Draft Terms of Reference for Health Area Service Reviews: Scope

To make progress on issues facing Ministers, officials propose that the terms of reference for the Reviews would ideally cover the following range of issues, within each service area.

Strategic coherence

The Reviews should clarify the feasible range or outcome targets within the service area (eg how much can NZ reduce our diabetes rate by 2015?); what would that take (ie bigger gains may require more resources; and what are the big investment choices for govt, bringing out health gains for different levels of spending. Ultimately, targets, policy, regulatory requirements (eg governing quality and safety issues), operational settings and budgets need to be aligned.

What is critical to achieving desired health outcomes (eg lower rate of diabetes): contribution of different sub-sectors (public health, primary care, hospitals, DSS); workforce requirements (skill mixes); etc

Allocative Efficiency

The reviews would first identify how much is being spent on the service area overall, on what services; what has been happening to the service volumes and prices over (say) the last 6-10 years; and what has been driving volume and price changes (eg changes in disease prevalence; service coverage changes, technological improvement, delivery configuration, wages, staffing levels). Initial inquiries suggest that this could be a time-consuming process, for services that span the organisational silos within the health sector (public health, PHOs, hospitals, DSS etc), because the information may not be collected by service area.

Next the reviews would examine how resources are allocated: how resource decisions are made; how different "purchasers" interact; what evidence is used in those decisions; what officials know about the efficacy and cost-effectiveness of known interventions; and how this feeds into final resourcing decisions.

The reviews would then consider whether better health outcomes are feasible, within the current overall expenditure (eg by changing models of care, service configurations, intervention choices, etc). Identifying the best use of resources within the particular service area (given current information) should enable each review to locate activities with relatively poor or questionable cost-effectiveness within each service area and, by implication, what activities ought to be last to be financed within current budgetary constraints.

The final stage in understanding allocative efficiency would be to compare the health gains achievable from more spending within the particular service area with the gains achievable by spending in other areas.

Organisational Performance

The Reviews would specify, as precisely as current information/analysis allows:

- *For what purchasers and providers should be held accountable* wrt the service area? Both in efficiency and effectiveness terms. This would be expressed in terms

that can feed into future planning and accountability documents, with clear targets and measures.

- *What constraints should government apply* to purchasers and providers involved in the service area. For example, what clinical quality and safety standards should be mandatory; what further restrictions on managerial discretion?

The idea is to specify more precisely what government expects by way of results, and leaving resource management decisions, as far as practicable, to entities. This means that government would not need to rely as much on explicit ring-fencing and other direct controls over local decision-making.

Demand management
The reviews should investigate the nature and extent of unmet need, and assess how the health sector might respond, both now and in the future.

Cost minimisation
The Reviews would investigate realistic opportunities for trimming and avoiding future costs, consistent with proposed outcome goals. The Reviews would look across all the significant cost drivers within the service area: models of care; skill mixes; technology; mode of intervention; compliance cost; delivery etc. The Reviews would come up with concrete suggestions for managing cost pressures, for purchasers and providers to adopt. The reviews would need to examine government's ability to influence all the major drivers of expenditure, beyond just the narrow health sector. Changes in housing quality could, for example, affect the likelihood of respiratory illness; or increases to tobacco tax could reduce smoking rates.

Information
The Reviews should specify what information is required for decision-makers within the service area, where the benefits of the information outweigh the cost of collection. This information set would typically focus on: improving clinical effectiveness, organisational efficiency and capability, and improving resource allocations. The Review should also try to identify any current data that need not be collected.

The key deliverable from each Review would be a clear plan for the particular service area, taking into the analysis under the headings above, setting out:

- what treatments ought be mandatory and what would be desirable but not mandatory
- agreed recommendations on reconfiguring current services and models of care, with any implications for budgets, workforce, and current purchasing arrangements
- agreed milestones for progress, and these will be reviewed and monitored
- how the overall plan would regularly updated and refocused as new evidence becomes available.

The above sets out the ideal set of information and analysis that Ministers would seek from the reviews. In practice, the terms of each Review would be tailored in the light of what is realistically feasible within each health service area to be reviewed. Initial inquiries into the prime disease candidates (eg cardiovascular disease, diabetes, cancer, and chronic respiratory diseases) suggest that the state of current practice and the available evidence base is likely to vary considerably between disease areas.

Along with the reviews of particular service areas, officials envisage a central process for drawing together common threads from the reviews of particular service areas (as well as coordinating the reviews themselves). These common issues would include:

- workforce implications;
- what performance information is required and how it should be used;
- medicines policy;
- regional service implications;
- capital investment implications (eg how many tertiary centres are required for NZ's population and where should be located)
- how payment and accountability systems should be designed for clinicians and other providers
- any other institutional design questions (eg how many DHBs are required, what issues should be determined nationally or regionally, rather than by DHBs).