Introduction

Following the 2009 Ministerial Review Group (MRG) Report (MRG, 2009), Cabinet recognised the need for better prioritisation of new and existing health technologies. Consequently, the National Health Committee (NHC) was refocused and re-configured in 2011 to improve prioritisation of new and existing health technologies, including systems and models of care. Better prioritisation means better investment and disinvestment in health technology. Whereas investment involves the assessment and prioritisation of spending on new health technologies, disinvestment involves the assessment and reprioritisation of spending on existing health technologies; both enable New Zealanders to get better quality health services. This paper sets out the NHC’s preliminary thinking around disinvestment. It starts by defining disinvestment and discusses where the NHC might focus its attention and the tools that could be used to develop advice on disinvestment. The paper concludes with a strategic section – that sets out a framework for the development of the NHC’s disinvestment programme.

Disinvestment rarely implies complete removal of a service or technology. Disinvestment is about better targeting of existing health services to those most likely to benefit. This Think Piece was developed as an internal document to initiate the NHC’s disinvestment program. It is not a concise blueprint for how the NHC will approach disinvestment. Feedback on any aspect of the Think Piece is welcome.

Defining the scope for better targeting

The NHC seeks to add value to the New Zealand Health and Disability sector by promoting effective prioritisation in order to deliver quality health care that is affordable and sustainable. This means supporting smarter investment and disinvestment decision making. To disinvest is to withdraw or reduce an investment (OED, 2012). In health care, the term usually implies reducing or withdrawing health services deemed unsafe, clinically ineffective, or cost-ineffective.
(Elshaug, Hiller, Tunis, & Moss, 2007; Ibargoyen-Roteta, Gutierrez-Ibarluzea, Asua, Benguria-Arrate, & Galnares-Cordero, 2009). Safety, clinical effectiveness, and cost effectiveness are also standard prioritisation criteria for investing in health care.

The NHC defines disinvestment as the inverse of investment so the same criteria used to evaluate an investment opportunity are also used to evaluate a disinvestment opportunity. Currently the NHC has 11 decision-making criteria to support smarter prioritisation:

1. **Clinical Safety and Effectiveness**
   Is the technology or service unsafe or clinically ineffective?

2. **Health and Independence Gain**
   Will the investment or disinvestment proposal result in an overall significant net benefit to patients, consumers, whanau, carers, providers, funders and population groups and improved health and independence outcomes for New Zealanders?

3. **Materiality**
   Will the investment or disinvestment proposal make a material and significant difference in the outcomes it delivers?

4. **Feasibility**
   Is the investment or disinvestment proposal practical, implementable and sustainable, in terms of both processes and outcomes?

5. **Policy Congruence**
   Is the investment or disinvestment proposal congruent with current Government and health and disability sector policies, strategies and priorities?

6. **Equity**
   Is the investment or disinvestment proposal fair and does it ensure equity of access and outcomes to different population groups on the basis of need and ability to benefit?

7. **Acceptability**
   Are there any significant ethical, legal, social, or political issues or consumer and stakeholder concerns around the investment or disinvestment proposal?

8. **Cost Effectiveness (Value for Money)**
   Is the investment or disinvestment proposal cost-ineffective?

9. **Affordability**
Is the technology or service proposed for investment or disinvestment unaffordable?

10. Risk

Have risks around the investment or disinvestment been adequately identified and assessed, and are there mechanisms to ensure that they are effectively managed?

11. Other Criteria as the NHC thinks fit.

Are there any other significant considerations that are not covered in the specified criteria that would influence the recommendation to invest or disinvest?

While the above criteria may change over time, it is envisaged that the NHC prioritisation criteria will apply equally to investment and disinvestment decisions.

Disinvestment can be classified as ‘implicit’ or ‘explicit’. Implicit disinvestment occurs as a process of natural attrition, where a technology or intervention is superseded and/or falls out of use (Pearson & Littlejohns, 2007). Conversely, explicit disinvestment involves taking resources from one service in order to use them elsewhere. While in the past, the disinvestment literature has largely focused on specific health technologies, it is now being discussed in much broader terms, including trading-off expenditures between different service groups, better integration of health services between primary and secondary care providers, and better integration of the health system with other government agencies (Cooper & Starkey, 2010; Fordham & Martin, 2011). Taking this broader view, disinvestment advice can further be classified by level – macro, meso, and micro, as summarised in Figure 1. Micro advice focuses on specific interventions; meso advice focuses on broad service groups (e.g. oncology, cardiology) and the drivers of technological change, and macro advice is concerned with resource allocation between Vote Health and other areas of government spending (Figure 1).

Explicit disinvestment means making recommendations with direct funding implications, i.e. removing the funding that supports service delivery. Implicit disinvestment concerns speeding up the natural rate of attrition, but it does not involve direct intervention through funding mechanisms. The categories in the matrix are not mutually exclusive and all measures (micro / meso / macro, explicit / implicit) can be thought of in terms of continuums. Nevertheless, the matrix is specific enough to illustrate our discussion of disinvestment.
Figure 1: Disinvestment Advice Matrix

<table>
<thead>
<tr>
<th>Micro</th>
<th>Implicit</th>
<th>Explicit</th>
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<tbody>
<tr>
<td>Advice given on whether to more specifically target funding for particular interventions (e.g., grommets, tonsillectomies, adenoidectomies, and non-medical male circumcision).</td>
<td>Advice given on the value of specific interventions without explicit linkage to funding decisions. Effective prioritisation of existing resource (not simply new funding) should see resources shift from low value interventions to higher value interventions (e.g., where clinical guidelines may be developed and implemented to better target the individuals or groups who receive specific interventions and reduce harm and waste).</td>
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<tr>
<th>Meso</th>
<th>Implicit</th>
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<td>Advice given on funding of major areas of vote health expenditure, shifting existing resource from areas of lower value to areas of higher value (e.g., shifting funding from oncology to cardiology or vice versa; or shifting funding from end-of-life care to early childhood services or vice versa).</td>
<td>Advice given to enable existing resources, in major areas of vote health expenditure, to shift from lower value areas to higher value areas without explicit linkage to funding decisions. This may occur through service group or system level prioritisation - as opposed to prioritisation for specific interventions. Advice given on the drivers of technological change to enable a shift away from obsolete interventions (e.g., improving workforce training for faster adoption of cost-effective technologies; promoting market mechanisms for price sensitive effective interventions).</td>
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<th>Macro</th>
<th>Implicit</th>
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<tr>
<td>Advice to actively shift resources into or out of the health system (e.g., back to the tax payer or to other social spending).</td>
<td>Advice around establishing prioritisation mechanisms that cross social sectors, potentially including the private sector.</td>
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**Why disinvestment is important**

Like investment, disinvestment is a form of prioritisation. Like all prioritisation it is necessitated by scarcity – unlimited wants for health care to be met with limited resources. A recent paper by the King’s Fund set out six prioritisation strategies in the UK National Health Service (Klein & Maybin, 2012). These are prioritisation by:

**Denial** - Specific forms of intervention are excluded from the NHS services on offer, on the grounds of lack of effectiveness, high cost or a combination of the two.
**Selection** - Service providers select those patients who are most likely to benefit from interventions or raise the threshold of eligibility for treatment.

**Delay** - The traditional form of prioritisation in the NHS, designed to control access to the system and match demand to supply by making patients wait.

**Deterrence** - If patients are not put off by queues, there are other ways of raising barriers to, and the costs of, entry into the health care system, for example, co-payments.

**Deflection** - All else failing, patients may be shunted off to another institution, agency or programme. ‘Difficult cases’ may be referred to another hospital or specialist.

**Dilution** - Services or programmes continue to be offered, but there are fewer nurses on the ward, doctors order fewer tests, the palatability of hospital food plunges, and the quality of care and treatment declines.

Disinvestment is principally concerned with the first two forms of prioritisation – prioritisation by denial and prioritisation by selection. Internationally, scarcity of resources and growing demand for health services make prioritisation unavoidable. The only choice is the type of prioritisation preferred. Whilst prioritisation by denial and selection may be done in a considered manner, accounting for the decision making criteria above, prioritisation by delay, deterrence, deflection and dilution are liable to reduce quality and equity of access. Thus disinvestment if done appropriately should improve the sustainability and quality of the health system.

**Where should the NHC focus its attention?**

The most appropriate quadrants for the NHC to focus its attention on will be determined by a number of considerations, including its Terms of Reference as well as the existing work programmes of the Ministry of Health, the National Health Board and the wider health and disability sector. The characteristics of the disinvestment matrix are discussed further below in this context.

**Micro**

The NHC has begun investigating disinvestment opportunities at the micro level and expects to continue to operate in this space. To do so, high quality clinical advice and data analysis are necessary to assess interventions against the NHC’s 11 decision-making criteria. Savings that might be made through reallocating resources will be estimated in many cases with available datasets. Where existing datasets cannot be employed, the NHC’s Innovation Fund may be
used to fund New Zealand field work and provide additional New Zealand data for further assessment and evaluation.

**Meso**

The meso picture is less clear. The NHC will never have the capacity to address all disinvestment activity so it must choose where it can best add value. There is room for the NHC to strengthen the prioritisation process at the meso level – i.e. trading-off service groups (specialty areas). The NHC has begun work developing a programme budget of Vote Health expenditure to get a clearer picture of current spending relative to the burden of disease. The programme budget will enable the NHC to better target its efforts and when combined with marginal analysis will be a very powerful tool for determining the best areas for investment and disinvestment. The NHC’s role is to provide a practical evidence-based clinical and economics lens to key questions around prioritisation, including both investment and disinvestment.

Advice on the drivers of technological change can easily straddle implicit and explicit disinvestment advice. For example, clinicians may be incentivised through funding (explicit disinvestment) or purely information channels (implicit disinvestment) to choose safe and cost-effective technologies and by implication disinvest in unsafe and/or cost-ineffective technologies. This is called a meso-level decision rather than a micro-level decision as it involves a whole system approach to incentivising, rather than specific incentives for individual technologies.

**Macro**

The extent of the NHC’s activity at the macro level is difficult to foresee, but is likely to involve working with other government agencies with significant influence on the broader determinants of health, such as housing and welfare.

**Implicit**

The implicit approach essentially relies on education and targeted information dissemination driving change. It is well established that provision of information often has limited effects on its own (Robertson & Jochelson, 2006). That is not to say that the implicit approach is necessarily ineffective. If information is credible and relevant and the workforce is self-motivated to improve their practice, it may be highly effective. Evidence-based guidance has reduced the inappropriate use of grommets in England, for example (Black & Hutchings, 2002). Likewise, the experience of the Ontario Health Technology Advisory Committee, as relayed to the NHC, is that evidence-based guidance has been enough to change practice over a short period of time.

The implicit approach is potentially more conducive to a co-operative and flexible means of identifying potential areas for disinvestment, but it also risks being ineffectual at times. It may
also be more difficult to attribute savings from implicit disinvestment, as funding is not directly withdrawn from a technology or service.

**Explicit**

The explicit approach uses coverage and funding levers to drive change, actively removing or shifting resources to prevent low value expenditure. This contrasts with the reliance on comparatively passive methods which are inherent in an implicit approach. The explicit approach potentially captures savings more convincingly, but risks being viewed as draconian and losing sector support. The need for an explicit approach will depend on the sector’s response to NHC advice.

Whatever approach is taken, it is imperative the NHC fully engage with stakeholders to ensure the quality and acceptance of its work. Stakeholders include but are not limited to: patients, clinicians, colleges, managers, DHBs, private providers, Ministry of Health (MoH), National Health Board (NHB), Health Workforce New Zealand (HWNZ), Health Benefits Limited (HBL), Pharmaceutical Management Agency (PHARMAC), Health Quality Safety Commission (HQSC). Sector buy-in is likely to be difficult in some instances, but it is an essential part of the process.

**Developing disinvestment advice – the tools**

This section sets out potential tools to identify areas for disinvestment. It does not represent an exhaustive set of tools; the NHC will develop tools as it develops its capability. The techniques identified are not specific to micro, meso, or macro-level prioritisation. For example, health technology assessment (HTA) guidance and benchmarking can inform both prioritisation of specific interventions and prioritisation across service groups more broadly.

The NHC gathers information about potential investments and disinvestments through formal and informal avenues. Key to the NHC’s operations would be referral rounds where proposals for investments and disinvestments are sought from the sector for prioritisation. A horizon-scanning capacity is currently being developed to complement the referrals process. Horizon scanning is expected to inform both investment and disinvestment activity. The NHC is becoming well-connected and ideas regularly flow to it from the sector. The NHC’s Executive team also has the freedom to approach clinical experts and professional organisations to ensure the quality of its work. Advice will be developed with a view to publication on the NHC website and, potentially, in medical journals. Publication of the NHC’s work is expected to generate debate and valuable feedback around investment and disinvestment priorities.

**Developing relevant health technology assessment products**

The NHC is currently developing a suite of fit-for-purpose HTA products to help inform investment and disinvestment decisions. The broad aim is to find the right balance between
scientific rigour and timely advice. Given that HTA has traditionally been a resource intensive business (in terms of time and money), and given that the majority of evidence for health technologies comes from abroad, it will be infrequent that the NHC’s advice is based purely on New Zealand-generated evidence. Rather, the NHC is often likely to contextualise international research to New Zealand. On the investment side of the NHC’s business, if a new technology or service is found to render a current technology or service obsolete, any recommendation to invest will be associated with a disinvestment recommendation.

Disinvestment rarely implies complete removal of a service or technology. The experience of the United Kingdom’s National Institute for Clinical Effectiveness (NICE) is that there are few obvious candidates for total disinvestment (Garner & Littlejohns, 2011). More often, disinvestment is concerned with changes at the margin, or what is termed ‘optimal targeting’: identifying subgroups of people with particular clinical characteristics in which an intervention is cost-effective or cost-ineffective. Accordingly, most of the disinvestment advice the NHC generates is expected to focus on better targeting of existing interventions.

**Mega-analysis**

The NHC is developing a capability in mega-analysis. Mega-analysis allows various technologies and treatment alternatives surrounding a selected disease or health state - including devices, drugs, imaging modalities and surgical interventions - to be assessed and compared to one another. Mega-analyses allow the most effective clinical interventions to be identified and provide opportunities to focus on the most effective and cost-effective options to optimize patient care. At the same time, obsolete clinical interventions are identified so that their use can be minimized or eliminated altogether. Mega-analysis involves multiple related HTAs, and while it is more resource intensive to undertake, it may be a more efficient means of identifying investments and disinvestments than single HTAs focusing on very specific technologies associated with different diseases or health states.

**Using international guidance**

As indicated, the NHC will use international disinvestment advice where it is available and relevant. For example, NICE is the most prolific producer of disinvestment guidance. NICE has published more than 1000 ‘Do-Not-Do’ recommendations. In England, various local health authorities have also developed lists of interventions of low clinical value often based around NICE advice. Such lists may also be useful in generating areas for disinvestment in New Zealand. The NHC is also aware the disinvestment interest sub-group of Health Technology

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Assessment International (HTAi) is currently developing an international list of interventions for disinvestment.

**Benchmarking**

Benchmarking involves comparing the provision of a service or intervention across different health providers, controlling for relevant socio-economic factors (e.g., age, gender, deprivation), to identify whether providers are operating efficiently and equitably. The yardstick for comparison can be best practice (established via HTAs if comparing interventions, or clinical groups developing guidelines) or an average rate of intervention. Benchmarking is widely used in the UK.

Benchmarking was highlighted in the Ministry of Health’s Briefing to the Incoming Minister in 2011 as a tool for driving investment towards better models of care (MOH, 2012). Benchmarking may spur providers (with or without incentives) to improve their performance if comparative results are robust. Benchmarking may also be used as an ‘opportunity locator’ to inform where best to focus health-service reviews.

National benchmarks using average rates of intervention are crude measures that do not take all local or specific clinical issues into account, and do not identify how achievable reductions are. More often than not, it will not be known what the ‘right’ rate is. Hence benchmarking is best seen as a tool to start a disinvestment dialogue, rather than conclusive evidence in its own right.

**A plan for disinvestment**

This section sets out a potential plan for disinvestment. The NHC will employ the full range of tools discussed above with work initially focusing on specific interventions at the micro level of disinvestment before looking at health services more broadly (the meso and macro levels). The overarching plan is to focus on the areas where the NHC thinks the maximum gains are available while building a credible prioritisation process, before turning to more technically difficult and challenging proposals. Engagement with the sector is crucial to ensure the quality and acceptance of the NHC’s work but also to avoid duplication of effort.

**Use the NHC decision-making criteria**

Proposals for disinvestment will follow the same process as proposals for investment and will be evaluated using the same 11 decision-making criteria. To this end, an HTA toolbox is currently being developed that will enable the Executive to provide sufficient information to support a recommendation from the Committee. Clinical Safety and Effectiveness and Cost-Effectiveness are the key criteria for identifying investment and disinvestment opportunities. If the volume of
disinvestment opportunities is such that a filtering process is necessary, then the pertinent questions are which interventions the NHC can influence and which will have the greatest associated potential savings. Here the Feasibility and Materiality criteria may be used as filters. Key to Feasibility is workforce sustainability. Disinvestment may take pressure off particular medical disciplines experiencing critical workforce shortages, freeing up resource to focus on more effective and feasible interventions. Hence disinvestment in ineffective interventions uncovered in vulnerable medical disciplines should be prioritised.

If a disinvestment is made in one area, re-investment in the same area should not be assumed

Whenever the NHC recommends a new health service or intervention it should also consider if a current service or intervention will therefore become obsolete and thus be subject to disinvestment. However, it should not be assumed that the NHC will automatically recommend reinvestment in areas subject to disinvestment. The next best spend is unlikely to always reside in the service group a disinvestment is proposed. Ultimately, the NHC want resources to be efficiently allocated not just within service groups but between them as well.

Start developing a Programme Budgeting and Marginal Analysis (PBMA) process for investment and disinvestment

If the NHC wishes to consider disinvestments in the context of service groups or disease categories alongside investment decisions, then a PBMA-style approach to prioritisation may be appropriate. PBMA has three essential steps. First, the programme budget is estimated by establishing the total resources allocated and identifying the services on which these resources are spent. Second, new areas for investment are identified with associated costs and benefits – often known as a ‘wish list’. Third, current and potential new services are assessed for their costs and benefits to see where resources can be released to fund items on the ‘wish list’. However, PBMA is a flexible model and there is no requirement for money realised from disinvestments to be reinvested in the same service group or disease category. Furthermore, because of the potential length of the ‘wish lists’ (particularly for new services), it is likely that an initial estimate of costs and benefits will be undertaken; followed by a more rigorous assessment where required. The process is usually run by an advisory panel that assess proposals against a set of criteria; they may also have access to subject experts as necessary.

As already indicated, the NHC has begun work developing a programme budget. Following this, the next stage is to use the programme budget for marginal analysis. Marginal analysis entails comparing the additional benefit from an additional resource used (marginal benefit) to the additional cost of the consumed resource (marginal cost). The idea is to compare the marginal

See NHC’s feasibility criteria: http://www.nhc.health.govt.nz/node/143
costs and benefits of different services or interventions to see where the next best spend /
disinvestment are. In practice marginal analysis is difficult as frequently very little reliable
information is available on the costs and benefits of services or available only as average cost
and average benefit. Estimation, informed by subject experts and HTA are two means of
overcoming this difficulty.

**Building a cooperative approach to disinvestment**

To be successful the NHC must take the sector with it. Hence heavy-handed intervention is not
the preferred starting option. The NHC intends to encourage and build on disinvestment
initiatives initiated by other organisations in any of the disinvestment quadrants. The NHC are
already aware of several disinvestment activities underway in the sector. However, some
providers may not respond to evidenced-based information and prioritisation tools (ie, implicit
approach); hence a more direct approach linked to coverage and funding (ie, explicit approach)
could at times be required.

In the immediate term, the NHC will identify candidates through: the referral rounds,
engagement with Colleges, DHBs, clinical networks and other experts, and internationally-
derived lists of low value interventions. The NHC also see value in working with the HQSC to
establish where the NHC can complement their work in benchmarking the safety and
effectiveness of common interventions. In the medium term, consideration may be given to
developing a national ‘low priority interventions’ list – where clinical effectiveness is marginal or
cost-effectiveness is assessed as inadequate. DHBs’ relative intervention rates could be
measured through analysing national data sets or benchmarking against this list. The NHC may
also look to develop prioritisation processes for specific interventions in collaboration with the
sector, for example, strategies developed for improved compliance with existing clinical
guidance.

**Implementation of disinvestment advice**

The NHC’s role is to establish a national assessment process for providing the Minister with
advice on the value-for-money and priority of (non-pharmaceutical) technologies, services,
models of care and programmes. The NHC is an advisory body where implementation is the
responsibility of other organisations (for example, MoH, DHBs, NHB, HBL, PHARMAC).
However, the NHC needs to account for implementation and monitoring when making
recommendations around investment and disinvestment. Implementation plans will need to be
developed alongside those responsible for implementation. The tools for implementation are
likely to be intervention/service-specific. This section sets out the NHC’s broad approach to
implementing disinvestment decisions. An exhaustive set of options is not presented. Ultimately
the best means of implementation will only come apparent through cumulative experience.
Options are discussed under five subheadings: Persuasion, Consumer Information, Monitored Self-improvement, Central Accountability and Performance Management, and Ministerial Directive. While Persuasion, Consumer information, and Monitored Self-improvement are aligned with an implicit approach to disinvestment, Central Accountability, Performance Management and Ministerial Directive are more aligned with an explicit approach.

**Persuasion**

There is extensive literature on how to change clinical practice in general but little focusing on disinvestment in particular. Nevertheless, the general evidence on changing clinical practice is still relevant. NICE guidance on changing practice supports the use of educational materials in combination with other methods (NICE, 2007; Robertson & Jochelson, 2006). Educational materials include online tools, booklets, journal supplements, DVDs, and computer programmes to inform health care professionals about the latest developments in their field. Educational meetings and outreach visits are also supported by NICE as methods for promoting change. Educational meetings include conferences, workshops, training courses and lectures, and are most effective when interactive. Outreach visits involve trained individuals visiting health care professionals in their own practice to offer information, support and instruction in line with current best practice. However, outreach visits can be time consuming and costly and it is unclear they are effective in supporting difficult change. Opinion leaders and Clinical Champions are generally an effective means of disseminating information.

The NHC is currently developing a suite of fit-for-purpose HTA products for investment and disinvestment decisions. They may be educational products in their own right, but their influence is anticipated to go beyond pure information dissemination. Various other persuasive opportunities may arise, for example, through contributing to evidence dissemination services such as the Canterbury initiative[^3], the Health Improvement Innovation Resource Centre (HIIRC)^[4], or publication in academic journals.

**Consumer Information**

This paper has focused on the supply side of disinvestment, but reductions in ineffective treatments might equally be achieved through educating the public not to demand them. An example of what might be termed ‘demand-side disinvestment’ is the public education campaign run by PHARMAC, clinicians, and others to reduce the inappropriate use of antibiotics so that patients do not expect antibiotics for colds and flu.

**Monitored Self-Improvement**

In health care, education is a necessary but often insufficient condition for behavioural change. More often than not education requires augmentation with more formal tools. One option considered above, and employed extensively in the UK, is benchmarking. Benchmarking can be used both to identify disinvestment opportunities and as a monitoring tool. External auditing or internal auditing of performance is another means of implementing advice. Feedback may be on health outcomes, costs or other elements of clinical performance and may be combined with benchmarking against peers (NICE, 2007). The effectiveness of auditing (internal or external) is enhanced by: timeliness, being rich in clinical data, staff having an active role in audit, those delivering feedback being respected, and by being combined with financial incentives (NICE, 2007).

Though not specific to disinvestment, the Western Australian Audit of Surgical Mortality (WAASM) provides a good example. WAASM is a voluntary scheme for auditing the performance of surgeons when patients admitted under the care of a surgeon die in hospital (RACS, 2012). Seventy-three percent of surgeons who replied to an audit in 2004 reported they changed their practice in response to the scheme (Semmens et al., 2005). Since WAASM was first piloted in 2011, the total number of patients who have died while under the care of a surgeon has decreased more than 20 percent (RACS, 2011). Such an audit process might be used to implement clinical guidelines aimed at reducing the inappropriate use of any particular intervention. Where internal auditing is transparent, consistent, and credible, it may substitute for external auditing.

**Central Accountability and Performance Management**

The Crown Funding Agreement is the formal agreement between the government and each District Health Board (DHB) governing the work they will do and the funding they will receive. It incorporates a Service Coverage Schedule on the services that are to be funded and the Operational Policy Framework (OPF) that is the set of operating rules. It also requires DHBs to give effect to their Plans.

The SCS can be used to specify the changes to services to be funded resulting from Government decisions on NHC recommendations. If the recommendations are on a specific technology used in a service then the indications (and exclusions) for the funding of that technology can be written into the relevant part of the Schedule. The SCS is mostly used to specify minimum service coverage. However, the NHC could put forward proposals to remove certain services from the Schedule, or change something from being fully-funded to partly-funded, or require certain access criteria to be met before a service is funded. The Service
Coverage Schedule is administered by the National Health Board (NHB) and reviewed annually as part of the DHB planning round.

The Operating Policy Framework (OPF) sets out the business rules for DHBs and may be used to outline change processes to be followed, for example, the 2011/12 OPF requires DHBs to implement evidence-based guidelines for diabetes and cardiovascular disease (MoH, 2011). DHBs now have a single planning document that combines the District Annual Plan and Statement of Intent. DHBs could potentially be required to include something in these documents, for example, as a way of agreeing how they will implement decisions (if there is any local flexibility). If close monitoring is thought necessary, the DHB monitoring framework may be employed to keep track of disinvested interventions. Further to these options there is the potential to influence Regional Service Plans to promote greater allocative efficiency of resources within a region – i.e. disinvesting in marginal services and pooling resources.

Monitoring

Where NHC recommendations are suggesting a technology or service be provided but under certain indications only, the NHB can require DHBs to identify how much funding is allocated to a disinvested intervention or service and then reduce funding accordingly or require DHBs to direct the funding to another service/intervention. DHBs may still choose to fund things over and above service coverage requirements if they have funding, but in the current fiscal environment if funding is removed it is unlikely a service will continue.

If close monitoring of a disinvestment is required, this can be specified in the SCS, and associated performance reporting. The Crown Funding Agreement creates an obligation on DHBs to report service coverage issues and gaps, either identified locally or at the request of the Ministry. Reports are twice-yearly and could be expanded to include a report back on service activity for a defined period, as part of a transition following a disinvestment decision. Alternatively the national data collections may be monitored by the NHC to track progress.

Ministerial Directive

The Minister of Health may, Under section 33B of the New Zealand Public Health and Disability Act 2000 (as amended in 2010), give a direction to all DHBs ‘…to comply with the stated requirements for the purpose of supporting government policy on improving the effectiveness and efficiency of the public health and disability sector’.

This power could be used to give effect to agreed NHC recommendations, including disinvestment recommendations, but it should be used only as a last resort. Directions are a strong tool generally reserved for over-riding resistance. They are best partnered with performance management consequences to form a late step in an escalating chain of action.
The direction powers in the legislation were included to resolve impasses that develop in the other processes.

The NHC’s approach to disinvestment can be summarised in the following pyramid adapted from the work of Professor John Braithwaite on responsive regulation (Braithwaite, 2002).

Figure 2: A responsive approach for building trust during the process of disinvestment

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Ministerial Directive

Central Accountability and Performance Management

Monitored Self-Improvement

Consumer Information

Persuasion
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The pyramid illustrates when to use an implicit approach (e.g., central intervention) versus an implicit approach (e.g., persuasion). The pyramid indicates that even with the most difficult disinvestment decisions the NHC should start by focusing at the base of the pyramid with persuasion. The idea is to give the most engaging option a chance to work (implicit disinvestment) before progressing up the pyramid to more direct control (explicit disinvestment). This process should build legitimacy, as those subject to disinvestment will see it as fair and accordingly compliance with disinvestment decisions is more likely. However, to be successful health providers have to see a credible threat of escalation should they not respond to persuasion so the NHC will need to ensure this is present.

The pyramid should not be viewed as the NHC’s blueprint for engagement; instead it is a representation of a preference for persuasion rather than heavy handed intervention. In reality a mix of the above tools will be employed on a case by case basis. An implication of the persuasion approach is that stakeholders such as patient groups, clinicians, colleges, managers, DHBs, private providers, MoH, NHB, HWNZ, HBL, HQSC and PHARMAC will need
to be engaged early and throughout the disinvestment process, just as they are in the investment process.
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National Health Committee (NHC) and Executive

The National Health Committee (NHC) is an independent statutory body which provides advice to the New Zealand Minister of Health. It was reformed in 2011 to establish evaluation systems that would provide the New Zealand people and health sector with greater value for the money invested in health. The NHC Executive are the secretariat that supports the Committee. The NHC Executive’s primary objective is to provide the Committee with sufficient information for them to prioritise interventions and make investment and disinvestment decisions. They do this through a variety of products including Prioritising Summaries, Technology Notes, EpiNotes, CostNotes, Rapid Reviews, and Health Technology Assessments which are chosen according to the nature of the decision required and time-frame within which decisions need to be made.


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