Regulatory Impact Statement

Executive summary

The proposal is to amend the NZ Public Health and Disability Act 2000 to give effect to the recommendations of the Ministerial Review Group (MRG) set up by the Minster of Health to advise on options improving clinical leadership, quality and value for money in the health sector.

Public feedback on the proposals has been generally positive.

A senior officials group led by Treasury, and including the Ministry of Health, the Department of the Prime Minister and Cabinet, and the State Services Commission developed two preferred options for implementing the MRG proposed changes for consideration by Cabinet:

1. establish a National Health Board as proposed by the MRG, with consequential amendments to the NZ Public Health and Disability Act 2000 to support the NHB's role and to mandate regional planning by District Health Boards (DHBs); or

2. establish the NHB functions within the Ministry of Health, with consequential amendments to the NZ Public Health and Disability Act 2000 to support and mandate regional planning by DHBs.

Adequacy statement

The Treasury confirms that the principles of the Code of Good Regulatory Practice and the regulatory impact analysis requirements have been complied with. A Regulatory Impact Statement (RIS) was prepared and the Treasury considers it to be adequate in its problem definition, description of options, and its assessment of the likely costs, benefits, and risks for the DHBs and agencies directly affected by the proposed governance and institutional changes.

The analysis is incomplete in its assessment of the potential benefits, costs, risks and compliance costs of these proposals for the health system's clients, and for providers and personnel below the level of DHBs themselves. However, the impact for these groups will depend more critically on how implementation takes place and on subsequent decisions on matters of detail, rather than on the high-level decisions that Ministers are being asked to take at this stage.

Consultation on the proposals has been adequate, with the feedback received actively considered and summarised in the RIS. There will be further opportunities for consultation and stakeholder input in subsequent stages of decision making and implementation. The final RIS was circulated (with the Cabinet paper) to the Ministry of Health, the State Services Commission and the Department of Prime Minister and Cabinet.

Status quo and Problem

Health Sector challenges

Various recent reports by the Ministry of Health, the Treasury, the OECD, and now the Ministerial Review Group (MRG) have noted that the sector faces serious financial challenges. The changed fiscal environment means that there will be a considerable reduction in the rate of growth in health funding.

Vote Health grew on average by more than 8 percent per year from 2000/01 to 2008/09. While the growth rate decreased below 6 percent in 2008/09, increases below 3-4 percent are likely in the future.

As well as reducing rates of funding growth, health systems around the world are also facing the challenge of rising costs from:

a. ageing populations and increased prevalence of long-term conditions;

b. rising public expectations from growing national wealth and technological change, which tends to increase costs and expand the scope of what is treatable;

c. sub-specialisation leading to narrow scopes of clinical practice; and

d. an increasingly expensive skilled workforce – this is a particular challenge in New Zealand, given that we are a small player in an international market.

Current service configuration and delivery models will need to be transformed to meet these clinical and fiscal challenges.

International trends in response to these broad challenges include consolidation of acute secondary and tertiary inpatient services into a smaller number of centres, shared services arrangements which provide standardisation, greater use of clinical networks across organisational boundaries, and health technology assessment playing a greater role in resource allocation decisions. These same trends are emergent in New Zealand, but the sector's current momentum is too slow and uneven.

Deficiencies in institutions and policy settings to meet these challenges

The health system is not well placed to respond to these challenges. The major weaknesses in institutional arrangements include:

a. lack of clarity in the roles and functions, and relationships between, the organisations in the sector, including the Ministry, DHBs, and PHOs;

b. insufficient autonomy for DHBs and PHOs alongside weak accountability for achieving key results resulting in poor performance and fiscal control;

c. fragmented decision-making - current collaborative mechanisms and accountabilities are weak, and do not lead to rational and coherent service and capacity planning or efficient use of resources;

d. inadequate engagement of clinical leaders in resource allocation and service change decisions;

e. lack of a systematic economic approach to priority-setting and new investments by funders/purchasers to get best value from scarce resources in respect of services and new technology generally, as currently happens only for pharmaceuticals; and

f. inadequate primary health care incentives, including incentives for small PHOs.

The MRG was established to provide advice to the Minister of Health on how bet to deal with these issues. Their report contains over 170 recommendations, to support a set of key proposals. The proposals and issues which they are designed to address are summarised in the following table.

Table 1: Summary of MRG's Key Issues and Proposals

Issue	MRG's Major Proposals
• Inefficient use and spread of capacity limits service reconfiguration and introduction of new models of care • Local DHB interests often take priority over regional or national interests, leading to suboptimal decisions and limited service reconfiguration where it is needed for clinical and financial sustainability of services and/or improved equity of access • Capital investment, IT and workforce planning aren't integrated, don't reflect changes needed in service mix, and don't optimise regionally and nationally	• Require regional decision-making through regional boards of DHB Chairs/CEOs, with National Health Board (NHB) as arbitrator • Centre to plan and fund truly national services (by top-slicing DHB funding) to address vulnerability • Abolish National Capital Committee and strengthen national prioritisation & decision-making on capital through an independently chaired committee of NHB • Integrate national level capacity planning (capital, IT and workforce) in the NHB, ensure that capacity planning is driven by service planning.
• The Ministry is expected to do too much across too diverse a spectrum of activity • Ministry was never intended to remain biggest purchaser in DHB model ('22nd DHB')	• Devolve remaining service funding currently purchased by the Ministry ($2.5b approx.) • Revamp the Crown Health Financing Agency into a National Health Board (NHB) to manage national capacity and service planning, to plan and fund national services, and to fund and monitor DHBs; • Ministry of Health to monitor NHB • Transfer payment processing functions on behalf of sector out of Ministry to a new Shared Services Agency
• Clinicians need to lead and support decisions to transform service delivery within budget constraint	• Regional and national decision-making processes (services, capital, workforce) to have strong clinical input eg through new capital board in NHB • Stronger clinical leadership and clinical-managerial partnerships, and strengthen clinical networks
• 21 x transactional functions and procurement is inefficient – collective efforts poor to date (except for Pharmac)	• Establish a new Shared Services Agency to manage 'back office' functions, including shifting some of the national operations currently managed by the Ministry on behalf of the sector, and procure clinical/non-clinical supplies for DHBs • PHARMAC to assess and prioritise medical devices for public funding, as it does for community pharmaceuticals
• Ad hoc introduction of new technology and new interventions, drives cost increases and compromises quality and safety	• Revamp the role of the National Health Committee to include economic analysis and prioritisation of new services, and over time expand this role to cover assessment of all publicly funding health care • expand PHARMAC's role, as above

Objectives

These proposals are intended to achieve a more rational allocation of services and capacity across regions and across the country through integrated service and capacity planning and stronger national leadership of DHBs. The proposals are also designed to shift resources to the front line.

MRG argues that:

> "The above changes will lead to reduced bureaucracy and a smaller Ministry of Health over time, with a much clearer focus on the Ministry's core policy and regulatory functions. The NHB will also bring a clearer focus to service and capacity planning and funding. These proposals will also require some changes by DHBs, albeit aimed at accelerating their current moves towards greater collaboration regionally on service planning and nationally on reducing common back office costs." (p. 5)

Recommended changes

The MRG recommended the following institutional changes to address the weaknesses in institutional arrangements and to strengthen central decision making:

1. Restructure of the Crown Health Funding authority to become a national health board with responsibility for:
   - Planning and funding of national services
   - funding and monitoring of DHBs
   - arbitration on regional planning
   - national capacity planning and funding including capital investment, IT/IS investment, and workforce development.

   with consequent changes to the Ministry of Health's responsibilities.

2. Require DHBs to plan and fund some services regionally, with decisions delegated to a regional board made up of the DHB chairs and CEOs in each region.

3. Develop a shared services agency as a Crown entity to reduce DHB spending on administrative services[1]

The MRG's advice was these changes could be achieved without changes to legislation.

[Withheld – Legal Professional Privilege]

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1. The MRG also recommends establishment of a national quality agency and strengthening the role of the National Health Committee, but these recommendations will be considered at a later date by the Ministry of Health.

Alternative options

The National Health Board

The senior officials' group considered alternatives to the governance and organisational arrangements of a Crown entity for the NHB functions. In particular, a range of departmental configurations were considered and these are outlined in the table below. One alternative (the 'branded business unit') has been further developed and has been provided to Ministers as an alternative to the proposed NHB.

Regional planning

The senior officials' group considered the use of existing instruments (such as Ministerial directions and Crown Funding Agreements) as alternatives to legislative change to support regional planning. Again, these alternatives have been provided to Ministers to consider.

Shared services

In relation to the MRG's shared service recommendations Ministers are being asked to approve investigative work on shared services to establishment their feasibility. Following that work Ministers will be asked to consider options for further development of shared services if the business case warrants it, including where appropriate legislative change. In the event that legislative approach is to be considered, a further RIS will be developed.

	Non-Statutory Configurations		Statutory Configurations		
	Standard Business Unit	**Branded Business Unit**	**Semi-Autonomous Body**	**Statutory Officer**	**Statutory Unit**
Examples	DIA: Local Government and Community Branch SSC: State Sector Performance Group MOJ: Public Law Group MED: Industry and Regional Development Branch DOC: Corporate Services IRD: Office of the Chief Tax Counsel Customs: Trade and Marine Group MAF: Maori Strategy Unit	MED: Companies Office MAF: Biosecurity NZ DPMC: Cabinet Office MSD: Work and Income MSD: Child, Youth and Family MSD: Office for Disability Issues MSD: Office for Senior Citizens DIA: Office of Ethnic Affairs National Library: Alexander Turnbull Library	MSD: Min of Youth Development DIA: Min. of Civil Defence Emergency Mgmt MOJ: Office of Treaty Settlements Treasury: CCMAU [formerly: NZAID in MFAT]	MOH: Director of Public Health DOL: Registrar of Immigration Advisers DIA: Director of Civil Defence Emergency Mgmt LINZ: Valuer-General LINZ: Surveyor-General LINZ: Registrar-General of Lands LINZ: Commissioner of Crown Lands	MOH: Public Health Group DOL: Immigration Advisers Authority
Characteristics	Set up to deliver outputs as part of departmental business The 'normal' arrangement for delivery of departmental outputs	Set up to pursue clearly identifiable policy objective, or to perform discreet set of functions and powers that can be ring-fenced from other activities of the dept Can have separate Vote and Minister	Key characteristic = separateness: - SAB is set up so that it clearly delivers the outputs rather than host dept e.g. OTS negotiates settlements rather than MOJ - host dept avoids involvement Cabinet agreement needed to set up SAB Usually has separate Vote and Minister Can have statutory functions, but not essential to constitute a SAB	Statutory officer position established by an Act of Parliament Act sets out functions and powers (may include power to delegate) Act may set out appointment provisions, including qualifications required Act may provide for acting independently or reporting directly to Minister	Established by an Act of Parliament Act sets out specific functions; may include powers Act may provide that the unit/body consists of officers or other employees/persons appointed by the chief executive

Preferred option

The senior officials group agrees that the functions recommended by the MRG are required in the NZ public health system, and has identified two preferred options for consideration by cabinet.

1. Establish an NHB as proposed by the MRG, with consequential amendments to the NZ Public Health and Disability Act to support the NHB role and to mandate regional planning by DHBs

2. Establish the NHB functions within the Ministry of Health, with consequential amendments to the NZ Public Health and Disability Act to support to mandate regional planning by DHBs

Costs and benefits

The costs and benefits of the proposed changes are set out below.

Table 2: costs and benefits associated with key areas of change proposed in the MRG report

Proposal	***Benefits / opportunities***	***Costs / risks***
Strengthen national service purchasing and devolve MOH NDE funding.	Devolution of services from the centre to DHBs enables DHBs to make allocation decisions across a broader range of services, potentially improving allocative efficiency and reducing the risk of cost shifting to MOH managed budgets. Allows clearer monitoring of entity performance in purchasing of national services (not spread across 21 DHBs and not buried in MoH functions). Grouping together purchasing of national services into one focussed unit may deliver gains from improved capability in purchasing, and sharper value for money focus. National service planning can improve clinical sustainability in small vulnerable services by development of shared workforce and IT strategies across providers. Potential to achieve safer and better quality services by provider rationalisation to obtain better critical mass. Potential to address clinical vulnerabilities arising through fragmentation. May make more efficient use of scarce skills. May allow subspecialisation and research leading to better recruitment and retention of scarce workforce.	Transition costs associated with changes in purchasing arrangements, which are likely to include disruption to contracting relationships. Costs of devolution including loss of national consistency and possible increased cost of purchasing 21 times. Possible loss of gains from monopsony purchasing / concentrated contracting capacity. If national services are broadly defined there may be increased opportunities for cost shifting by DHBs.

Proposal	*Benefits / opportunities*	*Costs / risks*
Strengthen regional planning	More effective collaborative planning resulting in more cost effective configuration of services across DHB boundaries, reducing service costs and making more effective use of scarce workforce and expensive equipment. Reduction in transaction costs associated with current protracted decision-making. Clinical quality and safety benefits associated with regional oversight of services and protection for vulnerable regional services.	Potential for divergence between local and regional plans with associated suboptimal decision making. Loss of local autonomy (and Board sovereignty) may impede local decision making. Risk of judicial review if regional decision making and arbitration not provided for by legislation.
Integrated capital, workforce, IT and service planning	Corrects an existing gap – where capital planning runs ahead of, and constrains, service planning, thereby restricting introduction of new models of care. Improved allocation of capital, workforce and IT resources in support of new models of care underpins fiscal and clinical sustainability. Improved allocative decisions from consistent national prioritisation within and across each capacity area. Potential to also improve productivity, if able to make appropriate decisions about investment in inputs – e.g. in standardised IT. Workforce vulnerability is a major issue for the health sector – building capacity to develop the future workforce to meet future health needs and new models of care helps avoid mismatch between workforce skills and clinical requirements.	Loss of autonomy for DHBs in making major capital decisions. Information costs of performing this as a central, as opposed to local, function – costs of getting information about local costs and benefits and achieving coordination. Costs (financial and public trust) of “getting it wrong” at a national level – e.g. high profile national IT project failures here and in the NHS.

Proposal	*Benefits / opportunities*	*Costs / risks*
National approach to administrative and support services (Shared Services)	Cost savings: Initial estimate of savings in procurement and logistics management is a $50 – $100m baseline reduction, and reduced growth path of 2% ($20m) thereafter, through*:* - price improvements through volume leverage - operating cost reduction through reduced duplication and reduced inventory - personnel cost reduction through leveraging skills. Quality and safety improvements are possible though product standardisation. Improved spread of innovation. Potential savings in other corporate support services to be reviewed on a case by case basis.	Benchmarking and analytical work to determine optimal implementation plan Cost of benchmarking and business case development. Transitional costs of building new systems, transferring functions and data, standardising infrastructure. Possible risk of loss of responsiveness. Possible loss of innovation and dynamic efficiency if multiple and competing providers are replaced by fewer large-scale providers (in-house or contracted) with strong incumbency advantages in retendering services.

Risks & Mitigations

The table below sets out the major high level risks associated with the changes proposed, together with the intended mitigations.

Table 3: High level risks and mitigations

Risk	Mitigation
National services	
The MOH/NHB may favour national services at the expense of DHB purchased services when making funding allocation decisions.	Keep list of specifically purchased national services small. Monitor MoH/NHB performance based on overall sector outcomes as well as specified national services.
A national services plan may be too prescriptive, reducing innovation and weakening local DHBs' ability to respond to their communities' needs and priorities, and weakening their accountability for performance.	Maintain national services planning at high level – using a framework & principle based approach rather than detailed prescriptions.
Devolution	
Disability and public health services that require a national overview may be devolved to 21 DHBs resulting in sub-optimal decision making. Potential loss of consistency in the services and	Continue national purchasing by MoH / NHB where appropriate. Strengthen use of other accountability documents, Ministerial directives and performance monitoring of

Risk	Mitigation
standards provided to patients in different DHB areas compared to previously nationally contracted/managed services.	DHBs for services resourced by devolved funding rather than centrally managed purchase agreements and contracts.
Regional planning & decision making	
DHBs may opt out of regional planning processes, or may confine regional planning to a small scope of services, or may agree regional plans but not implement them.	NHB/MoH to have the authority to take over regional planning decisions (arbitrate) if DHBs do not agree. Regional plans to be required to be signed off by Minister. NHB to monitor DHB progress in implementing plans.
Shared services	
If services are not mandated then DHBs may choose not to use them, reducing the effectiveness of collaboration.	Make participation mandatory through legislation and/or accountability documents.
If a shared services crown entity is established it may be inefficient and unresponsive.	Ensure DHB/sector involvement in governance. Do not establish a shared services function in any particular functional area without a clear business case setting out KPIs and output benchmarks in advance. Monitor performance against business case. Implement on a graduated basis (avoid big bang approach).
Possible loss of innovation and dynamic efficiency if multiple and competing providers are replaced by fewer large-scale providers (in-house or contracted) with strong incumbency advantages in retendering services.	Strong incentives on DHBs and potential competitors to scrutinise and benchmark SSA performance. Establish clear service standards and minimise incumbents' informational advantages.
DHBs may pass responsibility to the SSA for supply cost escalation.	Establish clear service level agreement describing roles and responsibility for each entity.
Access to important national health data collections may be restricted unduly, impeding MoH/NHB/DHB ability to perform.	Establish clear service level agreement describing access to information. Include access principles in accountability and funding agreements.
National Health Board / MoH	
If the NHB and MoH roles are not well differentiated, then they may duplicate work between them over time and accountabilities may become unclear, resulting in suboptimal performance and waste.	Ensure visibility of SOI outputs for each. Set out roles in enabling legislation.
If the MoH maintains the proposed NHB functions then the functions may be derailed by short term fire fighting / emergent new priorities / servicing Ministers.	Ringfence desired functions and resourcing within the MoH.
Transition	
Staff in affected organisations may be distracted / anxious throughout the change period and may be less effective.	Establish management of change principles that minimise risks of redundancy for staff. Establish clear communication channels.
If the transition is not well managed and timely, then affected organisations may lose experienced staff	Resource the change appropriately to move it at quick pace.

Compliance costs

The major compliances cost fall on crown entities: the Ministry of Health and DHBs. Both the MoH and DHBs have explicitly supported the functional changes proposed by the MRG.

The cost of the changes would be met within existing health baselines.

There may also be compliance and transitional adjustment costs imposed on private and community sector health providers and agencies. For example, these organisations may need to establish new relationships and adapt information and financial systems to deal with new NHB or MOH Business Unit, and a shared services agency. However, these costs are not necessarily increased by pursuing options involving legislative change as proposed by the senior officials group, as alternative courses of action involving managerial and systems changes without legislation or regulatory change could create similar costs.

Implementation and review

Once ministers have made decisions on the proposed changes, the next steps in regard to implementation will be:

a. the State Services Commission, in consultation with the Ministry of Health and the other central agencies, will prepare a report for Joint Ministers by 30 October 2009 seeking approval for the Terms of Reference and membership of:

    i. the Implementation Oversight Committee;

    ii. the Shared Services Board, and

    iii. the National Health Board Establishment Board if Option A is adopted; and the Advisory Board if Option B is adopted.

It is envisaged that each of these boards will be up and operating during November with detailed project plans ready prior to Christmas. Preparation of advice in regard to the necessary changes to legislation, included drafting changes is expected by 31 January 2010. Further consultation and regulatory impact analysis is likely to be required as legislative amendments are developed, depending upon the extent to which the changes emerging from the work of these bodies requires legislative and regulatory change beyond that already foreshadowed in these papers.

The Ministry of Health, as part of its policy advice function, will lead the follow-up policy work arising from the MRG report including consideration of recommendations not considered as part of this report, in consultation with central agencies and the IOC.

Officials recommend annual review of the effectiveness of the changes in addressing the problems identified by the MRG, with the option of wider review of the sector if progress is unsatisfactory.

Consultation

Public Feedback

The MRG report was made available by the Minister of Health for public comment. Feedback was received from 126 agencies & individuals. These responses included comments from DHBs and other Crown Entities in the Health Sector. Feedback was broadly supportive of the proposed changes.

A summary of the public feedback is attached as Annex 1.

Crown Agency feedback

The Ministry of Health, SSC, DPMC and Treasury have been involved in the development of this Cabinet paper and the options analysis preceding it through membership of a senior officials group established by the Minster of Health and supported by an interdepartmental working group.

Annex 1: Summary of public feedback on MRG report

Key	General support	Mixed responses	Concerns
Icons have been subjectively allocated on the basis of the overall response.			

	Theme	Summary
	**Problem definition**	▪ Strong support for dealing with the sustainability issues facing the sector. ▪ Strong support for improving the system by reducing duplication and bureaucracy within and between organisations.
	**Establishment of a National Health Board (NHB)**	▪ Strong support for the need to deal more appropriately with national services (particularly high cost low volume services), and for an integrated approach to workforce. ▪ Less feedback was received on capital and IT capacity planning, but was generally supportive. ▪ Concerns expressed around the potential for weakened public accountability and increased bureaucracy (FTEs and/or "red tape"), fragmentation at the centre, role confusion between NHB and MOH and trying to do this without legislation. ▪ Many respondents suggested that the number of DHBs should be reduced.
	**Refocus of the Ministry of Health**	▪ Strong support for the concept of a "refocus". ▪ Various suggestions on the content of the refocus – including: o policy, regulation and ministerial advice only; o as above, with the addition of quality and performance improvement (ie. take on the functions proposed for the NQA); o becoming "more grounded" – with equal focus on policy and implementation (ie. take on the functions proposed for the NHB). ▪ General support for further devolution of NDE.
	**Establishment of a National Quality Agency (NQA)**	▪ Wide and strong support for a stronger focus on quality improvement. ▪ Respondents showed strong support for an <u>independent</u> national quality agency with a sector-wide, patient-centric focus, (rather than a provider-centric model) and open disclosure. ▪ Respondents consistently stressed the importance of building on the existing work of the QIC and existing sector-led quality initiatives in both secondary and primary care. ▪ Concerns were expressed around the following aspects: o potential for fragmentation: options suggested for addressing this concern included locating the functions within the Ministry, joining with those of the NHC, or under the NHB; o the recommendation that the agency become partially self-funded.
	**Establishment of a National Shared Service Agency (NSSA)**	▪ Very strong support was expressed for a national shared service agency for common back office functions for DHBs. Recommendations in this area were seen to be long overdue. ▪ Concerns were expressed around the following aspects: o some clarity was sought concerning the definition of shared HR functions, in particular it was not considered efficient to move payroll functions to a shared service agency; o inflexibility and limitation of choice were the main concerns expressed;

		○ there was very little support for moving National Collections out of the Ministry of Health, with only one submitter suggesting devolution to DHBs.
▲	**Regional decision-making**	▪ Very strong support, across the majority of agencies, was expressed for a better framework for regional planning and coordination. ▪ Several respondents commented on the need for transparency and equity in prioritisation processes. Respondents also commented on a need to improve equity of access within and between regions. ▪ Accountability to communities and the public was further identified as highly important. ▪ Disparate opinions were expressed concerning how best to make the governance arrangements for regional decision-making work. Some feedback expressed a preference for DHB-driven governance mechanisms and others recommended a centralised approach (ie. via a NHB).
▼	**Areas not covered by the report**	▪ Concerns were expressed around the report's relatively low coverage of: ○ the potential for preventative and public health services to address the core problem definition of system sustainability – particularly in comparison to the recent report of the Australian National Health and Hospitals Reform Commission; ○ reducing inequalities, Maori and Pacific health, and Treaty commitments.
▲	**Funding new services**	▪ Support was strong for a structured, centralised and consistent mechanism to assess the value and priority of new health and disability interventions. ▪ Greater clarity concerning the MRG recommendations in this area was sought by a large proportion of the respondents, in particular clarification around: ○ the exact scope of the role proposed for a 'strengthened' National Health Committee; ○ how health and disability interventions differed from service planning and medical devices; ○ the links between decisions and implementation (ie. funding).
▲	**Funding new medical devices**	▪ A great deal of support was expressed for centralising the arrangements to purchase medical devices, with the majority of feedback supporting an expanded role for PHARMAC (exception was the Medical Technology Association of New Zealand). ▪ The main reservations concerning an expanded role for PHARMAC were: delays in the introduction of new technologies, the stifling of innovation, the need for great transparency, and the significant differences between evaluating pharmaceuticals and evaluating new technologies and devices.
▲	**Clinical leadership**	▪ Strong support for the focus on clinical leadership. ▪ Clear support for the continued development of clinical networks. ▪ Respondents additionally suggested that: ○ the focus should to be widened to the "front line" – incorporating others involved in delivering non-clinical services; ○ managerial leadership (eg, DHB CEOs) equally requires focus and investment.
▲	**New models of care**	▪ Respondents recognised the importance of managing health, particularly chronic conditions, within community settings. ▪ Several submitters agreed with the need to change models of care. These included: encouraging and supporting individuals and their families to take a greater role in managing their own care, avoiding hospital admissions by keeping people well at home, and reinforcing the continuum of care where the patient is the focus, not the institution. ▪ Some suggested that the MRG report lacked an emphasis on the need to recognise patient

		or consumer expertise in establishing new models of care. ▪ Generally respondents supported the devolution of secondary services to primary care settings. Several respondents pointed to the need for careful planning of this devolution process and that there were few incentives for DHBs to devolve secondary services to primary care settings.
	Primary care	▪ Respondents supported the need for clarification of the role of PHOs. Several wanted to see the Primary Health Care Strategy underpin this work and highlighted the need for national guidelines and examples of best practice to guide future PHO activity. ▪ Moving services from secondary to primary care settings where appropriate was viewed favourably, as was greater focus on integrated care, stronger community services and prevention programmes. ▪ A few respondents supported reducing restrictions on the movement of GPs between PHOs, as well as the conditions on introducing new PHOs. ▪ Proposals in relation to the size of PHOs received a mixed response: o significant concern over increasing the size of PHOs; o mixed response on the proposal to limit the management fees available to small PHOs: many are concerned this would affect vulnerable populations and requested further impact analysis before any decision is made on this. ▪ A new model of primary care and funding was supported by a number of respondents who wanted to see incentives used appropriately to support improved quality and services to high health need populations.
	Information technology	▪ There was broad support among respondents for a safe sharable electronic patient record. Several expressed a concern that the available record be a summary of important data, rather than the primary record. Some respondents expressed concerns around privacy implications. ▪ While opinion was divided over the form IT architecture should take, many supported the continuation of a distributed approach.