires funding for regional delivery of services to be channelled through DHBs at a district level, potentially creating more administrative complexity
Option B: A 'lead DHB' for each region charged with planning services on behalf of that region.	• Does not require structural change	• Exacerbates existing difficulties and risks parochial pursuit of own interest by lead DHB • May merely lead to large DHBs becoming "lead DHBs" by default, and without the support of smaller DHBs.

Proposal 5b: DHB Board Committees

44. Currently the NZPHD Act states that DHB Boards *must* have a 'community and public health advisory committee' (Section 34), a 'disability support advisory committee' (Section 35), and a 'hospital advisory committee' (Section 36). Māori representation on each committee is also required.

45. The NZPHD Act does not currently constrain Boards from establishing other sub-committees explicitly. However, to ensure the alignment of new Board committees with government priorities, the NZPHD Act could be amended to introduce a requirement for DHBs to secure Ministerial approval prior to establishing new Board committees. This would help encourage Boards to establish regional sub-committee structures and/or share advisory support more efficiently (e.g. regional disability committees, clinical leadership).

46. There are risks associated with this proposal: requiring Ministerial approval of committees may be seen by DHBs as a further move toward reducing their autonomy, and would also add a potentially administrative task to the duties of the Minister.

Costs and Benefits

Proposal 5b: DHB Board Committees		
Options	**Benefits/Opportunities**	**Costs/Risks**
Option A: Repeal sections 34-36; replace	• Increases DHBs' autonomy to choose the number and nature of committees established according to local DHB	• Likely to be met with vocal opposition by existing committees and other stakeholders, particularly in terms of

with flexible legislation requiring DHBs to establish, as appropriate, such committees as are required to provide effective advice on public and community health, disability support and Maori health.	preference and reflecting the specific needs of their local populations rather than central requirement. • The use of the term "as appropriate" leaves DHB Boards free to obtain advice from other sources and by other means, such as advisory groups, and still discharge their responsibilities as a Board.	disability support and Māori representation. • Removes explicit legislative requirement to have Māori representation on sub-committees. DHBs will be expected, however, to establish committees capable of providing specific advice on Māori health. • Potential that advice pertaining to community and public health, Māori health and disability support may not be adequately sought by DHBs. • Potential for a lack of consistency across DHBs.
Option B: (Cabinet Paper rec 26) amend the NZPHD Act to require Ministerial approval for the establishment of new advisory committees to a DHB Board (in addition to those required by Sections 34, 35 and 36).	• Potential for more national consistency (and alignment with government priorities) than option A. • Would enable DHBs to establish, with the Minister's support, advisory committees that best fit the business needs of the DHB, while also enabling DHBs to receive advice on how to implement government priorities (such as greater collaboration).	• Ministerial approval of committees may be seen by DHBs as a further move toward reducing their autonomy – and may involve resistance from DHBs. • Increase in administrative workload of Minister (and Ministry).

Consultation

47. This paper responded to directions from Cabinet following Ministers' consideration of the report of the Ministerial Review Group [CAB Min (09) 37/13-15 refers]. The MRG report was made available by the Minister of Health for public comment. A range of stakeholders made submissions on the report, which were subsequently published via the Beehive website. The papers considered by Cabinet in response to the MRG report, and CAB Min (09) 37/13-15 were also made available to the public via the Beehive website. There has been no public consultation on the specific options set out in the Cabinet paper.

48. In addition, a Sector Reference Group (comprising clinicians and managers from DHBs and senior Ministry officials) was convened by the Ministry to inform the development of this paper. The views of this group have informed the subsequent analysis and policy development process. This group expressed support for establishing greater legislative support for collaboration between DHBs at the regional level within the existing DHB model.

49. The Implementation Oversight Committee, convened by the Minister of Health following Cabinet's initial consideration of the MRG report, was consulted on the final version, and various draft versions, of the Cabinet paper to which this RIS is attached.

Crown Agency Feedback

50. The Treasury and the State Services Commission were also consulted and their comments have been taken into consideration. The Department of Prime Minister and Cabinet was informed of the proposals in this paper.

Conclusions and recommendations

51. This RIS describes the options that have been considered to improve collaborative decision-making processes for the planning and funding of health and disability services by DHBs, and for moving more rapidly towards shared administration, support and procurement services across DHBs. These options have been considered in response to Cabinet's decision to pursue amendments to the NZPHD Act that would support achieving these objectives.

52. As a starting point, the RIS has argued for more clearly including collaboration within the NZPHD Act's definitions of the objectives of functions of DHBs.

53. Central to undertaking Cabinet's instructions has been consideration of whether amendments to the NZPHD Act should be flexible or prescriptive; that is, whether the NZPHD Act should specifically define how collaboration on planning, funding, administration and procurement should be undertaken by DHBs (and what it should produce), or whether the NZPHD Act should establish a framework for collaboration without defining the specific requirements and outputs in specific and prescriptive detail. In general, the Cabinet paper has opted for flexible solutions with further detail to be prescribed in Regulations.

54. In particular, a key aspect of the analysis has been whether the mechanism for requiring and evidencing collaboration should be specifically defined in the NZPHD Act or if the NZPHD Act should be amended to enable greater flexibility with regard to the overall accountability framework. Although adding a statutory requirement to develop RSPs would establish certainty regarding outputs, it would increase the rigidity and compliance costs of the prevailing accountability framework.

55. Despite these amendments, regional collaboration may continue to be hindered by tension and disagreements over regional and district priorities. For this reason, and as directed by Cabinet, additional legislative amendments to strengthen the Minister of Health's powers to intervene in the event of disputes between DHBs have been canvassed.

56. This RIS has also described the options that have been considered to establish more effective governance mechanisms to encourage regional collaboration, and has noted the Cabinet paper's proposal to achieve this by enabling the appointment of elected Board members to the Board(s) of other DHBs, which is currently prohibited by the NZPHD Act. This amendment will further facilitate Boards adopting a regional, rather than an exclusively district, perspective.

Implementation

57. Implementation of the proposed options in the Cabinet paper is dependent on further work as follows:

Amendments to the legislation (January-July 2010)

58. Amendments to the legislation would be triggered by Cabinet signing off the proposals with authority to instruct Parliamentary Counsel, followed by drafting, and passage through Parliament.

59. If required by Cabinet, further legislative safeguards may need to be developed in respect of the section 33 direction power. To meet drafting requirements, advice would be required by the end of February 2010.

Drafting the Regulations (January - May 2010)

60. Drafting of the Regulations would be dependent on two streams of further policy work:
    a. Regulations clarifying the planning and accountability framework including the content and format of planning documents and a clear planning and accountability process
    b. Regulations to determine the rules governing dispute resolution processes including:
        i. Circumstances under which intervention in disputes should take place
        ii. Roles and functions of the NHB with respect of providing advice on dispute resolution
        iii. How to embed the dispute resolution framework into accountability documents
        iv. Safeguards to ensure consistency, impartiality, and protection from conflicts of interest.

Funding and accountability arrangements (January to May):

61. The development of funding and accountability mechanisms to reinforce:
    a. collaborative planning and delivery of health and disability services; and
    b. faster movement towards shared back office services (eg human resources, payroll, finance); and more joint procurement of supplies by DHBs.
62. This will need to include specific advice about the planning and funding of national services linking closely with parallel work on devolution of health and disability services currently managed by the Ministry of Health.

Further work on shared services (January to May)

63. Shared Service Establishment Board to conduct further work and provide advice on:
    a. Optimal service solutions;
    b. Design elements of an effective shared service organisation (eg transition arrangements, sharing benefits, service level agreements, performance, incentives etc).

Implications and Risks

Implications and Risks during Transition Period (January to July 2010)

64. The period between January and July 2010 constitutes a drafting and transition period, during which there is considerable work to be done to allow successful implementation and ensure that all those affected are fully aware of the nature of the changes and the expectations that will be placed on them. There is a level of detail yet to be resolved, particularly around the precise circumstances that will trigger the use of the powers in the legislation, and the development of clear, specific and transparent specifications in regulation.
65. As noted above, further policy work is being developed in parallel with legislative amendments to support DHBs to progress further and faster on regional decision-making, shared services and joint procurement through non-legislative means, particularly in respect of funding and accountability mechanisms and the advice being prepared by the Shared Services Establishment Board. This work, which is already underway, may have

impacts on the legislative amendments being proposed here and may need to be considered before legislation is passed.

66. Further work is also needed on the balance between national and regional/district decision-making, and what are the best legislative, accountability and funding mechanisms to ensure that those services that remain or are transferred to the national level best support the Government objectives for the health and disability system. This work will take place as part of the parallel policy process agreed by IOC and referred to above.

67. There may be a period of uncertainty for DHBs, for example, about expectations of them in relation to regional service planning, shared services and any potential changes to funding and accountability arrangements. This will need to be managed carefully to avoid disruption to service delivery, manage fiscal risk and maintain appropriate accountability for performance.

Implications and Risks Once Enacted

68. These proposals clearly have a number of implications for the health and disability system. The introduction of these amendments will result in the centre (i.e. the Minister of Health or a designated agent) having greater powers to direct DHBs' decisions when and where it is considered to be in the broader regional or national interest. The intention of these new powers is to ensure that planning and purchasing decisions best promote the clinical and financial sustainability of services, either by incentivising DHBs (through the possibility that the powers could be used) or directing them (through the actual use of powers), to act against individual local interest if this runs counter to the regional or national interest.

69. At this stage it is not possible to speculate on the nature or impact of future decisions which may follow the introduction of these powers. However, the introduction of the powers (as opposed to the specific instances of their use) is expected to improve the regional and national focus of DHBs' collective decision-making, and produce decisions that better support a sustainable health system for the long term.

70. It is proposed that the existence of these new powers will provide sufficient incentive to ensure that DHBs will prioritise the broader regional or national interest, in the event that conflicting local interests arise. However, given the incentives that will continue to exist in the health system to prioritise the district interest (for example, locally-elected Boards), and given the difficult choices that will be necessary to preserve the long-term clinical and financial viability of health and disability services, there are likely to be some circumstances in which the Minister may wish to exercise these new powers.

71. To address the risks associated with the use of such powers of direction it will be very important that these powers are used, and are seen to be used, in a fair and transparent manner.

The re-balancing of decision-rights towards the centre and consequent potential loss of local autonomy and accountability for performance

72. One potential risk associated with these legislative amendments is the impact that a loss of DHB autonomy in certain areas may have on the Government's ability to hold DHBs to account for their performance (including their financial performance). Cabinet has previously noted [Cab Min (09) 37/13-15 refers] that "the decisions [in relation to regional decision-making] will result in greater central direction over DHBs and a stronger assessment by the centre of planning and funding priorities, although DHBs will still have

responsibility for planning and funding the majority of services, albeit with a stronger regional focus" (Cabinet decision 34).

73. The rebalancing of decision-rights towards the centre is an explicit consequence of the options discussed in this RIS. Cabinet also noted "that although there is widespread support for enhancing regional and national decision-making, there is some risk that locally elected boards will resist the proposed changes to the extent that local autonomy may be reduced overall" (Cabinet decision 35).

74. Inherent in these changes is the risk that some DHBs will face changes to their businesses that may affect its staff or district population. The Ministry will be working with DHBs to develop appropriate transition measures to manage these risks.

Need to develop additional safeguards to protect the Minister from the risk of legal challenge

75. As stated above, the options discussed give the Minister additional powers to intervene in DHB decision-making processes, and to overturn DHB decisions in certain circumstances. While the intention is that these powers are intended primarily to signal the Government's desire for behavioural change by DHBs (i.e. more effective collaboration), and would therefore only be used as a last resort, further work needs to be done to ensure that the appropriate checks and balances on these powers are in place before they are introduced.

Potential for additional, unintended consequences as supporting policy and regulation are developed

76. There are a number of areas where detail will be specified in regulation, such as the precise form that effective planning should take, and the specific documents that DHBs will be required to produce, enact and be held accountable for. There are risks associated with developing these specifications in regulation in parallel with the legislative drafting process, which could delay implementation of the legislation.

77. In addition to this, further policy work will take place in parallel with legislative amendments to support DHBs to progress further and faster on: regional decision-making; shared services and joint procurement through non-legislative means (in particular through possible changes to funding and accountability mechanisms); the potential benefits and risks of the options for the form of a shared services agency; and the best mechanisms to ensure that those services that remain or are transferred to the national level are appropriately planned, funded and managed.

78. As stated above, the legislative amendments proposed are intended to be sufficiently permissive that they do not result in unintended consequences or limit the Government's ability to develop solutions to address the non-legislative barriers. However, it is possible that the outcomes of this policy work, which is already underway, may impact on the detail of the legislative amendments being proposed in this paper and may need to be considered before legislation is passed.

79. There may also be a period of uncertainty for DHBs while supporting policy and regulation are being developed, for example, about the Minister's expectations of DHBs in relation to collaborative service planning, shared services and any potential changes to funding and accountability arrangements. This will need to be managed carefully to avoid disruption to service delivery and to minimise fiscal risks.

Monitoring, evaluation and review

80. Cabinet has already 'agreed to a further review of the DHB model within the three next years to assess whether more fundamental reform will be needed to create strong enough incentives for efficiency and to enable the sector to lift its performance within a more sustainable growth track' [CAB Min (09) 37/13-15 refers]. This review will include an assessment of the extent to which the amendments proposed in this paper have been effective in ensuring that decisions concerning the planning and funding of health and disability services are made at the right level in order to realise improvements in the effectiveness and efficiency of those services.