

## **Napier City Council**

### **Napier-Hastings Hospital Rationalisation**

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***A report prepared for the Napier City Council in 1994. At the time we wrote it, this report was acknowledged by legal advisers to the Central Regional Health Authority as being a definitive statement of the principles which should apply to consultation in the health sector. It is re-published to assist health sector managers as they look at options for meeting the Government's objectives of increasing public confidence in the health system.***

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#### **1.0 INTRODUCTION**

This report has been commissioned by the Napier City Council ("the Council") from McKinlay Douglas Limited ("MDL") as part of the work which the Council is carrying out in preparing a major submission to the board of directors of Health Care Hawkes Bay Limited ("the CHE") on the report of the Regional Hospital Task Force "Hawkes Bay Regional Hospital: Superior Services for the Future" ("the Task Force Report").

The brief given MDL by the Council for this assignment is to identify and comment on:

- ▶ The statutory responsibilities of the Central Regional Health Authority ("the Central RHA") in the provision of health and hospital services in Hawkes Bay.
- ▶ The nature of the relationship between the Central RHA and the CHE (Health Care Hawkes Bay) and other health providers in the Hawkes Bay region.
- ▶ The nature of the 1994/95 Government Policy Guidelines to the Central RHA and how these impact on the provision of regional health services.
- ▶ The role and responsibilities of the Central RHA in the consultation process with the Hawkes Bay community on future hospital services in the area.
- ▶ In the light of the preceding points, an evaluation and assessment of the process which has been put in place in Hawkes Bay to determine the future provision of hospital services locally.
- ▶ Any other issues considered relevant to this overall matter.

This brief was commissioned by the Council on 2 June 1994 with a request that a final report be in the Council's hands on 8 June 1994, a deadline since extended to mid-morning on 9 June. Inevitably, this has imposed severe constraints on the extent to which matters relevant to the brief could be reviewed. In practice, our review activity has been confined to:

- ▶ Interviews, some in person, some by phone, with officials and other parties from the Central RHA, the Ministry of Health, the office of the Minister in charge of Crown Health Enterprises, public relations consultants advising the CHE, the CHE itself and the Council.
- ▶ Background material consulted has included the Health and Disability Services Act ("the Act"), ministerial policy guidelines for regional health authorities, the Ministry of Health's post-election briefing, a range of sources on consultation, and material provided by the Council and other parties as well, of course, as the Task Force Report itself.

Much recent emphasis on consultation issues has focused on the legal requirements which parties, with a duty to consult, must observe. The past few years have seen a significant amount of litigation on consultation. Best known are the so-called Wellington International Airport case, which involved decisions by the High Court and the Court of Appeal, and the series of cases which came out of challenges to establishment plans for energy companies under the Energy Companies Act 1992.

This report accepts that the nature of the legal obligations which any particular party may have is of major importance but prefers to see consultation as primarily a public policy rather than a legal issue. The reasons for this will become clearer later in this report.

The report, proper, begins by providing brief background to the issue and then:

- ▶ Reviews recent developments in relation to consultation generally.
- ▶ Considers the nature of the obligations to consult created by the Health and Disability Services Act.
- ▶ Considers the Task Force Report and the process of consultation in respect of that.
- ▶ Presents conclusions and recommendations.

## **2.0 BACKGROUND**

Provision of hospital services in Hawkes Bay has been a matter of concern to providers, funders, and the Hawkes Bay community for a number of years. The issue has, inevitably, been intertwined with the somewhat unique situation, in New Zealand, of two relatively major cities within a short distance of each other. At least within health management and some health professional circles, the view has existed for some years that the optimal solution is the concentration of acute hospital services within a single facility. In the early 1980s, it was proposed that both Napier and Hastings Hospitals be replaced with a third hospital located between the two centres. This proposal was

rejected by Government.

Ten years later, at the beginning of the 1990s, the then Hawkes Bay Area Health Board commissioned the American consulting firm Booz-Allen and Hamilton to carry out a study the terms of reference for which commenced "construct a brief for a single acute hospital to serve the population projected for Hawkes Bay in 10 - 20 years".

That report, which recommended consolidation on a single site in Hastings, met substantial opposition, particularly within the Napier community. According to the Council, 10,000 people marched the streets of Napier in protest and 30,000 signed a petition rejecting the report.

It is against that background that the Regional Hospital Task Force was set up by the CHE, to examine the rationalisation of Napier and Hastings Hospitals. Against this history, consultation on a fresh endeavour to look at rationalising acute health care services in Hawkes Bay was clearly going to be an extremely sensitive issue. How this should be dealt with was the subject of discussion, between the Central RHA and the Council, in June 1993. The Central RHA proposed a formal public consultation process with facilitation. The Council argued against this, informing the Central RHA that:

*"The disadvantages of the hospital issue being publicly debated again are:*

- (1) Anxiety and apprehension will again be created in both Napier and Hastings, generating parochial competition and distrust.*
- (2) Interest groups may capture the process and the media will have a field day.*
- (3) Consequently, the rational process of determining what is best for the process will be compromised. It will create difficulties, particularly for the CHE board."*

*"The more appropriate process in our view would be to let the CHE board deal with the issue objectively but in consultation with the Hawkes Bay Health Council and the affected local authorities."*

That view was subject to certain conditions, including adherence to certain principles which had been agreed amongst the Hawkes Bay local authorities the previous year. At the heart of the Council's concern regarding the consultation process followed in respect of the Task Force Report is the belief that those conditions were not complied with.

### **3.0 CONSULTATION GENERALLY**

It has become increasingly common, in recent years, for legislation to include a requirement to consult. In the present context, the Health and Disability Services Act is an obvious example and will be discussed in the next section of this report. It is far from being the only one. Nor is the term "consult" or "consultation" always used. Sometimes,

instead, public authorities are required to go through processes which in form have all the appearances of consultation without in practice (or in the legislation) being defined as such. Examples of consultation requirements include:

- ▶ Section 62 of the Education Act 1989 which provides that "Before preparing a proposed charter for a school, or a proposed amendment to a school's charter, the board shall take all reasonable steps to discover and consider the views and concerns of Maori communities living in the geographical area the school serves".
- ▶ Section 5 of the Foundation for Research Science and Technology Act 1990 which sets out the functions of the Foundation including the provision of independent policy advice to the Minister following consultation between the Foundation and representatives of industry, researchers, Maori and the community. The Foundation is required to institute a programme of regular consultation to ensure views are considered in the formulation of advice.
- ▶ Section 4(2)(a) of the Airport Authorities Act 1966 (inserted by an amendment act in 1986) which expresses the powers of airport companies to set fees, charges and dues as "After consultation with airlines which use the airport, charge and set such fees, charges, and dues as it from time to time thinks fit for the use of the airport operated or managed by ...".
- ▶ Section 716A of the Local Government Act 1974 (inserted by a 1989 amendment) which sets out the so-called special consultative procedure which governs local authority consultation on certain specified matters. This procedure includes giving public notice of the proposal concerned, providing a period of not less than one month nor more than three for public submissions, giving people a reasonable opportunity to be heard and ensuring that the final decision in relation to the proposal is made at a meeting of the local authority. Amongst the matters subject to the special consultative procedure are the consideration and adoption of the annual plans of local authorities and the disposal of any significant undertaking. Local authorities and electric power boards were required to use this process, by the Energy Companies Act, in the course of preparing establishment plans for energy companies.

It should be clear, from these four examples, that consultation is intended to serve a wide range of purposes. Thus, from the examples cited above, it could be inferred that the purpose of consultation was as follows:

- ▶ With respect to school boards determining the views and concerns of Maori communities, to ensure that the Crown's obligations under the Treaty of Waitangi are respected.
- ▶ In the case of consultation by the Foundation for Research Science and Technology, to ensure that advice which goes forward to Ministers, on science matters, is well informed and soundly based so as to produce policy recommendations and decisions which are effective to achieve their desired objectives.
- ▶ Between airport companies and airlines, in respect of the setting of charges, fees

and dues, to provide some restraint on the monopoly powers of airport companies, particularly as their legislation gives them an explicit exemption from the application of the Commerce Act.

- ▶ For the process imposed on local authorities, when set in the context of local authority accountability, not only to provide for public input but to act as a constraint on local authority activity as it provides a means of giving public information about the performance of local authorities which, presumably, will influence voting decisions at local authority elections.

Each of these examples implies a public policy purpose lying behind the requirement to consult. In each case, the purpose can be seen, in narrow terms, as ensuring that more efficient decisions are taken and that they better reflect the concerns of parties who will be affected by them.

This narrow purpose has been recognised in litigation, most notably in the so-called Wellington International Airport case (Air New Zealand and Ors v Wellington International Airport Limited, Attorney-General and Ors [1993] 1NZLR671(CA)). That case concerned a challenge, by airlines using Wellington Airport, to the process which Wellington International Airport had followed in setting landing charges. Counsel for the airlines sought to argue that the purpose of consultation, under the Airport Companies Act, was to provide an opportunity for airport users to negotiate a level of charges that ensured that the monopoly position which the airport company occupied was not being abused. In making this argument he drew on background material leading up to the passage of the legislation including statements in the House, Ministerial statements, officials' reports, policy papers and Select Committee proceedings. He found references in some of the officials' papers that the requirement for consultation would provide the users of airport services the opportunity to negotiate charges directly with each airport and thus exert pressure for efficiency improvements and overall cost reduction.

The Court of Appeal rejected the argument that it should have regard to background material in determining the intent of the legislation and stated:

*"The law is to be found in the enactment itself, and not in the subjective intentions of the draftsman or of the department, nor in those of the Minister or of other members of the legislature".*

It went on to say in respect of consultation itself that:

*"We do not think "consultation" can be equated with "negotiation". The word "negotiation" implies a process which has as its object arriving at agreement. There is no such requirement in the present case. The airport company is given the power to fix charges. Before doing so it must consult, and for consultation to be meaningful, there must be made available to the other party sufficient information to enable it to be adequately informed so as to be able to make intelligent and useful responses. The process is quite different from negotiation, however. One cannot expand the statutory requirement by replacing the word "consultation" with "negotiation" and then*

*importing into the section the very different meaning of the latter word".*

Finally, at the end of its judgement, the Court set out its view of consultation as:

*"If the party having the power to make a decision after consultation holds meetings with the parties it is required to consult, provides those parties with relevant information and with such further information as they request, enters the meetings with an open mind, takes due notice of what is said, and waits until they have had their say before making a decision, then the decision is properly described as having been made after consultation".*

That statement by the Court of Appeal has been extremely influential on parties considering what their duties to consult may be. Currently, it is the only definitive statement available to people wrestling with the issue of what consultation actually means and how it should be carried out, usually because the statutes requiring consultation provide little or no guidance as to what is intended.

In MDL's judgement, there is a fundamental difference between the legal requirements for effective consultation and the public policy requirements.

A court, when considering whether or not there has been proper consultation, is normally doing so in the context of an application for judicial review of a particular decision where the focus of the court is on the question of due process rather than on the quality or impact of the decision arising out of that process (unless it is also asked to consider the question of whether the decision was so unreasonable that no reasonable body could have made it, a test which it is extremely difficult for challenges to satisfy).

The public policy perspective on an individual decision is also, obviously, concerned that due process should have been followed. However, it has another and usually overriding concern which is quite separate from issues which a court can consider; this is with the legitimacy of individual decisions and of process, generally, in the area of policy concerned. From a legal perspective, it is sufficient, in the case of an individual decision, that it is robust against legal challenge. From a public policy perspective, that can be almost irrelevant if the decision, and its impact, are such as to undermine public confidence in the process. Policy makers must always be concerned that the processes which they have put in place serve not only to produce individual decisions which are robust against legal challenge but also to ensure that the decisions are perceived as legitimate or, at the very least, immune from being set aside or attacked on other grounds (this issue is discussed in more detail when the Health and Disability Services Act itself is reviewed).

The distinction between the legal and the policy interests in consultation can be looked at in another way. From a legal perspective, it is sufficient that a proposal, once developed, is put through an appropriate consultation process. From a public policy perspective, the real issue requiring consultation might be one of how or by whom the proposal itself is developed. There is evidence, from experience with public consultation

processes, that it may be impossible to obtain public support if the public feel that they are being presented with a fait accompli no matter how carefully the proponents go about satisfying the formal legal requirements for consultation or how genuinely they endeavour to remain open minded. The public consultations over the proposed sale, by the Auckland Regional Council, of its shares in the Ports of Auckland Ltd and by the Invercargill City Council, of its shareholding in Electricity Invercargill Ltd, support this contention.

In MDL's view, it should be a primary objective of public officials undertaking, or considering, decision making processes which require consultation to consider not just the particular instance they are involved with but the implications, long term, for the legitimacy of both the decision itself and of the policy environment within which it is made.

We turn now to consider consultation under the Health and Disability Services Act against this specific background.

#### **4.0 CONSULTATION UNDER THE HEALTH AND DISABILITY SERVICES ACT**

A number of sections in the Act bear on the nature of the obligation which regional health authorities ("RHAs") have to consult.

The starting point is Section 18 which provides, in sub-section 4:

*"Every regional health authority shall consult in regard to its intentions relating to the purchase of services in accordance with Section 34 of this Act".*

Section 34 itself reads:

*"Every regional health authority shall, in accordance with its statement of intent, on a regular basis consult in regard to its intentions relating to the purchase of services with such of the following as the authority considers appropriate:*

- (a) Individuals and organisations from the communities served by it who receive or provide health services or disability services:*
- (b) Other persons including voluntary agencies, private agencies, Departments of State and territorial authorities".*

Consultation is carried out not just in the context of the RHAs' statement of intent but of their objectives and those of the Crown. Section 10 of the Act sets RHAs' objectives as:

*"The objectives of every regional health authority, in carrying out its functions, shall be -*

- (a) To promote the personal health of people; and*
- (b) To promote the care or support for those in need of personal health*

- services or disability services; and*
- (c) *To promote the independence of people with disability; and*
  - (d) *To meet the Crown's objectives notified to it under Section 8 of this Act -*
- in accordance with, and to the extent enabled by, its funding agreement."*

The relevant provisions of Section 8 are sub-sections (1), (3) and (4). They provide:

- "(1) Before entering in a funding agreement with a purchaser (other than the Public Health Commission), the Minister shall give to the purchaser written notice of the Crown's objectives in relation to the following matters:*
- (a) The health status of the communities served by the purchaser:*
  - (b) The health services or disability services, or both, to be purchased by the purchaser:*
  - (c) The terms of access to those services; and the assessment and review procedures to be used in determining access to those services or such of those services as are specified in the notice:*
  - (d) The standard of those services:*
  - (e) The special needs of Maori and other particular communities or people for those services."*

*"(3) Every objective given to a purchaser under this section must be an objective that, if met, will, in the Minister's opinion, assist in securing for the people of New Zealand -*

    - (a) The best health; and*
    - (b) The best care or support for those in need of services; and*
    - (c) The greatest independence for people with disabilities - that is reasonably achievable within the amount of funding provided."*

*"(4) The Minister may at any time, by written notice to a purchaser, amend a notice given to that purchaser under this section".*

Creation of RHAs was part of a major restructuring of New Zealand's health services intended to achieve a number of goals. As background to these goals, and the process to be followed in achieving them, it is useful to look both at the Ministry of Health's 1993 Post Election Briefing and at the Minister's 1994/95 Policy Guidelines for Regional Health Authorities. The former sets out officials' views on the nature and purpose of the reforms, and what remained to be done. The latter amounts to a detailed exposition of the Crown's objectives and, as such, may be seen as binding on RHAs. The Post

Election Briefing set out the goals of the reforms as:

- ▶ **Improving access to care and support services**, including improvements in the affordability of services for those on low incomes.
- ▶ **Improving the influence of consumers** in decisions that are made about priorities in treatment and care services nationally.
- ▶ **Improving the efficiency** of service delivery and the overall use of resources. *Particularly relevant here is the need to control government expenditure within the health sector, and to change the previous structural rigidities which prevented resources being moved to higher priority areas (emphasis added).*

Mechanisms for achieving these goals included:

- ▶ Splitting the roles of purchaser and provider. Justification for this is expressed as "... the creation of service purchasers who will be able to purchase services from the providers they consider most appropriate. This should increase efficiency by allowing purchasers to choose the lowest-cost service that ensures appropriate quality; and it should increase consumers' access to services by generating incentives for cost efficiencies. Giving organisations clear roles means that confusion and conflicts of interests are reduced. In addition, the purchaser/provider split helps reduce the dominance of hospital-based providers in resource allocation".
- ▶ Allowing purchasers to choose the most appropriate provider. This expected to mean that "the purchaser can contract with the most appropriate providers for particular services - including services and providers which have not been available to consumers in the past".

These are statements of ideals; of the objectives which full implementation of the reforms are intended to achieve. In practice, there are major transitional issues, including sunk cost considerations with significant investment in existing provider structures, lack of information on pricing and other matters which will be needed to make contestability feasible, and the need to build new structures, understandings and processes for community input.

The Ministerial briefing document recognised this. It noted, for example, the need to ensure "service continuity while purchasers develop their contracting strategies".

It also recognised that "community consultation is an essential mechanism for ensuring that services reflect users' needs and priorities - and [that] clear identification of public preferences becomes particularly important when resources are constrained". It stressed that "community consultation must also involve the full range of community health needs: it must not reflect limited interests". At the same time, in respect of transition it recorded that "to ensure a smooth roll-over, a number of transitional arrangements were put in place. Purchasers and CHEs are constrained by requirements to provide the same range and level of services, with the same terms of access, as were available on 30 June 1993".

A move to contracting requires more information and clear specification of what is being

contracted for. The briefing paper stated "there is an urgent requirement for the Ministry of Health and purchasers to develop high level specifications for service obligations and health objectives. These specifications must ensure that purchasers are clear about what the funding they receive from the Government is to be used for and that they can be held accountable for their use of it".

As against this, "purchasers and providers currently have limited scope for shifting resources or changing the mix of services. The Government also has a fundamental interest in ensuring continuity of service for consumers. In practice, purchasers and providers are interdependent".

The shift to contracting is seen as the central mechanism for achieving the reform's objectives:

*"The emphasis is moving away from funding providers, and towards ensuring that consumers have access to appropriate services. To maximise the benefits of the new funding and purchasing arrangements, it is imperative to replace the current roll-over provisions with contracts for services".*

Specifically in respect of developing service contestability, the briefing paper separates existing secondary care services into three categories:

- ▶ Services where there is good information about service volumes and where pricing information can be obtained through the tendering process (for example, elective surgery). The Ministry estimated that between 15% and 20% of CHE business is in this category and stated that RHAs anticipate these progressively becoming contestable over a period of about three years.
- ▶ Services where further work is needed to define the products and required services. There is some information available from the private sector, for example on long stay care of the elderly and on maternity services. The category is expected to account for another 15% to 20% of CHE business. There is a feeling and expectation that, once the further work on definitions is completed, this category also will become contestable.
- ▶ CHEs' remaining business, such as 24 hour accident, emergency, and associated acute services. The Ministry commented that, rather than planning to introduce contestability for these services in the short to medium term, RHAs are likely to want to achieve managed efficiency gains and to exert some influence on CHE prices. This represents the remaining 60% to 70% of CHE business.

The practical realities of transition, and of providing certain categories of health services, such as acute services, are major factors in considering consultation under the Health and Disability Services Act. So is the stated objective, emphasised above, of controlling Government expenditure within the health sector. Although the objectives stated in the Act are written in terms of health goals, clearly implicit within them, especially as regards the objectives of the Crown, is the need to protect the Government against fiscal risk. The qualification, in Section 8(3) that every objective is to be "reasonably achievable

within the amount of funding provided" emphasises this.

The same emphasis on managing fiscal risk is carried through in the 1994/95 Policy Guidelines for Regional Health Authorities. Certain one-off increases are being made for funding, for example for personal health, but the overriding emphasis is on restraint with an emphasis on developing and implementing strategies for controlling demand-driven expenditure.

The guidelines also emphasise the need for consultation. This is stated as:

*"RHAs have a responsibility to ensure that the communities they are consulting with are provided with adequate information on the issues and their complexity before being asked for a view. Thus, RHAs must be aware of the values and aspirations of communities, such as Pacific Islands people, and women, and that they have an obligation to provide feedback to the community at the end of the consultation process".*

That statement is interesting for at least two reasons:

- ▶ The definition of community, although not spelt out, is clearly extensive, it includes ethnic and gender communities as well as (by necessary inference) geographic communities. It can be reasonably inferred that, on any particular service issue, the RHA will be expected to have means for consulting with the specific user groups for whom the service is intended.
- ▶ It may suggest that the consultation process must go beyond the principles spelt out in the Wellington International Airport case. Thus, the requirement to "be aware of the values and aspirations of communities ..." carries with it an implication which goes beyond consultation on any particular issue to ensuring that, as a matter of practice, RHAs have an awareness of the concerns within particular communities, prior to developing specific proposals which may affect them.

Effective management of the process is essential to minimise fiscal risk. The Ministry's briefing paper recognised this. In speaking of the potential impact of changes in the population based funding formula and the shift of resources between services, the Ministry observed:

*"In short, under the current policy settings for funding RHAs, the Government may face the issue of hospital closure and extensive restructuring, and may face some costs as owner of CHEs in strengthening CHE balance sheets. Local communities will lobby very hard to preserve their facilities. This is likely to create pressures to review RHA funding policy".*

There is a recognition, in this material, that consultation is not concerned solely with producing individual, legally robust, decisions; perhaps more importantly from the Government's perspective, it is concerned with achieving acceptance of an overall approach to the management and allocation of the resources available for New

Zealand's health services. The clear implication of the concern over lobbying by local communities is that, if decisions on the withdrawal of hospital facilities are not seen as legitimate, every attempt will be made to use the political process to obtain a reversal. This risk which underlies consultation over the Task Force Report.

Achieving broad acceptance of the overall approach seems implicit in the structure of the Health and Disability Services Act itself. The role of the RHAs, under that Act, is quite different from the role of some of the other agencies, whose requirements to consult have been discussed in this report. Most specifically, it seems to be very different from the role of airport companies under the Airport Companies Act.

They are concerned with a very narrow function, the setting of fees, charges and dues which form the basis of their revenue. The key issue, between them and their customers, is whether the charges they set are reasonable and do not reflect (at least unduly) an exploitation of their monopoly position. Their consultation is to provide a means of constraining the abuse of monopoly power (a position recognised by the Court of Appeal).

In contrast, RHAs are performing a quite different function. They are purchasers on behalf. The issue which is somewhat unclear, from the wording of the Act, is on whose behalf. In a formal sense, they can be seen as acting on behalf of the Crown. It is the Crown which provides them with funding, through their funding agreement, and it is the Crown which sets the objectives which they should pursue.

Arguably, however, the real answer to the question of "on whose behalf?" is the community or communities whom they serve. It is those communities, not the Crown, which receive health services. It is those communities which, by and large, will make the judgement as to whether those services are adequate and will react accordingly. From a public policy perspective, it is the response of those communities which will ultimately determine the fate of the health sector reforms.

The inter-relationship between Sections 8 and 10 of the Act, and the Policy Guidelines issued by the Minister, support this approach. In terms of Section 8, the Minister is to give the RHA written notice of the Crown's objectives on matters such as the health status of the communities which it serves and the terms of access to and standard of services. The RHA itself is to promote the personal health of people and the care or support for those in need of personal health services or disability services. Implicit in this is a process of assessment of community health status, identification of community health needs, and the purchasing of services to meet those needs.

The Guidelines are explicit as to the principles which RHAs should apply. They are:

- ▶ Equity
- ▶ Effectiveness
- ▶ Efficiency
- ▶ Safety
- ▶ Acceptability

► Risk management.

These various principles, as elaborated in the Guidelines, are very focused on identifying the needs and preferences of the people who are served and ensuring changes are implemented in a way that minimises disruption to their lives.

In MDL's view, as a matter of public policy, consultation by RHAs under the Health and Disability Services Act should be seen, quite explicitly, as consultation by a purchaser acting on behalf of the communities whom it consults but constrained by objectives, and funding limits, set by Government.

This may imply a somewhat different approach than has been usual with public consultation. Typically, organisations wishing to consult the public first develop a proposal, and then expose it to public consultation. This approach assumes that the public has no interest in, or does not need to be consulted about, the selection of the particular proposal or how that proposal is to be developed.

In practice, these may be the really critical decisions. The earlier review, by the Hawkes Bay Area Health Board, of its options provides an example. In that case the brief to the consultant began with the stipulation that it should "construct a brief for a single acute hospital to serve the population projected for Hawkes Bay in 10 - 20 years". That single instruction had the effect of excluding a number of options which people within the community may have wished to consider. Speaking hypothetically, some within the community, at least, may have wished to start from the perspective of how best to meet the health needs of the people of Hawkes Bay without necessarily assuming a particular institutional framework.

Where public support for, and acceptance of the legitimacy of, decision making processes is important, consultation needs to be more than just a matter of presenting the best preferred option and consulting over its implications, including how to deal with its side effects and ease the process of transition. It needs also to have an emphasis on gaining public understanding of what the options are and of the best means of developing a preferred option so that, when major changes are proposed, there is a reasonable prospect of taking the community with the process.

At the same time, it must be recognised that consultation is far from easy. It requires an understanding, not only on behalf of those who wish to consult, but on behalf of those who wish to be consulted, as to what it can and cannot achieve and of the constraints within which it is carried out. One of the difficulties, in a New Zealand context, is that there is still a real lack of awareness, within the community at large, of the need for trade-offs; that the same dollar cannot be spent twice. There is, for example, clearly a mismatch between public expectations of what the health service should deliver and the resource implications of achieving that level of delivery. One major objective, of effective consultation processes, should be to give the public some sense of ownership of the need to make choices in the allocation of scarce resources rather than simply provide a means of hearing, from the community, a list of everything which they would like to have make available. (A problem which we understand surfaced in consultation, with the Thames/Coromandel community, on health care services for that area).

Before leaving the discussion of consultation under the Act, generally, it is appropriate to comment on the consultation obligations of Crown Health Enterprises. There is no specific requirement in the Act for CHEs to consult. However, an obligation can be inferred from two different sources, the objectives set for CHEs, and good business practice.

Section 11 of the Act, in setting objectives for CHEs, requires a CHE "to exhibit a sense of social responsibility by having regard to the interests of the community in which it operates". It is extremely difficult to see how a CHE could have regard to those interests without actually consulting the community to determine what they might be.

It is simply good business practice for any service provider to do whatever it reasonably can to understand and respond to the requirements of the people whom it serves. The extent to which individual businesses will feel it appropriate to go public on their intentions and the detailed justification for them will vary from industry to industry. With a monopoly service provider - and CHEs in many respects are still in this category - open and extensive consultation is consistent with their business objective of being "as successful and efficient as comparable businesses that are not owned by the Crown" as it is a key means of ensuring public support for their activities.

The possibility of separate consultation, by RHAs regarding the services which they should purchase, and by CHEs regarding the services which they should offer, does suggest a need for careful management. Even during the present transition period, the interests of RHAs and of CHEs are not identical. There is already an element of contestability in the purchase, by RHAs, of services which CHEs have traditionally provided. Both the legislation, and the ministerial guidelines clearly contemplate an extension of contestability.

The guidelines also distinguish between RHA decisions regarding their purchasing plans, and Crown Health Enterprise intentions to withdraw from providing a service. There is at least an implication that these matters should be the subject of separate consultations. At the very least, a clear distinction is required between purchase issues, which would need to recognise the six principles set out in the Ministerial Guidelines, and service delivery decisions taken by CHEs as providers. The relevant sections of the Guidelines provide:

*"Before making decisions that could significantly affect any of the current providers or the delivery of services to a population, RHAs must undertake an appropriate consultation process with the affected providers and populations".*

*"Where a Crown Health Enterprise (CHE) wishes to withdraw from providing a service and this potentially has a material effect on the availability of services, RHAs are to:*

- *Consult with the affected communities on CHE plans to alter or withdraw the service.*

- *Consider all alternative proposals, including any community health initiative, where they wish to continue or alter service delivery".*

In this context, it will be important for RHAs to ensure at least four things:

- ▶ That the public is able to distinguish between the RHA's objectives, in consultation, and those of CHEs.
- ▶ That RHA decision making processes are structured so that the CHE, in areas which are actually or potentially contestable, is not given an advantage over actual or potential competitors.
- ▶ The CHE is not given either explicitly, or by implication, an expectation of continuing funding for services which could or should be subjected to contestability.
- ▶ That the RHAs' decisions on the service purchase issues concerned, for inclusion in its purchase plan, are taken and justified separately from any decision taken by the CHE.

## **5.0 HEALTH CARE HAWKES BAY: THE REGIONAL TASK FORCE REPORT**

In MDL's judgement, the Regional Task Force was faced with an unenviable task. The history of attempts to rationalise acute hospital services in Hawkes Bay has been outlined in Section 2. It is clear, from that history, that any decision to consolidate acute services on a single site would encounter substantial opposition from interests within the area which could be seen as losing its hospital.

We consider, also, that, from a health management perspective, the decision to consolidate on a single site was inevitable. Furthermore, the issue is not simply one of cost, although this is a major factor. It is also a question of ensuring that sufficient critical mass can be achieved to ensure ongoing expertise in the treatment of severe illness or trauma. We understand that, internationally, a catchment area of the order of 300,000 - 400,000 residents is regarded as the desirable base for a full service acute hospital.

In a technical sense, therefore, we believe that the decision to consolidate on a single site was inevitable. In terms of timing, it can be seen as triggered by the health sector reforms with their emphasis on:

- ▶ Managing Government's fiscal risk and promoting the efficient allocation of resources.
- ▶ Monitoring provider performance as a means of identifying high cost providers or practices.
- ▶ Service specifications and quality requirements.

Prior to the implementation of the health sector reforms, some of these issues went by default. Services which were not able to perform to what are now regarded as adequate

standards, either financially or technically, were nonetheless able to continue, usually because of an unwillingness to upset local sensitivities. Instead, problems were dealt with by means such as:

- ▶ Providing additional funding.
- ▶ Diverting funding from capital maintenance to service provision.
- ▶ Tolerating lower than desirable standards of performance.

The Task Force began work in July 1993 and reported in March 1994. Before it began work, discussion took place between the Central RHA, the individual territorial authorities, and the regional council. Views were invited as to the consultation process which should be followed. As already noted (see Section 2 above) the Council advised the RHA that it did not believe that a process of full public consultation was appropriate (subject to certain conditions discussed below).

That decision was a very understandable one. The previous review, carried out by Booz-Allen Hamilton for the then Hawkes Bay Area Health Board, had undoubtedly had an unsettling impact on at least the Napier community. We can understand and empathise with the Council's wish to avoid a repetition of this and to opt for what it thought would be an orderly, considered and relatively non-controversial process.

We can also accept the decision of the RHA to abide by the Council's wishes. It seems not unreasonable to accept a territorial authority as representing its community (and indeed, MDL expects to see territorial authorities play an increasingly prominent role in health services planning). On the other hand, it also seems clear that the absence of community consultation, through the process of preparation of the Task Force Report, has incurred costs. Amongst these we identify:

- ▶ The loss of nine months which could have been used as an educational process focused on identifying public understandings of the pre-requisites for an effective secondary health care service and explaining the financial and technical constraints which now operate.
- ▶ Loss of the opportunity to achieve a sense of public ownership of the report itself (we emphasise the word "opportunity"; closer involvement in development of the report might not necessarily have led to this desirable outcome).
- ▶ From the community perspective, a relatively narrow emphasis on health care services as such.

We see this last point as both particularly important and as being at the heart of the difference of view between the Council on the one hand and the CHE (and the RHA if it adopts the Report's recommendations) on the other hand. We note also that, as a consequence of the process which has been followed, it may be difficult for the RHA to argue that it has consulted, as required by the Ministerial Policy Guidelines, in terms of the Crown's principles. We would expect the RHA to respond to this interpretation by arguing that such consultation was at least implicit in the process which has been followed. The Council, however, may take the view that such consultation should have

been explicit and undertaken quite overtly by the RHA in its role as purchaser on behalf of the community.

The Task Force focus appears to have been on the requirements for the efficient and effective delivery of secondary health care services in Hawkes Bay. Social impact concerns have been confined to issues such as physical access, recognising both the logistics of getting patients to care and those of facilitating hospital visiting. The reference to provision of a bus service suggests that the CHE wants to make sure there is adequate means enabling people to get to and from Napier and other areas to the hospital in Hastings.

The Council's concerns go well beyond these issues. It considers that the downgrading of Napier Hospital will have a major impact on the local and regional economy. In part, it sees this coming as the result in a shift of jobs away from Napier to Hastings (any negative impact from that will be on the Napier rather than the regional economy). This is an inevitable consequence of consolidation.

It also sees it as impacting Napier, and by definition Hawkes Bay, as a preferred location. In the past two to three years Napier has been the driver of economic growth in Hawkes Bay. Growth in population and in business activity has significantly exceeded expectations. The Council believes that what it sees as the loss of essential community service will act as a major dampener. In particular it fears:

- ▶ The attractiveness of Napier as a retirement destination will be seriously undermined.
- ▶ It will be much more difficult to attract new firms to the city, or skilled staff to existing businesses, as people will not want to move to a city which does not have a 24 hour acute hospital service (which the Council believes is the public perception of the current facility).

These concerns were expressed by the City Council, to the RHA, when it set out its views on consultation. It noted that it would accept the outcome of the Task Force subject to certain conditions which included:

*"The CHE board accepts and pays heed to the "Seven Guiding Principles for Reform", agreed to by the four Hawkes Bay territorial local authorities in July 1992".*

In elaboration of this point, the principles also stated "... it needs to be appreciated that concentrating specialist medical services may have significant social and community "costs". These include physical and financial accessibility to health service provision, employment, economic costs and the use of the available health services infrastructure".

It is clear the Council considers that the basis of its agreement to the process which was followed has not been adhered to. From the Council's perspective, therefore, the process of consultation has fallen short of what it required. It is entitled to feel concerned that this should be so and to insist that the matters which it sees as important are

adequately addressed. It might also seek to argue that, by not addressing social and community costs in the way sought by the Council, the RHA has not fully observed the principle of ensuring acceptability.<sup>1</sup>

At the same time, it would be wrong to attribute any sinister motives to the CHE or the RHA. The wording of the Seven Guiding Principles for Reform is capable of carrying different interpretations. In MDL's view, the Task Force Report is not inconsistent with a narrow interpretation of the emphasis, in the guidelines, on social and economic issues. In the absence of evidence to the contrary, we would conclude that what has happened is simply a miscommunication. The Council clearly believed that its requirements as regards consultation and the preparation of the Task Force Report would be met. They were not. On the other hand, the CHE and the RHA believe that they have acted in accordance with the principles set out in the Mayor's letter of 23 June, as they understood them.

We see little merit in trying to determine whether blame should be attributed for what has happened and, if so, to whom. Instead, we consider the focus should be on addressing the issues which concern the Council.

The first, which we understand is already implicit in the process, is to make a sharp distinction between planning the business of Health Care Hawkes Bay, which is the focus of the CHE's concern, and planning for the purchase for health care services on behalf of the people of Hawkes Bay, which is the role of the RHA.

The Task Force Report is essentially a business planning document; its focus is on how best the CHE can meet its contractual obligations to deliver services in an effective and efficient manner. That is a narrower brief than the brief which the RHA has, particularly if it recognises that issues of health service planning cannot be considered in isolation from the impact on the wider community. We have no reason to believe that the RHA will take a contrary view; to do so would seem to run counter to the Policy Guidelines.

The key issue, it seems to MDL, is how to deal with the difference which has now arisen. We would not suggest that the process should be started yet again; that would benefit no one.

On the other hand, the Council clearly believes that the failure to abide by the Seven Guiding Principles for Reform, as it understands them, has denied it the opportunity of making an effective contribution to a decision which will have a major impact on Napier for years to come. It is here that the distinction between business planning for the CHE and the planning of health services purchasing by the RHA becomes important. Once the CHE board has reviewed the Task Force Report, and the public submissions on it, it may conclude that the recommendations of the Task Force should be adopted, perhaps with some modifications arising out of the public submissions.

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<sup>1</sup> Technically, the principles stated by the Minister on behalf of the Crown are to apply during 1994/95 whilst any change in hospital services within Hawkes Bay could not be implemented until the latter half of 1996 at the earliest. We would not expect the Crown to agree that, for this reason alone, its principles should not apply to this consultation.

That decision will not bind the RHA. It has separate obligations as purchaser and full authority, if it sees fit, to decide that it will address the issues which concern the Council.

It will also want to be sure that it has complied, fully, with the Policy Guidelines. In doing so, it may wish to indicate to the CHE that any decision the CHE takes should be deferred until the RHA has had the opportunity of addressing the Council's concerns.

Initially, it is for the Council to decide the extent to which it would want to go in putting its own separate views forward. MDL understands that the Council may be prepared to accept that development of a single acute hospital is inevitable but believes that the alternative, of a new purpose built facility located between Hastings and Napier, should also be considered. We support the interest in reviewing this option, not because we are necessarily making any judgement as to its appropriateness, but because we think it important, for the legitimacy of this major decision, that the Council's preferred option should also be considered. Unless it is, there will be a risk that the decision to relocate to Hastings will never be really accepted by the Napier community. We note, also, that doing so would comply with the Guidelines' requirement to "consider all alternative proposals".

Apart from this issue, the Council is also concerned to look at questions of economic and social impact. In MDL's view, these issues sit rather more in the domain of the RHA than of the CHE. The CHE does have an obligation "to exhibit a sense of social responsibility by having regard to the interests of the community in which it operates" but that responsibility is clearly constrained by financial resources. It is for the RHA to decide the extent to which the CHE, or any provider, has the capability to address economic and social impacts associated with health service delivery.

The Council's concern in respect of social issues ranges over matters such as ready access to hospital services, both for patients and for family and friends, to the confidence which elderly people may have in the ready availability of health services.

Its concern regarding economic impact has already been outlined; it believes that the downgrading of Napier Hospital will have a markedly adverse impact on the local and regional economy. It is a matter which should be capable of some empirical testing, for example, by sampling the views of businesses and/or individuals who have recently moved to Napier or who may be known to be contemplating such a move. In part it is a question of how the change in service arrangements is perceived by the public at large. Their concerns are with matters such as access to the facility itself, the nature of the services which remain in Napier and the networks which are in place at a community level (where most health care delivery actually takes place) to ensure effective coverage.

It would seem appropriate for the Council to develop, for the RHA, some reasonably detailed proposals as to how it believes the RHA should undertake consultation on matters of economic and social impact. By so doing, we believe that the Council would both assist the RHA to focus on the issues which concern the Council and give the RHA needed assurance that the Council would accept the outcome of that consultation.

## 6.0 CONCLUSIONS AND RECOMMENDATIONS

MDL has the following conclusions and recommendations for the Council:

### Conclusions

- ▶ Consultation, by RHAs, under the Health and Disability Services Act, should be undertaken from the perspective that the RHA, as purchaser, is acting as agent for the community. Within the resources available to it and subject to the objectives set by the Crown, it should be seeking to purchase that set of services which best meets the needs of the community. An important part of determining those needs is effective and ongoing consultation.
- ▶ Consultation processes, developed under the Health and Disability Services Act, should be assessed from a public policy perspective and not merely from a legal perspective. The focus of the latter is on whether a particular decision complied with due process; the focus of the former is on maintaining legitimacy, that is, public acceptance of particular decisions and the process within which they are embedded.
- ▶ There is merit in separating out planning for and consultation on the purchase of health services, by RHAs, and planning for and consulting on the business activities/configuration of Crown Health Enterprises.
- ▶ The Ministerial Policy Guidelines can properly be seen as part of the process whereby the objectives of the Crown are communicated to RHAs. As such, they should be seen as having a binding rather than an advisory character.
- ▶ Those Guidelines explicitly require RHAs to consult before making decisions that could significantly affect the delivery of services to a population. Where a CHE wishes to withdraw from providing a service and this potentially has a material effect on the availability of services, the RHAs are not only bound to consult, they must also "consider all alternative proposals".
- ▶ The Task Force proposal, although intended to at least maintain the volume of activity, is nonetheless a proposal to withdraw from providing a service.
- ▶ In the particular case of the Task Force proposal:
  - It is highly unlikely that the option of continuing with two acute hospitals is viable, either financially or medically.
  - It seems possible that the approach actually taken to consultation may have somewhat confused the role of the RHA, in consulting on service purchase objectives, and the role of the CHE in considering its service delivery options. In particular, combining the two processes may have adversely impacted on the Ministerial requirement for RHAs to undertake an appropriate consultation process which we interpret as a process which focuses on their ability to comply with the six principles set out in the Policy Guidelines.
  - There appears to have been a basic misunderstanding between the Council, on the one hand, and the RHA on the other, regarding the conditions which the Council wished to apply if the approach to consultation outlined in the Mayor's

letter of 23 June 1993 was to be adopted.

- There is little point in attempting to assign blame or revisiting the entire process. Instead, the RHA in particular and the Council should seek to make good what has been lost, in terms of the Council's objectives, through that misunderstanding.
- To achieve this, opportunity should be afforded for the Council's preferred option, of a single purpose built facility located between Hastings and Napier, to be reviewed as an alternative to the Task Force recommendation. It is within the purview of the RHA to do this as it represents an "alternative proposal" in response to the proposed withdrawal of a service. It would be legitimate for the RHA to conclude, if evidence supported it, that such an option was preferable to consolidation on either the Hastings or Napier sites. This would involve it factoring in to its purchase decisions the service specifications and funding which would support such a decision.
- The RHA and the Council should also agree processes for reviewing the potential economic and social impacts of the consolidation decision including determining whose responsibility they might be and how they should best be addressed. We note that this will require the RHA to consider the extent to which economic and social impacts are matters to which it should have regard when purchasing health services (on a broad interpretation of the Policy Guidelines, this would be covered by principles such as acceptability). We also note that there are parallels in this issue, with the question of non-commercial objectives for state owned enterprises or local authority trading enterprises. In each of these cases it has been recognised that, if other parties wish to purchase outputs to promote social outcomes, which may fall outside the responsibility of the SOE or LATE, then it is open to them to negotiate contractual arrangements for their production.

### **Recommendation**

It is recommended that the Council adopt the above report and seek the RHA's agreement to:

- ▶ Facilitate consideration of the alternative of establishing a single acute hospital between Hastings and Napier.
- ▶ Establish a process for consulting on and addressing the economic and social impacts of the reconfiguration of hospital services in Napier and Hastings.