

Part One: Introduction and Overview

Introduction

The overriding aim of the health and disability support system is to achieve healthy New Zealanders. Central to achieving this goal are the activities by the health and disability support workforce, whose actions span the life cycle of New Zealanders and include health promotion, disease prevention, disability support, primary health care, and hospital and mental health services. These activities can be supported by individual New Zealanders' activities to achieve greater health and independence and through wider influences from activities by the Government, the private sector, the voluntary sector and social groups.

The *Health and Independence Report 2004* documents the state of public health in New Zealand – how healthy we are and how our health and disability support system enables us to live to the fullest degree possible.

The report's focus is the progress the health and disability support system is making towards strategic goals. It identifies the successes and achievements of the health and disability support system and discusses critical issues and challenges facing the sector. It is intended to be a resource for a wide range of users, including health planners, health service providers, policy analysts, community groups and anyone with an interest in the health and disability support sector.

The report is a major statement of accountability for the health sector, and provides information on not only how the \$10 billion of taxpayer funding is distributed, but how the system is performing and how the system is contributing to the overall goal of Healthy New Zealanders.

The Health and Independence Report 2004 examines:

- the strategies and structures underpinning, and the funding, workforce and information infrastructures of, the health system
- progress towards the societal goal of healthy New Zealanders
- progress towards a fair and functional health system
- health and disability support system funding and services.

Throughout the report, readers will find system performance in New Zealand compared with other countries' performance. The report also details health and independence outcomes for subgroups of populations, particularly Māori, Pacific peoples and people with varying levels of wealth or deprivation.

Structure of the report

The *Health and Independence Report 2004* is in three parts. Part one describes the strategies, structures, funding and workforce that underpin the system. Part two analyses progress towards overarching societal outcomes. Part three analyses the attributable system outcomes of the health and disability support sector.

The conceptual link between the health and disability support sector and its contribution to the overall goal of healthy New Zealanders is demonstrated in the Ministry of Health's (the Ministry's) outcomes framework (Figure 1). The outcomes framework, drawn from the Ministry's Statement of Intent (SOI), reflects the directions established by the two overarching strategies, the New Zealand Health Strategy (NZHS) and New Zealand Disability Strategy (NZDS). The outcomes framework has three outcome levels that are logically connected and flow through to the Ministry's actions:

- **Societal outcomes – healthy New Zealanders:** These are the health and disability support outcomes valued by the Government and citizens, which are necessary for healthy New Zealanders. They are influenced by the health and disability support sectors and broader activities of the Government and society.
- **System outcomes – a fair and functional health system:** These are outcomes that reflect the health and disability support system's achievements, encompassing how people access services, the quality and effectiveness of services, the extent to which the system uses public resources in the best way, and how the system interacts with other sectors to enhance health and independence outcomes.
- **Ministry outcomes – ensuring the system works for all New Zealanders:** These are outcomes that reflect the levers the Ministry has available to it to achieve a well-functioning health and disability support system. These outcomes are largely determined by the functions the Ministry performs.

The report focuses on the top two tiers of the outcomes framework: healthy New Zealanders and a fair and functional health system. Outcomes at Ministry level are currently discussed in the Ministry's annual report. However, some attention is also paid in this report to the Ministry's role in delivering some system outcomes, particularly in direct funding of public health and disability support services, and through links with other potentially health-promoting organisations.

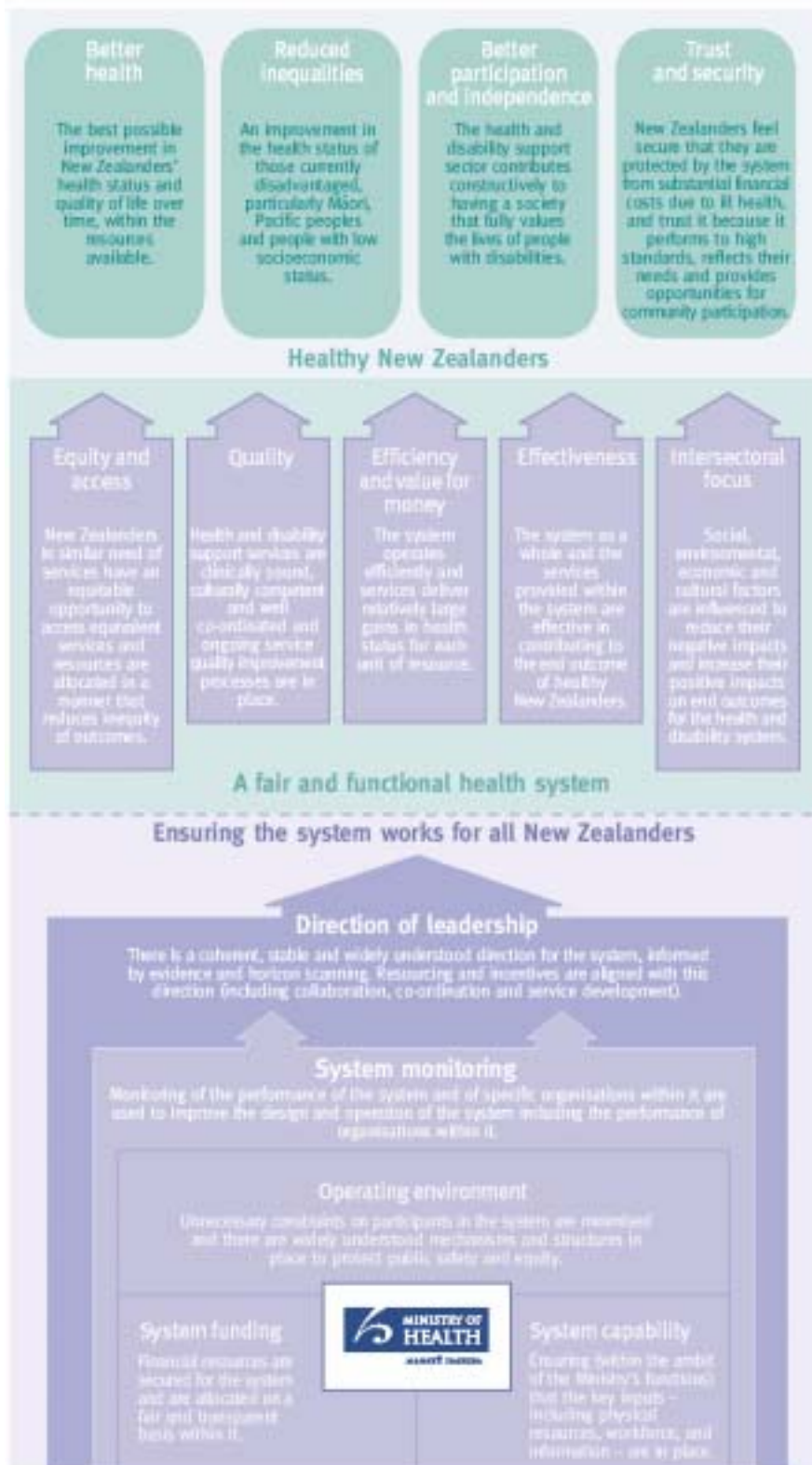
Chapter 1 (which forms part one with this introduction) briefly examines the health and disability support system, how it functions and the overarching strategies – the NZHS and NZDS.

Chapters 2–5 (part two) examine societal outcomes of healthy New Zealanders, represented by better health, reduced inequalities, better participation and independence, and trust and security. These chapters make some general observations about how the system is contributing to improved societal outcomes.

Chapters 6–10 (part three) discuss the progress of the health and disability support sector towards a fair and functional health system, focusing on different aspects of performance in the areas of equity and access, quality, efficiency and value for money, effectiveness and intersectoral focus respectively.

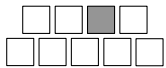
Appendices to the report provide substantial detail (in the form of tables and graphs) about system inputs, such as funding and workforce (Appendix A) and outputs, such as services (Appendix B).

Figure 1: Ministry of Health Statement of Intent outcomes framework

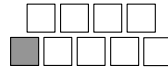


Parts two and three carry a footer with a summary diagram, indicating which dimensions of 'a fair and functional health system' or 'healthy New Zealanders' each section relates to, following the order of the outcomes framework in Figure 1. Example 1 would appear in part two, chapter 4 (better participation and independence), while example 2 would appear in part three, chapter 6 (equity and access).

Example 1



Example 2



Indicators and analysis

Interim 'headline' indicators

The chief purpose of the *Health and Independence Report 2004* is to discuss the contribution the health and disability support sector is making to health and independence outcomes. A notable feature of the report is its reporting of progress against health and independence indicators, nested within discussion of the overall functioning of the system. Among the many indicators used within the report, a limited number of interim 'headline' indicators are highlighted, within each domain of system performance. These indicators link back to the goals and objectives of key sector strategies, including the NZHS, the NZDS, He Korowai Oranga (the Māori Health Strategy) and the Primary Health Care Strategy. They also reflect the Ministry's policy priorities for 2004/05. The indicators have been identified as having potential to shed light on wider aspects of system performance. However, they are only interim indicators and will be reviewed in 2005 as part of the Ministry's wider examination of system performance indicators.

Comprehensive picture of performance

It should also be noted that the health and independence outcome indicators used throughout the report are important signals of where progress is being made. However, importantly, they do not tell the whole story; rather, indicators are 'quantities that reveal qualities' (Cobb and Rixford 1998). They provide often narrowly focused insights into particular aspects of system performance.

More complete pictures of performance tend to emerge from evaluations of individual projects and larger programmes or policies that draw on a range of research methods, both qualitative and quantitative. Across the health and disability sector, a wide range of evaluations have been undertaken in recent years, from evaluations of individual projects (such as smoking cessation initiatives) to large-scale evaluations of the Primary Health Care Strategy and implementation of the 2001 health reforms.

The emphasis therefore throughout this report is on a multifaceted examination of system performance. This involves using different indicators to signal different aspects of system performance supported by analyses of the context and intervention logic behind health and disability support services and supplemented, where possible, with evaluation evidence.

Note on data reporting

The *Health and Independence Report 2004* provides an annual compendium of Ministry reports and information, providing or summarising a great deal of statistical and financial information. In all cases, the most recently available data have been used and, wherever possible, these have been for the 2003/04 year.

Chapter 1: The Health and Disability Support System

This chapter provides an overview of the strategic framework, sector structures, processes linking elements of the system, and infrastructure supporting the health and disability support system. It examines the health and disability sector's:

- key overarching strategies – the NZHS and NZDS – and related strategies
- structures, including District Health Boards (DHBs), Primary Health Organisations (PHOs) and other service funders and providers
- strategic processes that link the strategies and structures to deliver services and promote healthy New Zealanders
- funding, workforce and information infrastructures.

Strategic framework

The New Zealand Public Health and Disability Act 2000 requires the NZHS and NZDS to be in place to provide the framework for the sector's overall direction. These strategies take a population approach to identify the areas where intervention will make a contribution to the goals of healthy and independent New Zealanders. The Act also requires the Minister of Health and Minister for Disability Issues to report annually to the public and House of Representatives on progress in implementing the NZHS and NZDS (for example, Minister for Disability Issues 2002; Minister of Health 2003b).

These two strategies sit alongside each other and guide the development and implementation of more detailed service, health issue and population-group specific strategies and action plans. These strategies and action plans identify how objectives identified in the NZHS and NZDS will be addressed.

New Zealand Health Strategy

The NZHS was launched in December 2000. It emphasised improving population health outcomes and reducing disparities in health between all New Zealanders, including Māori and Pacific peoples (Minister of Health 2000).

The NZHS identifies seven fundamental principles that should be reflected across the health and disability sector:

- acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
- good health and wellbeing for all New Zealanders throughout their lives
- an improvement in the health status of those currently disadvantaged
- collaborative health promotion and disease and injury prevention by all sectors
- timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- a high-performing system in which people have confidence
- active involvement of consumers and communities at all levels.

New Zealand Disability Strategy

The NZDS was launched in April 2001. It is an intersectoral strategy relevant across the whole public sector (Minister for Disability Issues 2001).

The Ministry of Health was initially responsible for leading the NZDS's development and overseeing its implementation. On 1 July 2002 this role shifted to the Ministry of Social Development's Office for Disability Issues.

The Ministry of Health funds a range of disability support services for people with long-term or lifelong disabilities (mostly people aged under 65).¹ Funding for disability support services for people aged 65 and over was devolved to DHBs on 1 October 2003.² Disability support services comprise a range of services to increase people's independence and participation, from home-based support to residential support services.

The NZDS presents a long-term intersectoral plan for changing New Zealand from a disabling to an inclusive society. Its overall vision is to enhance the participation and independence of people with disabilities. The Ministry, along with all other government departments, must develop an annual work plan to implement the NZDS and must report annually on the plan to the Office for Disability Issues. The Ministry also actively works to implement the NZDS within the wider health and disability support sector.

The NZDS identifies 15 objectives underpinned by detailed actions to advance New Zealand towards being a fully inclusive society:

- encourage and educate for a non-disabling society
- ensure rights for disabled people
- provide the best education for disabled people
- provide opportunities in employment and economic development for disabled people
- foster leadership by disabled people
- foster an aware and responsive public service
- create long-term support systems centred on the individual
- support quality living in the community for disabled people
- support lifestyle choices, recreation and culture for disabled people
- collect and use relevant information about disabled people and disability issues
- promote participation of disabled Māori
- promote participation of disabled Pacific people
- enable disabled children and youth to lead full and active lives
- promote participation of disabled women in order to improve their quality of life
- value families, whānau and people providing ongoing support.

¹ Along with people with long-term disabilities aged 65 years and over until they require aged residential care.

² People with disabilities aged 50–64 whose health support needs are assessed as 'close in interest' to older people are also funded by DHBs.

Taking the overarching strategies forward

Population-, disease- and service-based strategies

Although the NZHS and the NZDS provide the overarching framework for action in the health and disability sector, they do not identify how specific priority objectives or services will be addressed. Population-, service- and disease-based strategies sit underneath the umbrella of the NZHS and NZDS and provide more detailed guidance for the health and disability sector, especially DHBs, on how to achieve NZHS and NZDS goals (illustrated in Figure 2). These strategies include:

- He Korowai Oranga (the Māori Health Strategy) (discussed in chapter 3)
- the Primary Health Care Strategy (discussed in detail in chapter 6)
- the Health of Older People Strategy (discussed in chapter 7)
- Improving Quality (IQ): A systems approach for the New Zealand health and disability sector (discussed in chapter 7)
- the New Zealand Cancer Control Strategy (discussed in chapter 7)
- Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau: A strategic framework (discussed in chapter 10).

Figure 2: Strategic framework for the health and disability sector



Action plans

The various population-, disease- and service-based strategies provide the basis for other policy initiatives the Ministry develops. These initiatives include action plans that guide the sector on how to achieve the goals and objectives of strategies, such as the Pacific Health and Disability Action Plan and Improving Quality Action Plan (Minister of Health 2002; Minister of Health 2003d).

Toolkits and guidelines

Toolkits have also been developed to help DHBs to address the NZHS's population health objectives. These Web-based resources provide background on the various objectives, as well as policy developments and guidance on recommended interventions.

Guidelines have been established for the provision of services, ranging from the support and management of people with dementia to opioid substitution treatment. These guidelines provide frameworks for effective and appropriate service delivery.

Sector structures

Figure 3 shows the structure of the health and disability sector in 2003 under the New Zealand Public Health and Disability Act 2000.

Minister of Health

The Minister of Health has overall responsibility for the health and disability support system. The Minister determines the content of the NZHS, works through the Ministry to enter into accountability arrangements with DHBs and agrees with government colleagues how much public money will be spent on the public delivery of services.

Ministry of Health

The Ministry aims to ensure the health and disability support system works for New Zealanders. It is the Government's primary advisor on health policy and disability support services. The Ministry:

- provides policy advice on improving health outcomes, reducing inequalities and increasing participation
- acts as the Minister of Health's agent (as shown in Figure 3)
- monitors the performance of DHBs and other health sector Crown entities
- implements, administers and enforces relevant legislation and regulations
- provides health information and processes payments
- facilitates collaboration and co-ordination within and across sectors
- provides nationwide planning and maintenance of service frameworks
- plans and funds public health, disability support services³ and other service areas that are retained centrally.

³ From 1 October 2003, only for people with long-term disabilities, largely under the age of 65.

District Health Boards

Role of District Health Boards

DHBs were established in 2001 under section 19 of the New Zealand Public Health and Disability Act 2000. The 21 DHBs are Crown entities responsible to the Minister of Health (and administered through the Ministry). Each DHB board has up to 11 members: seven elected by the community and four appointed by the Minister of Health to ensure an appropriate mix of skills and representation.

DHBs plan, fund and ensure the provision of health and disability services to a geographically defined population. DHBs are responsible for improving, promoting and protecting their populations' health and independence. They are required to assess the health and disability support needs of the people in their regions, and manage their resources appropriately in addressing those needs. Funding is allocated to DHBs using a weighted population-based funding formula (PBFF).

Devolution of responsibilities to District Health Boards

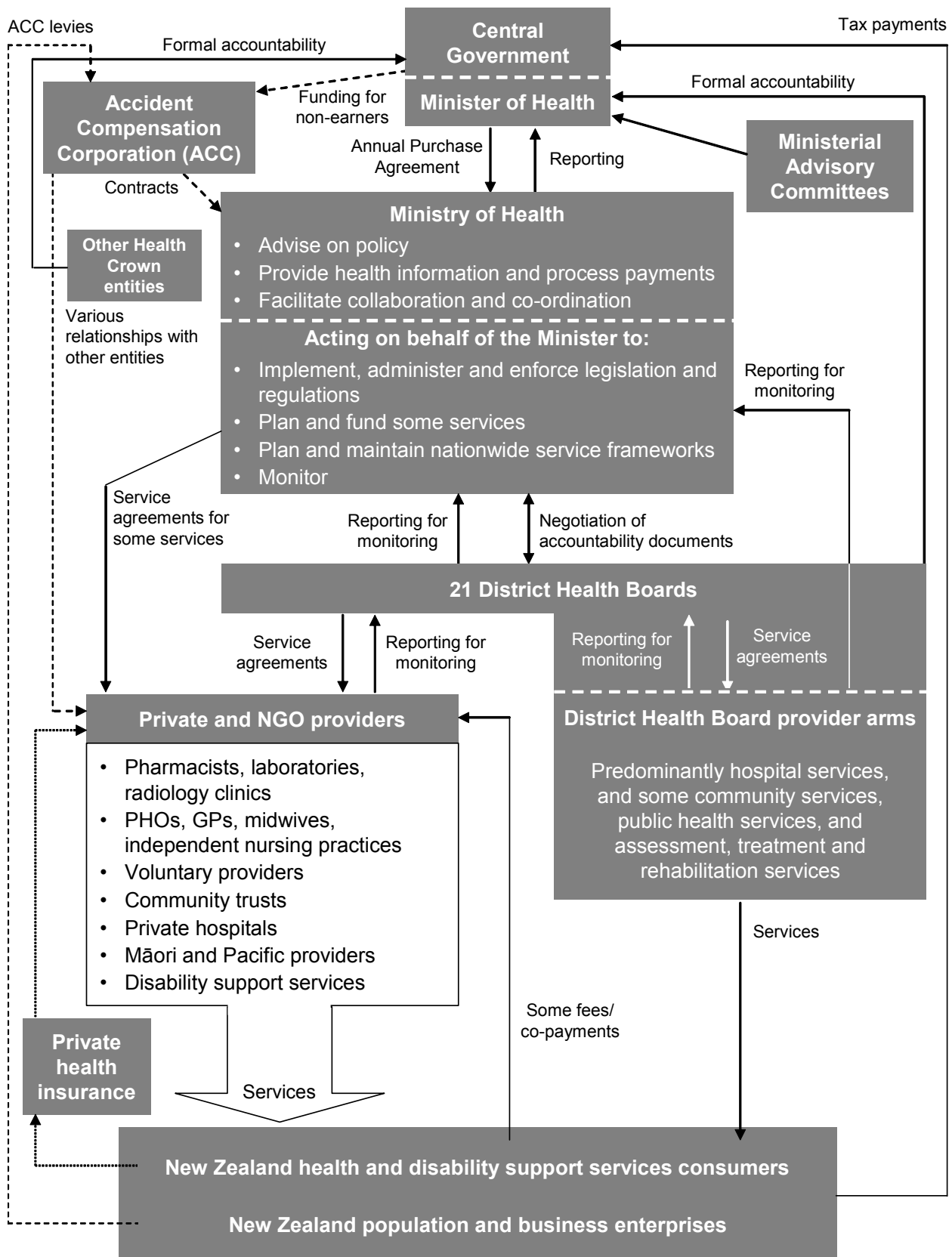
Since 2000, greater responsibilities have been progressively devolved to DHBs. In October 2003 they took on responsibility for disability services for older people. This means DHBs are responsible for all services except public health, disability support services for people with long-term disabilities (largely under the age of 65) and some national contracts, which all remain the responsibility of the Ministry.

Public health units

DHBs own public health units (although public health services are centrally funded by the Ministry). Twelve public health units throughout New Zealand provide more than half the country's public health services. The remaining services are provided by more than 200 non-governmental organisations (NGOs). These services include environmental health, communicable disease control, tobacco control and health promotion programmes.

Many of these services include a regulatory component performed by statutory officers appointed under the Health Act 1956. DHBs employ these officers but they are personally accountable to, and subject to direction from, the Director-General of Health.

Figure 3: Structure of the New Zealand health and disability sector, 2003



Other service providers

Acute hospitals, some services such as assessment, treatment and rehabilitation services, and more than half the public health services come under the wing of DHBs. General practitioners (GPs), PHOs, rest homes and midwives are independent and/or contracted to supply services by DHBs or the Ministry. There are about 80 public hospital facilities and a large number of privately operated aged-care facilities in New Zealand.

Primary health care

Primary health care includes a broad range of first-level services, although not all of these are government funded, including:

- health improvement and preventive services such as screening
- general practice, mobile nursing, community health and pharmacy services
- first-level services for certain conditions, such as maternity, family planning and sexual health services, or using particular therapies, such as physiotherapy, chiropractic and osteopathy services, and alternative healing.

Primary Health Organisations

In February 2001 the Minister of Health released the Primary Health Care Strategy. Primary Health Organisations (PHOs) are the local structures that will achieve this strategy's objectives. The first PHOs were established in July 2002. As at 1 October 2003, 77 PHOs had been established and about 3.7 million New Zealanders were enrolled with a PHO. DHBs are responsible for establishing, funding and monitoring PHOs.

PHOs provide a set of essential primary health care services to a defined population, including at least first-level general practice services, some health promotion services, services specifically to improve access for groups known to be in most need, and the management of prescribing and laboratory test use. PHOs and the Primary Health Care Strategy are discussed in chapter 6.

Non-governmental and voluntary organisations

NGOs and voluntary organisations are an important part of the health sector. Not-for-profit services are provided by more than 200 national organisations and local providers. This group of providers includes some large organisations such as the IHC, Royal New Zealand Plunket Society, Family Planning Association of New Zealand and National Heart Foundation.

Community trusts and iwi-based bodies have also expanded in number and scope of activities. Several communities, especially in rural areas, have established community trusts to develop health services for people in their area, and iwi-based organisations are providing an increasing range of health and social services.

Accident Compensation Corporation

The accident compensation scheme is a 24 hour per day, 7 day per week no fault scheme that provides treatment, rehabilitation and compensation for New Zealand citizens, residents and temporary visitors to New Zealand who suffer personal injury through accident in New Zealand. In return people who have cover under accident compensation legislation may not sue for personal injury, other than for exemplary damages.

The Accident Compensation Corporation (ACC) is the Crown entity responsible for administering the accident compensation scheme. Its responsibilities are:

- preventing injury
- collecting accident levies
- determining whether claims for injury are covered by the scheme and providing entitlements to people who are eligible
- paying compensation
- buying health and disability support services to treat, care for and rehabilitate injured people
- advising the Government.

The ACC is funded principally by levies collected from a range of sources, including employers, self-employed people, employees and motor vehicle licensing. The ACC also receives direct government funding. The ACC is not funded from Vote Health.

Statutory advisory committees

Advisory committees have been established under various statutes to provide independent advice to the Minister of Health on specialist issues.

- The National Advisory Committee on Health and Disability (also known as the National Health Committee) advises the Minister of Health on the type and relative priorities of public health services, personal health services and disability services it believes should be publicly funded. The committee is also required to advise on personal health and regulatory matters relating to public health. The committee formulates its advice in consultation with the public and health service providers.
 - The Public Health Advisory Committee is a subcommittee of the National Health Committee. It advises the Minister of Health on public health issues including the:
 - factors influencing the health of people and communities
 - promotion of public health
 - monitoring of public health.
- The Health Workforce Advisory Committee advises on health workforce issues that the Minister of Health specifies by notice to the committee.

- The National Advisory Committee on Health and Disability Support Services Ethics (also known as the National Ethics Advisory Committee) advises the Minister on ethical issues of national significance regarding health and disability research and services, determines nationally consistent ethical standards and scrutinises research and services.
- The National Ethics Committee on Assisted Human Reproduction reviews research and innovative treatment proposals involving assisted human reproduction, and advises the Minister of Health on ethical issues relating to assisted human reproduction.
- The National Health Epidemiology and Quality Assurance Advisory Committee advises the Minister of Health on any matter of health epidemiology and quality assurance.
- The Child and Youth Mortality Review Committee's functions are to review and report to the Minister on deaths of people aged between 28 days and 24 years, with a view to reducing the numbers of deaths of this group, and for continuous quality improvement through the promotion of ongoing quality assurance programmes.

Other technical committees advise on medicines safety and classification, new prescribers and other matters.

Making the links between strategies and structures

As discussed earlier in this chapter, overall health and independence goals are set in the NZHS and NZDS. The NZHS makes a start on how these goals are to be worked on by indicating service priorities and population objectives. The NZDS similarly identifies key objectives and actions, which are backed up by specific service and population strategies to take the objectives further.

The Ministry's SOI (discussed in the introduction) sets out the outcomes the Ministry seeks to influence and the activities undertaken to do this. The SOI's outcomes framework reflects the direction established by the two overarching strategies. The SOI framework also provides the basis of the Ministry's performance assessment framework (under development) that will be used for measuring progress towards system- and societal-level health and independence outcomes. The Ministry's Output Plan details the activities the Minister of Health has agreed to purchase, their performance attributes and costs, and related terms and conditions. Projects within each output class are linked to the SOI outcomes framework.

At the same time, the Minister monitors public concerns and service provision. With these considerations in mind, along with her consideration of the strategic framework, the Minister determines her priorities at various times. These inform the Ministry's priorities for the sector (see page 18 for a description of the 2004/05 priorities). These priorities are consistent with the NZHS and NZDS, and signal particular areas for the sector's attention.

Parallel to activities at the ministerial and Ministry level, DHBs are required to perform a health needs assessment. This involves assessing its population’s health status (including existing health inequalities), factors that may affect the population’s health status, the services the population needs, and the contribution those services are intended to make to the population’s health status. These assessments must be undertaken before a DHB establishes, or makes significant amendments to, its District Strategic Plan. The District Strategic Plans set out the strategic direction each DHB expects to take over the next 5–10 years.

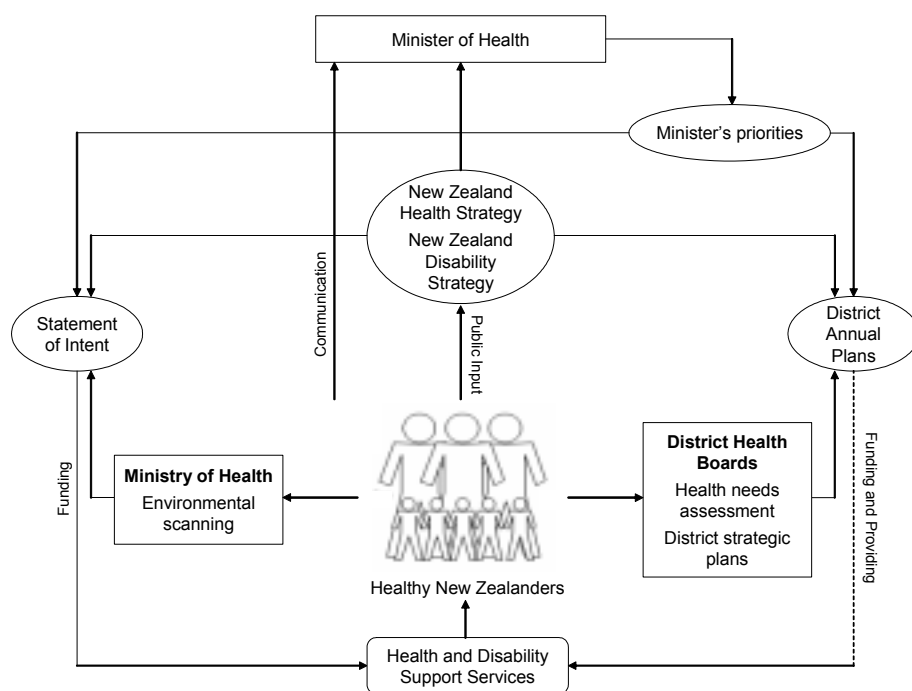
The preparation of the District Strategic Plan is guided by the NZHS, NZDS, Minister of Health’s letter of expectation, and DHBs’ health needs assessments. DHBs must also consult their communities as a part of their planning process.

Once a year, this input is combined in the District Annual Plan (DAP) agreed between the DHB and the Minister of Health. This tells the Ministry how DHBs will run their services (that is, maintain current services and make changes over time to service provision) to achieve the aims of the three processes described above. The funding to provide these services, along with accountability and monitoring arrangements, are agreed annually by the Minister and DHBs in Crown funding agreements.

The processes above have different timelines and constitute a strategic management approach for the sector that enhances its responsiveness within an overall framework. Sector responsiveness is further enhanced by the flexibility within the DAP to allow DHB management to move in response to pressures and opportunities and the Minister to interact with DHBs through the year.

Figure 4 illustrates the strategic management processes, their flow-on effect to service planning and delivery, and, ultimately, to health and independence outcomes.

Figure 4: Strategic management in the health and disability support sector



The Ministry of Health's policy priorities for 2004/05

The Ministry's policy priorities for 2004/05 build on the priorities developed over previous years and flow from the implementation of key health and disability strategies and government decisions to extend and establish specific services. The following priorities and related roles are set out in the Ministry's 2004/05 SOI:

- Diabetes: Facilitate improving effectiveness in prevention and detection.
- Elective services and radiotherapy: Ensure service delivery, setting service frameworks, standards, targets, monitoring, reporting and agreeing to escalation pathways in the event of non-compliance.
- He Korowai Oranga: Define the strategic approach, implement accountability and operating frameworks and assist in performance monitoring and reporting.
- Mental Health Blueprint: Define the strategic approach, implement accountability and operating frameworks and assist in performance monitoring and reporting.
- New Zealand Disability Strategy: Define the strategic approach, implement accountability and operating frameworks and assist in performance monitoring and reporting. Note responsibility for monitoring the strategy's implementation was transferred to the Office for Disability Issues on 1 July 2001.
- Primary Health Care Strategy: – Further develop PHO initiatives in relation to their workforces, improving population health, associated promotion focus, community involvement in governance arrangements and assist in the provision of lower cost services for people enrolled in PHOs.
- Reducing inequalities: Undertake further work to develop a common understanding of concepts and actions to reduce inequalities in health, including further work on the intervention framework and health equity tool.
- Breast screening: Ensure service delivery by setting policies and standards, accountability and operating frameworks, and monitoring, reporting and agreeing to escalation pathways in the event of non-compliance.
- New Zealand Cancer Control Strategy: Define the strategic approach, implement accountability and operating frameworks, and assist in performance monitoring and reporting.
- Trans-Tasman regulator: Provide advice and support to the Minister of Health and her Australian counterpart on the development of a joint regime for regulating therapeutic products.
- Health workforce: Develop policy and set standards to support the sector in planning, supplying, training and retaining staff and in relation to industrial relations.
- Nationwide implementation of Healthline: Ensure Healthline is aligned to key Ministry strategies and national roll-out is achieved in the reporting year.
- Mental health services: Review the first plan and develop an approach for the revised second national plan.

- Meningococcal Vaccine Strategy: Define the strategic approach, implement accountability and operating frameworks, and assist in performance monitoring and reporting.
- Orthopaedics: Ensure service delivery by setting service policies and standards and accountability and operating frameworks, and monitoring, reporting and agreeing to escalation pathways in the event of non-compliance.

Health system funding overview

The total Vote Health in 2003/04 was \$9.55 billion, rising to \$9.92 billion in 2004/05. In 2003/04, \$6.75 billion was devolved to DHBs. Most DHB funding is allocated using the PBFF. The PBFF gives each DHB the same opportunity, in terms of resources, to respond to its population's needs. The formula is explained in chapter 6.

The largest part of public sector funding is the Government's direct health funding through Vote Health to DHBs. DHBs are funded to ensure the provision of health and disability services to their resident populations. Some services are based in other DHB's districts, so DHBs arrange funding transfers among themselves to recognise the revenue associated with the flow of patients between districts (that is, the inter-district flow). The Ministry and DHBs work together to estimate payment for inter-district flows and payments are made through a central system.

Public sector funding sources

Public sector funding is the major source of funding for health and disability support services in New Zealand. It accounts for 79.5 percent of all health expenditure in the country, with out-of-pocket expenditure and private insurance being the other main contributors.⁴

Other public agencies provide a significant amount of funding for activities directly and indirectly related to health. This includes health-related expenditure by the ACC, other government agencies and local authorities (for example, city and district councils).

Figure 5 shows total government expenditure on health and disability services as a proportion of total government expenditure for 2004/05. At \$9.92 billion, it was 20 percent of total expenditure budgeted for 2004/05 (\$44.5 billion) (The Treasury 2004).

Vote Health

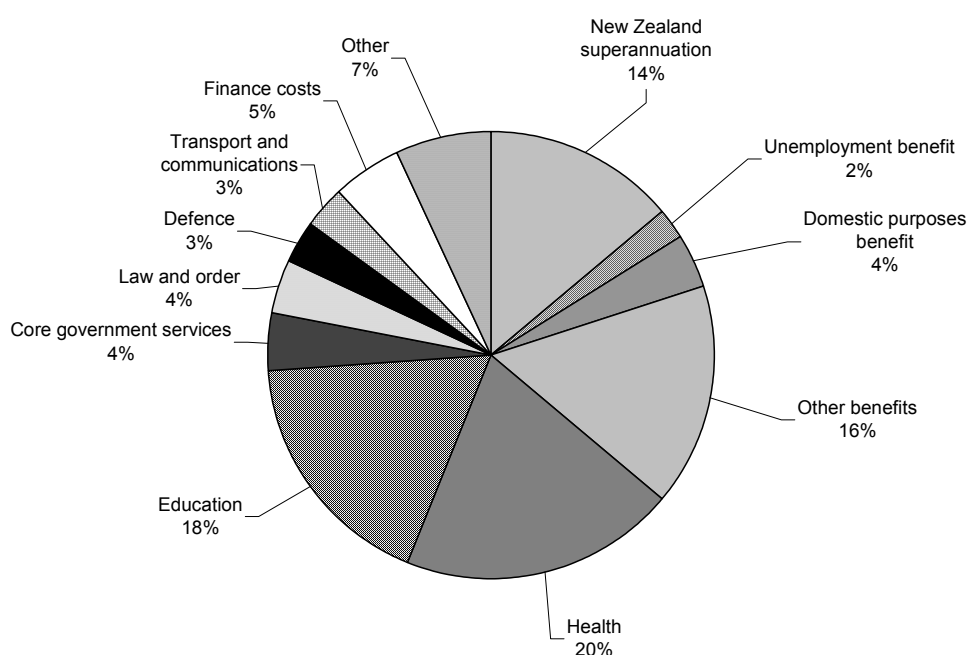
Vote Health is the Government's main contributor to publicly funded health and disability services expenditure. Vote Health funds DHBs, the Ministry and other health and disability service providers to purchase or provide:

⁴ This discussion draws extensively on, and updates information in, *Health Expenditure Trends 2002* (Ministry of Health 2003d).

- personal health services⁵
- public health services⁶
- mental health services
- disability support services⁷
- independent services, which represent a residual category of health funding outside personal health, disability support services and public health and of which the main expenditure items are provider development and health and disability promotion services.

Vote Health expenditure excludes capital, on the basis that those funds do not directly influence service provision in the year they are incurred.

Figure 5: Government expenses, 2004/05



Notes:

- 'Health' includes expenditure on departmental outputs, health service purchasing, other non-departmental outputs and health payments to the ACC.
- Health payments to the ACC are not included in Vote Health.
- 'Other benefits' includes family support, the accommodation supplement and the invalids benefit.

Source: The Treasury (2004)

⁵ Funding related to health services provided to individuals to improve or protect their health.

⁶ Services concerned with the whole population or population groups. This broad focus distinguishes it from funding for individual personal health services. Public health services are primarily concerned with health protection, improvement and/or promotion.

⁷ Individuals are eligible to enter the needs assessment and service co-ordination process for disability support services funded by Vote Health if they have a physical, a psychiatric, an intellectual, a sensory or an age-related disability (or a combination of these) that is likely to continue for a minimum of six months and reduces their independent functioning to the extent they need ongoing support.

Expenditure growth under Vote Health has accelerated in recent years, particularly following the transfer of disability support services and funding from other government departments, most notably the Department of Social Welfare, and the additional funding from the Health Funding Package, discussed in chapter 6.

Table 1: Vote Health expenditure, excluding capital and transfers, plus deficit financing, 1989/90–2002/03

	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03 ¹
Total (\$ million nominal)	3702	4015	4006	4053	4425	4688	4855	5263	5641	5836	6114	6593	6918	7407
Total real (\$ million 2002/03)	4792	5050	4983	4975	5374	5434	5514	5906	6227	6463	6634	6925	7056	7407
Per person – resident population basis														
Per person (\$ nominal)	n/a	n/a	1145	1147	1236	1292	1317	1407	1493	1534	1599	1708	1769	1863
Per person real (\$2002/03)	n/a	n/a	1418	1401	1494	1490	1488	1570	1638	1688	1723	1788	1804	1863
Total as percentage of GDP (%)	5.2	5.5	5.5	5.4	5.4	5.4	5.2	5.4	5.6	5.7	5.7	5.8	5.7	5.8
Total as percentage of government expenses ²	12.6	13.5	14.0	14.1	15.5	15.9	15.9	16.1	16.8	16.9	17.0	17.9	18.1	19.0

Notes:

1 Financial data for 2002/03 was derived from various Ministry and DHB sources.

2 To form a consolidated view some allocations, where appropriate, have been based on best estimates.

Source: Ministry of Health (2003d)

Table 1 shows the following trends.

- Nominal Vote Health expenditure (including deficit financing) grew steadily throughout the review period, except in 1991/92. Expenditure in 2002/03 was 99.6 percent higher than in 1989/90 (increasing by an average 5.9 percent each year).
- Reflecting the trend in total Vote Health expenditure, nominal per person spending increased through the period, with the exception of 1991/92–1992/93. Estimated 2002/03 nominal per person spending was 62.3 percent higher than in 1991/92 (increasing by an average 4.5 percent each year).⁸
- From 1991/92 to 2002/03, real (that is, consumer price index adjusted) spending decreased from 1991/92 to 1993/94 before beginning a sustained increase from 1993/94. Real expenditure growth averaged 3.6 percent each year from 1991/92.

⁸ Because of changes in the definition of populations, data under the new definition are available from only 1991/92. Discussion on per person (resident population) trends is restricted to the period since then.

- Real per person growth followed a similar pattern to growth in real spending, averaging 2.5 percent each year from 1991/92.
- In the review period, Vote Health (including deficit financing) as a proportion of GDP was at its lowest in 1995/96 and 1989/90 (5.2 percent). It was at a 5.8 percent high in 2002/03.

Vote Health by major expenditure category

Table 2 details the amount of expenditure for Vote Health service categories for the three years to 2002/03.

Table 2: Components of Vote Health expenditure, excluding capital and including transfers, 2000/01–2002/03¹

Expenditure categories	2000/01		2001/02		2002/03	
	\$000	Percentage of Vote Health	\$000	Percentage of Vote Health	\$000	Percentage of Vote Health
Personal health ²	5,022,533	70.5	5,650,393	76.2	5,969,390	76.8
Disability support services ³	1,758,700	24.7	1,373,078	18.5	1,416,054	18.2
Public health purchasing	124,755	1.8	138,421	1.9	141,966	1.8
Independent service providers	46,926	0.7	77,123	1.0	77,848	1.0
Other payments	47,989	0.7	85,209	1.1	72,624	0.9
Ministry of Health ⁴	126,370	1.8	93,854	1.3	95,993	1.2
Total⁵	7,127,273	100.0	7,418,078	100.0	7,773,876	100.0

Notes:

- 1 This table represents Vote Health as appropriated. It excludes deficit financing and capital but includes transfers.
- 2 Mental health services are included in personal health *and* disability support service categories.
- 3 The decline in disability support services expenditure from 2000/01 to 2001/02 was as a result of funding for younger people with psychiatric disability being transferred out of the ringfenced to mental health.
- 4 The Ministry merged with the Health Funding Authority in 2000/01.
- 5 Column totals may not sum due to rounding.

Source: 2002/03 financial data was derived from various Ministry and DHB sources, to form a consolidated view some allocations where appropriate have been based on best estimates.

Overview of the health workforce

The effectiveness of the health and disability services in delivering successful outcomes depends to a large extent on the effectiveness of the workforce. The health system is labour intensive, involving people who are providing clinical and personal care services (such as registered health practitioners and support workers), public health workers, people who operate technical equipment and people who make sure the system works effectively (such as administrative personnel, orderlies and managers).

All have a crucial role in a successfully functioning system. The key to success is ensuring the system has the right balance of appropriately trained and qualified people to deliver a quality health service to the public.

In New Zealand, as in other countries, personnel costs represent a significant proportion of total health expenditure. For example, in 2003/04, more than 70 percent of DHB provider arm funding (predominantly hospital services), or about \$2.6 billion was allocated to funding personnel costs of more than 44,000 reported full-time staff. In addition, services such as optometry, dentistry, physiotherapy and alternative and complementary health services are delivered largely by self-employed practitioners. Private hospitals also provide a range of services. Support and care of people with disabilities or aged over 65 is provided in the community or residential facilities.

The Health Workforce Advisory Committee estimated that, in 2001, about 67,000 health workers were deployed in the health sector (Health Workforce Advisory Committee 2002). They were supported by a further 45,000 informal health and disability support workers (Faculty of Medical and Health Sciences 2004) and about 10,000 complementary and alternative health workers. Māori comprised 5.4 percent of the regulated workforce and Pacific peoples 1.8 percent (Health Workforce Advisory Committee 2002).

Disability support services employ a varied workforce, with a considerable volunteer and unpaid workforce, including family/whānau members, providing support for people with disabilities. The disability sector has been marked by a lack of consolidated workforce information to inform planning and purchasing. As with the wider health workforce employed to provide personal health services, it is often difficult to recruit and retain disability support services health and disability professionals, for example, orientation and mobility instructors for people who are blind, deaf-blind or vision impaired. Pay rates and career pathways are often better overseas.

Internationally, there are very different levels of physicians and nurses (measured by their number per one million population) across Organisation for Economic Co-operation and Development (OECD) countries. In 2000, New Zealand had a relatively low density of physicians (2232 per one million population), higher than the United Kingdom (UK), Ireland and Canada, but lower than the United States of America (US) and Australia. However, New Zealand had a relatively high density of nurses (9582 per one million population), higher than the UK and US, but lower than Australia, Ireland and Canada (Simoens and Hurst 2004).

At a national level, from 2010 to 2040 the population will increase with more people in the over 65 and over 80 age groups and a different ethnic mix, with proportionately fewer Europeans/Pākehā and more Māori, Pacific peoples and Asian peoples. This will require a national strategic response to support the DHBs to ensure sufficient health practitioners can meet the change in demand for services and the education sector is responsive to the health sector's needs.

Despite substantial increases since the early 1990s, the health and disability workforce continues to employ low numbers of Māori and Pacific peoples in almost all areas. The need to further develop the Māori and Pacific workforce is well documented (Health Workforce Advisory Committee 2003). The proportion of Māori in the health workforce remains at about 5 percent (excluding informal support workers and alternative complementary health practitioners). Only 3 percent of active medical practitioners are Māori and 1 percent are Pacific peoples. Proportionately more Māori and Pacific peoples work as registered nurses and midwives, at 8 percent and 3 percent of these professions respectively.

Chapter 3 discusses the Māori and Pacific workforces in more detail, from a perspective of reducing inequalities. Further information on the contribution of the health workforce to achieving quality outcomes is in chapter 7. Appendix A contains workforce data.

Information management

Introduction

To enable the right information to be available at the right time, in the right place and to the right people the Ministry is working with the sector to build on existing achievements to enhance information management capability. Information management can be improved to gain administrative efficiencies and increased effectiveness and quality in service delivery.

Effective information management is crucial to achieving the health and participation gains we want for New Zealanders. As population-based health care and co-ordinated care programmes such as disease management and well person population-based programmes mature, decisions are increasingly involving many more people and requiring a wider range of information.

A broad programme of work is being undertaken, including joint projects and commissioned work with sector organisations and Ministry-led and funded initiatives. This work will contribute to the system outcomes of quality, efficiency and effectiveness.

Primary care

The roll-out of PHOs occurred throughout 2004, with well over 3.5 million New Zealanders enrolled. To enable correct funding to be allocated to PHOs, the capitated-based funding has been enhanced to align with revised PHO business rule changes. The development of capitated-based funding is a significant achievement in enabling the Primary Health Care Strategy to be implemented. A data warehouse sourced from the capitated-based funding is being developed to better enable DHB and PHOs to understand their enrollee populations.

Associated systems, including pharmaceutical and other primary care claiming systems, are also being enhanced to process Primary Health Care Strategy changes to subsidy criteria. Similarly, system changes to support the devolution of disability support services for people over 65 have been managed successfully. At the same time, existing payment and agreement development services to the sector are being maintained with about 12,000 agreements for services.

Nationwide systems

The national immunisation reporting system, developed to support public health immunisation programmes, is now live. This system is a significant step forward in New Zealand's ability to support nationwide public immunisation programmes. This system's development used information management techniques piloted in Lakes and Counties-Manukau DHBs. This model demonstrates the sector's ability to take local innovations and turn them into nationwide systems.

The National Health Index (NHI) Upgrade Programme has been developed to maintain and strengthen the existing uses of the NHI and improve NHI data quality. This will enable greater benefit to be derived from using individual NHIs and enable the NHI system to be used for population-based initiatives.

NHI material for consumers is progressively being released with current health initiatives, for example, in consumer material about PHOs and the National Immunisation Register. Messages about the importance of the NHI and the need to advise patients about the NHI are also being promoted in publications aimed at health and disability support services. A consumer representative is a member of the NHI Upgrade Programme Steering Group. A consumer advisory group has been established to help the programme and this group has met and provided a valuable perspective.

The Ministry has been working with the ACC in a jointly sponsored consultation with the sector to implement a Health Practitioner Index. This index will reduce compliance costs for practitioners who have multiple identifiers and improve information quality.

Workforce information

The ongoing development of the Mental Health Workforce Information System is an initiative intended to pilot a health-wide workforce information system. It is a partnership between DHBs and the Ministry, and will improve the Ministry's ability to target workforce issues, such as recruitment to rural areas. The system will provide national information in a consistent format about how many qualified staff provide care in the area of mental health. This will include people working in primary and secondary care services. The New Zealand Health Information Service (NZHIS) will manage the system for the sector.

National collections

Data on services need to be collected and transformed into information. As DHBs and PHOs mature, their management expertise is becoming more sophisticated and the relevance of the saying, 'You can't manage what you can't measure' is becoming increasingly relevant. This awareness has led to several requests for new national collections to support inter-district flows, a better understanding of service delivery changes and to analyse population needs.

A wide range of health information is collected nationally and held in various collections.

- The **National Minimum Dataset** is a single, integrated collection of secondary and tertiary hospital health discharge data.
- The **Cancer Registry** is a population-based tumour register of all primary malignant diseases, operating since 1948.
- The **Mortality Register** contains coded causes of death for New Zealanders who die in New Zealand and is based on the legal death certificate or coroner's report, and autopsy reports.
- The **Mental Health Information National Collection** contains information on specialist mental health and alcohol and drug services. This collection contains comprehensive information from DHBs and approximately 10% of NGOs.
- The **National Booking Reporting System** provides information by health specialty and booking status on how many patients are waiting for treatment, and also how long they have had to wait before receiving treatment.
- Primary health sector data collections, including the Pharmhouse, Laboratories and general medical subsidies data collections.
- The **Maternity and Newborn Information System** contains data on the use of maternity services and health outcomes for mothers and babies.

The Ministry is leading studies on the feasibility of collecting nationally consistent data on outpatient services, cancer treatment, diabetes, cardiovascular and oral health services and outcomes. Associated work is being undertaken to increase access to existing collections including the inpatient National Minimum Dataset, the Pharmaceutical Warehouse and the Laboratory Orders Warehouse.

Data quality

The successful development of ethnicity data protocols has enabled a clear and consistent process for collecting, recording and using ethnicity data to be provided to the sector. The protocols will enable the ongoing improvement of ethnicity data quality. This will make it easier to determine the health needs and effectiveness of service delivery for ethnic populations.

A Data Quality Strategy for the New Zealand health sector is under development. The initial stage involves producing a data quality framework. The framework will allow for a clear and consistent assessment of the level of data quality for each national data collection the Ministry manages. The strategy will be based on a total quality improvement philosophy and address systemic process problems when they are identified.

Collaboration

The Ministry continues to work with DHBs and other sector organisations to finalise a sector-wide strategy for managing information. This involves agreeing accountabilities for information management into local, regional and national responsibilities, developing common DHB information system strategic plan and information technology business case templates, including transparent guidelines for DHB information technology investment. This will involve DHBs collaborating with other DHBs before submitting a business case for purchasing information systems or technology.

The result of this work is being documented in the Health Information Strategy. This strategy will identify further 'action zones' and priorities for sector members to work collaboratively in the next three to five years.

The pan-sector Ministerial Committee on Health Information Standards is up and running. This body was established to ensure appropriate health information standards were available for the safe exchange of health information and to provide a vehicle for pan-sector collaboration. This committee has adopted the From Present to Future Standards Plan. It has endorsed the ethnicity data protocols and established two standards working groups on Health Practitioner Index data standards and laboratory results codes. Further work addressing the accreditation of primary care practice management systems, sponsored by the ACC, has been established with Standards New Zealand.

The Ministry is also working closely with the State Services Commission to further e-government initiatives. This collaboration provides for common information standards between government agencies to enable greater electronic connectivity between government departments and seamless information services across government to the public.

Conclusion

A significant amount of work is under way. As elements of this work programme are completed, they will contribute towards improving the sector's ability to appropriately manage health information. However, as is evidenced by the British National Health Service's information development programme and Australian endeavours, a significant amount of investment is still required if New Zealand wishes to maintain and develop its world class status in information management.

