

# **Health and Participation**

## **An active agenda**

Advice to the incoming  
Minister of Health

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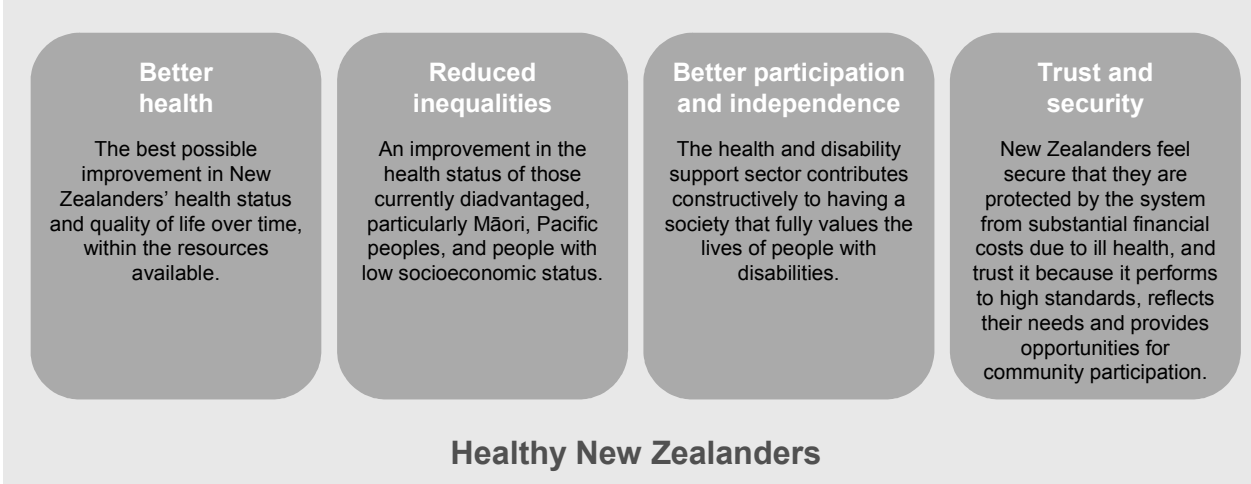
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# Introduction

New Zealand’s health system works to:

- improve health and participation for all New Zealanders, especially for groups at risk of poor outcomes
- deliver health and disability support services of high quality that New Zealanders can have confidence in.



It works towards the four outcomes shown here, for healthy New Zealanders.

## About this document

This document provides the Ministry's view at a strategic level of the key issues facing you as Minister and the approach we recommend for making progress.

It describes the key challenges for New Zealanders' health and participation. There have been steady improvements, but not all New Zealanders have shared in these.

The key challenges for our health and disability support system, now and into the future, are:

- community and government working for health and participation
- services delivering for populations in need
- services there for individuals who need them most
- planning and funding for the short and long term
- capability to deliver what New Zealanders expect.

We recommend that New Zealanders, their communities, businesses, government and the health and disability support sector are all involved in health and in the inclusion of people with disabilities.

### Key recommendations

- Strengthen functionality and performance management
- Invest in critical capability development
- Increase opportunities to recognise and reward improvements
- Ensure a long-term planning horizon
- Provide stability in overall settings and structures

## Action for health and participation

<b>All New Zealanders</b>	active people, actively participating in communities
<b>Professionals and services</b>	learning, innovating, improving, focused on outcomes for people
<b>District Health Boards</b>	encouraging community participation, using knowledge, integrating services, collaborating, planning and preparing for future challenges
<b>Central government</b>	finding out what works, setting direction, removing barriers, investing, evaluating

New Zealand's health and disability support system is a solid performer. But, like the rest of the developed world, we face the convergence of four major trends: an ageing population, increased expectations of health care, unhealthy lifestyles and an increasing risk of rapid international spread of new diseases.

To continue to achieve better health and participation for New Zealanders in the face of these challenges requires action beyond maintenance of the existing health and disability support system (in itself a challenge with an ageing workforce). Lack of action will result in declining performance, lower public confidence and increasing costs to catch up with public expectation.

## Why is an Active Agenda Needed?

Good health and good health services are both high priorities for New Zealanders. They are not the same thing. Good health and disability support services help to restore people to good health and independence, or provide care and support for people when they are most in need. Any problems with service availability and quality raise instant public concern about the support our society provides to the sick or vulnerable.

Good health is determined by many things and only partly by health services. However, the state of health of the population affects the availability of services to those who need them. Healthy, participating people need fewer services and are also able to generate more wealth to support economic growth and service provision.

District Health Boards work across these two priorities – their role is to improve the health of their populations and also to ensure good service delivery.

Participation is an important ingredient in achieving the goal of healthy New Zealanders. Participation includes:

- people with disabilities being able to live full and valuable lives in our society
- all groups in our society having opportunities to be involved in, and a sense of ownership of, our health and disability support system (helping enable high-need and/or hard-to-reach groups to get the services they need)
- having a range of strong non-governmental organisations supporting innovation and learning and contributing to public involvement in our health system
- all relevant agencies and organisations taking the opportunities available to improve our health
- all New Zealanders participating in their own wellbeing and that of their families and communities.

The health and disability support system is continually seeking to improve its work in the prevention of ill health and disability, the early identification and response to those developing or at risk of ill health, maximising recovery and minimising the impacts of ill health and disability.

But an active agenda for health means more than this. An active agenda seeks to engage individuals, whānau, communities, organisations and government in promoting health across the board – an approach epitomised by the current campaign to encourage physical activity. As Minister, you can act to promote health across sectors as well as leading the development of the health and disability support system.

## Inspiring Action

People rely on the Minister of Health to ensure that good health and disability support services are available when they need them.

Our acute services are world class. Creating the capacity to satisfy the wider range of public expectations is more difficult – deferral of elective services to deal with acute demand is highly visible.

Since healthy people have fewer health crises, a key strategy in managing demand for hospital services is ongoing investment in prevention and early identification and management in primary health care. We need innovative service delivery, particularly for groups who are not well served now. Improved primary health care may initially create more rather than less secondary demand, however, even with exceptional management. When more health needs are recognised, more intervention is required in the short to medium term before early intervention starts to reduce the need for late (and higher cost) intervention. Managing expectations and maintaining confidence is a key challenge for you as Minister.

One of the biggest contributions you can make as Minister is to inspire action to promote health and participation across the full range of central and local government, and across New Zealand communities, businesses and organisations.

## How Healthy are New Zealanders?

New Zealanders overall have good and steadily increasing life expectancy in comparison with the 30 OECD countries (OECD 2004).

The gains achieved in life expectancy and health status are not shared equally across the population, however. As in other developed countries, New Zealanders living in more deprived communities have worse health and die earlier, on average, than those in wealthier communities.

Māori have significantly worse health, greater disability and lower life expectancy than other New Zealanders across all socioeconomic groups. High-income Māori of either gender can expect to die younger than low-income non-Māori (Ministry of Health and University of Otago 2005).



Our health can be considered alongside the four outcomes leading to healthy New Zealanders.

### Better health

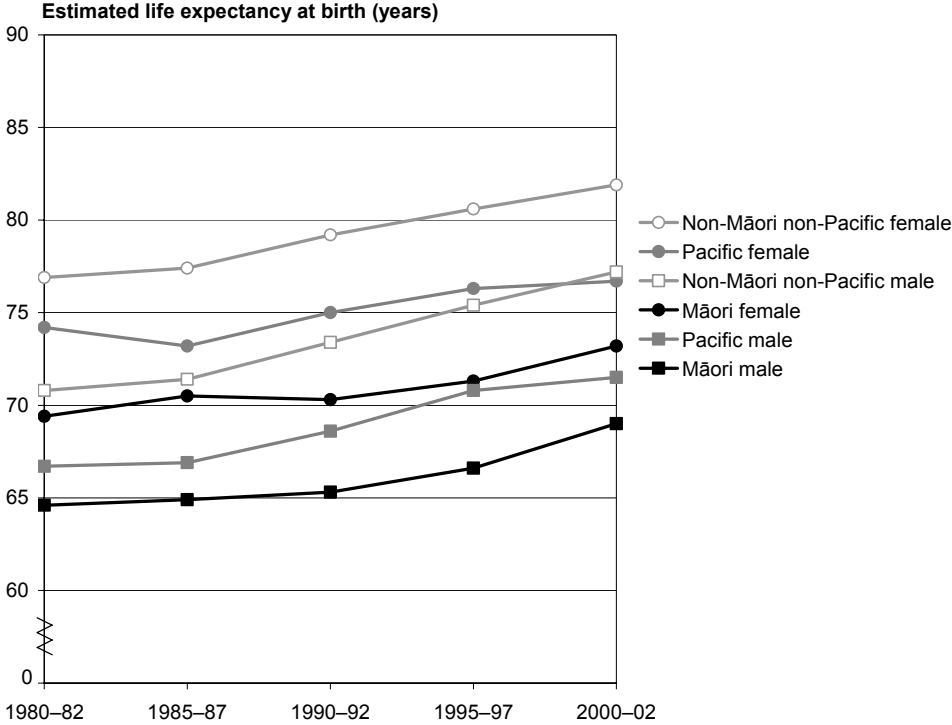
Length of life (life expectancy) is the aggregate measure of health used for international comparison since data between countries is comparable. Its calculation is based on death rates by age.

Life expectancy at birth in New Zealand has improved by 7.4 years since 1960. This increase is slightly lower than the OECD average for the full period, but higher than the OECD average in the last 20 years. In 1960 New Zealand ranked seventh equal in the OECD for average life expectancy at birth. After dropping as low as 17th equal in 1980, our ranking returned to 11th in 2003, with the most rapid improvement relative to other OECD countries occurring in the most recent five years.

Gender differences in life expectancy are in line with international trends. Male life expectancy has improved more rapidly in the last decade than female life expectancy (see Figure 1).

Gains in life expectancy have been slower for Māori and Pacific peoples. Ethnic disparities in life expectancy have widened over the last 20 years (see Figure 1), although for Māori this disparity narrowed slightly in the most recent five-year measurement period.

**Figure 1:** Life expectancy at birth by gender and ethnicity



In all countries there is variation in life expectancy across different cultural, ethnic and socioeconomic groups. While differences in measurement and situation make it difficult to compare this variation across countries, it is increasingly a matter of policy concern to governments (UK Department of Health 2003).

Ethnic and socioeconomic differences in life expectancy are independently important – there are ethnic differences within socioeconomic groups, and there are socioeconomic differences within ethnic groups (see Figure 2).

**Figure 2:** Life expectancy at birth by gender, ethnicity and domicile deprivation index

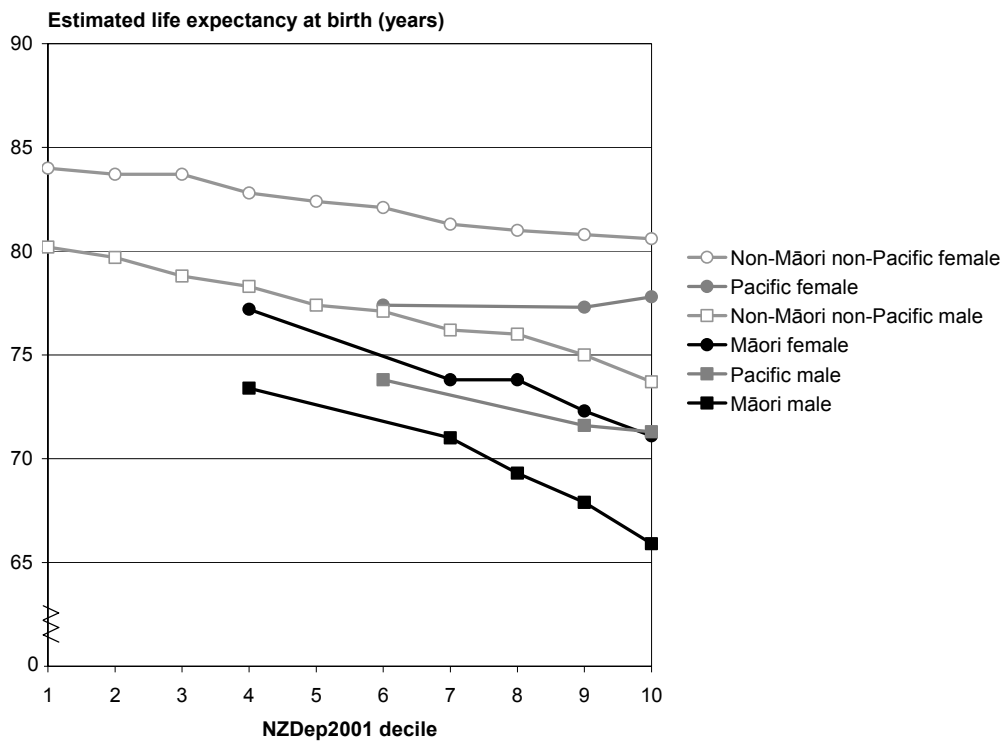
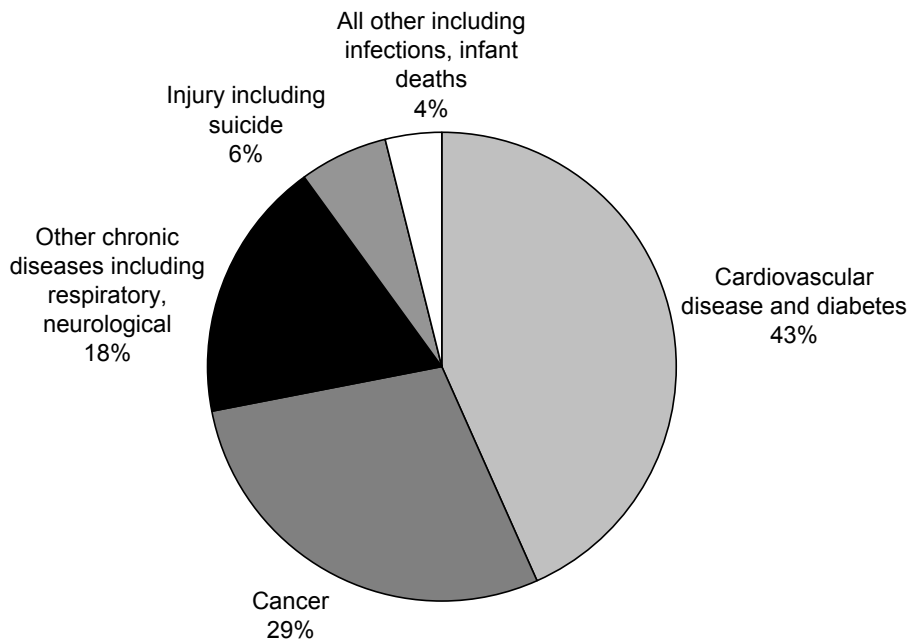


Figure 3 shows the major causes of death for New Zealanders.

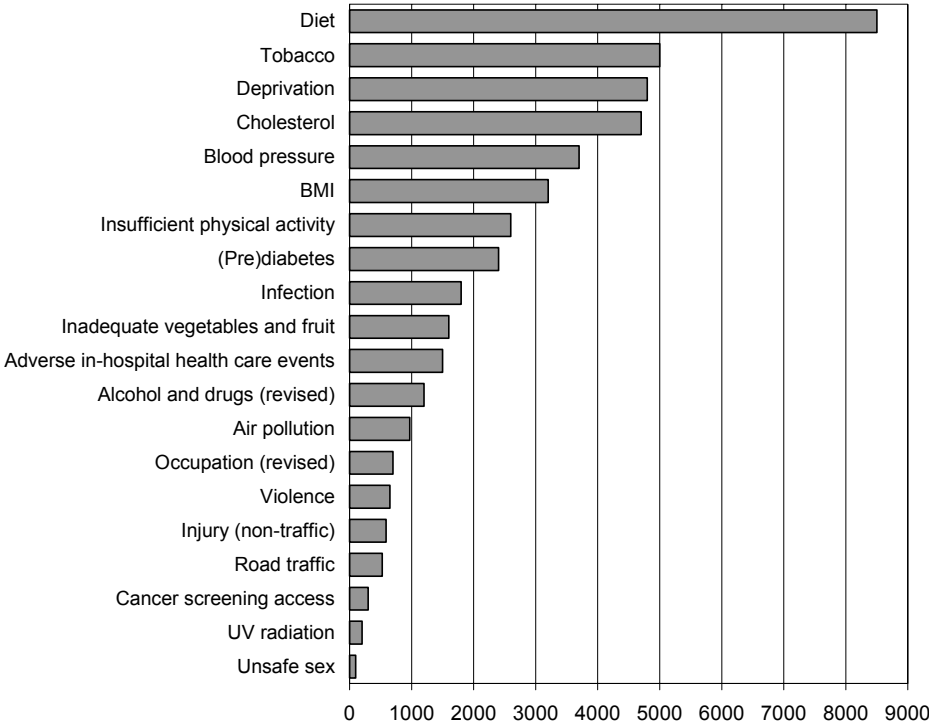
**Figure 3:** Causes of death, 2000–02



New Zealand shows typical developed-nation trends for the major illnesses and causes of death. There are some exceptions: New Zealand has some of the highest death rates in the OECD for suicide and both prostate and colon cancers (OECD 2004). We are also experiencing different patterns of communicable diseases (eg, greater impacts of meningococcal disease, rheumatic fever).

Attributing deaths to known risk factors gives some idea of the potential impact of prevention measures. Improvements in nutrition and physical activity and reducing smoking, for example, have great potential to reduce premature death for New Zealanders, as indicated in Figure 4 (Ministry of Health 2004a). The assessment will be updated after the 10-yearly nutrition survey is undertaken in 2006.

**Figure 4:** Risk factors, 1997, attributable causes



Note: Not mutually exclusive, add up to more than 27,687 deaths.

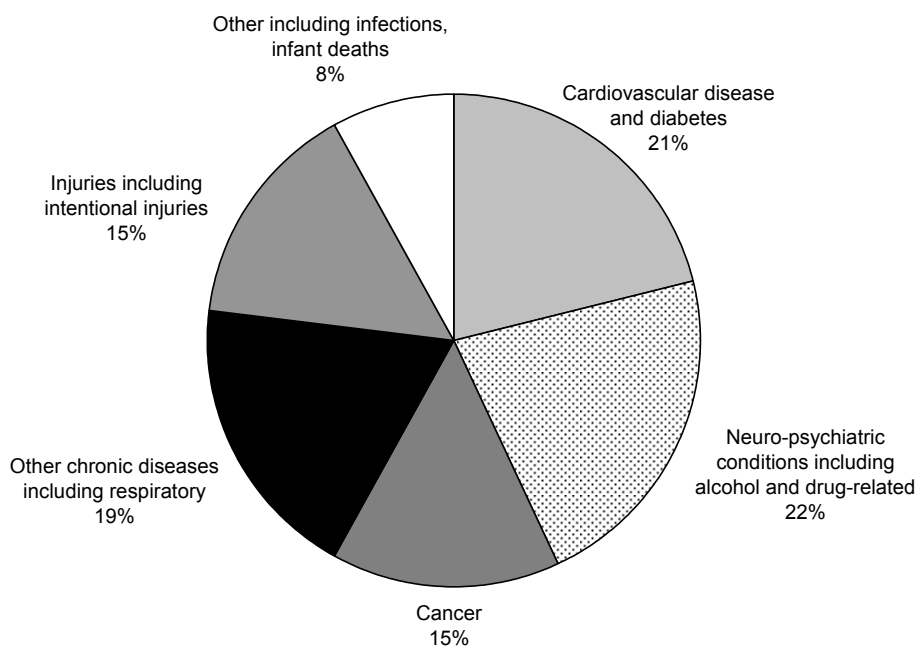
Using death rates to monitor improvement in health means there will be lag times before the full effects of improvements are seen. This is especially the case when improvements reduce the risk of premature death occurring in future decades.

Death rates do not indicate the full impact of ill health on people’s daily lives. Disability is the aggregate measure of the impact of non-fatal conditions, and is discussed under better participation and independence, below.

A focus on preventable deaths also may neglect the major impact on people's lives of non-fatal illness and disability. The World Health Organization, the Harvard School of Public Health and the World Bank have estimated the 'burden of disease' or overall impact (both fatal and non-fatal, from illness, disability and premature death) attributable to various conditions (Murray and Lopez 1996). Their estimate for developed nations, shown in Figure 5, is relevant for New Zealand. (Data limitations mean these estimates are uncertain.)

Burden of disease assessment gives a more complex picture of the impact of ill health than that derived from causes of death. Ischaemic heart disease, for instance, causes 23% of all deaths in New Zealand but is estimated to contribute to 9% of overall burden of disease.

**Figure 5:** Causes of disease burden for developed nations, 1990



## Reduced inequalities

Ethnic and socioeconomic disparities in life expectancy have widened over the last 20 years (see Figure 1, above). For Māori this disparity did not further widen in the most recent five-year measurement period. However, disparities in a wide range of health indicators between Māori and non-Māori New Zealanders have continued to widen (Ajwani et al 2003).

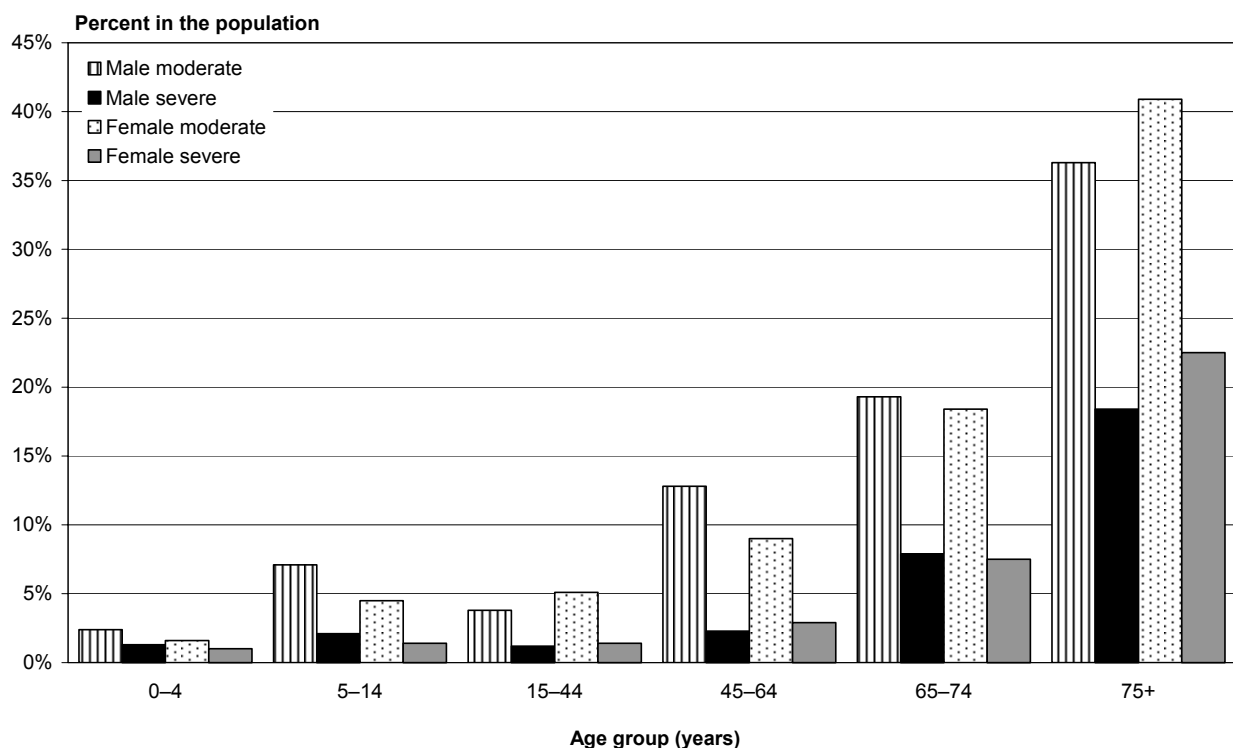
Pacific peoples in New Zealand have also experienced widening disparities with other New Zealanders in some indicators.

## Better participation and independence

Around 12% of New Zealanders have a disability requiring assistance (Ministry of 2004b). They include some 3.2% requiring daily or continuous assistance or living in residential facilities. (While there are reasons other than disability for people to live in residential facilities (eg, companionship or safety), 83% of people with disability living in residential facilities require daily or continuous assistance.)

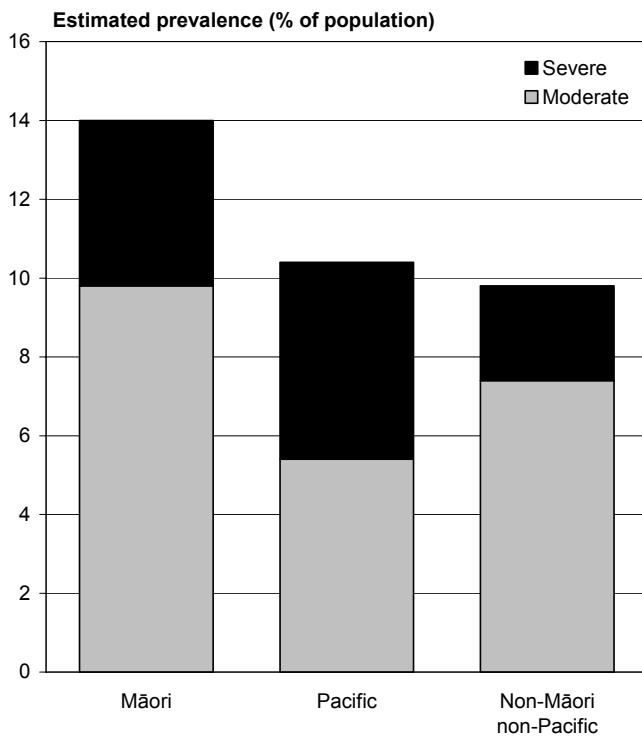
The prevalence of disability increases with age, especially for New Zealanders 65 years and over. Of 27,300 New Zealanders living in residential facilities, over 90% are in the 65+ age group, and 45% in the 85+ age group.

**Figure 6:** Rates of disability requiring assistance by age group and gender, percentage of population

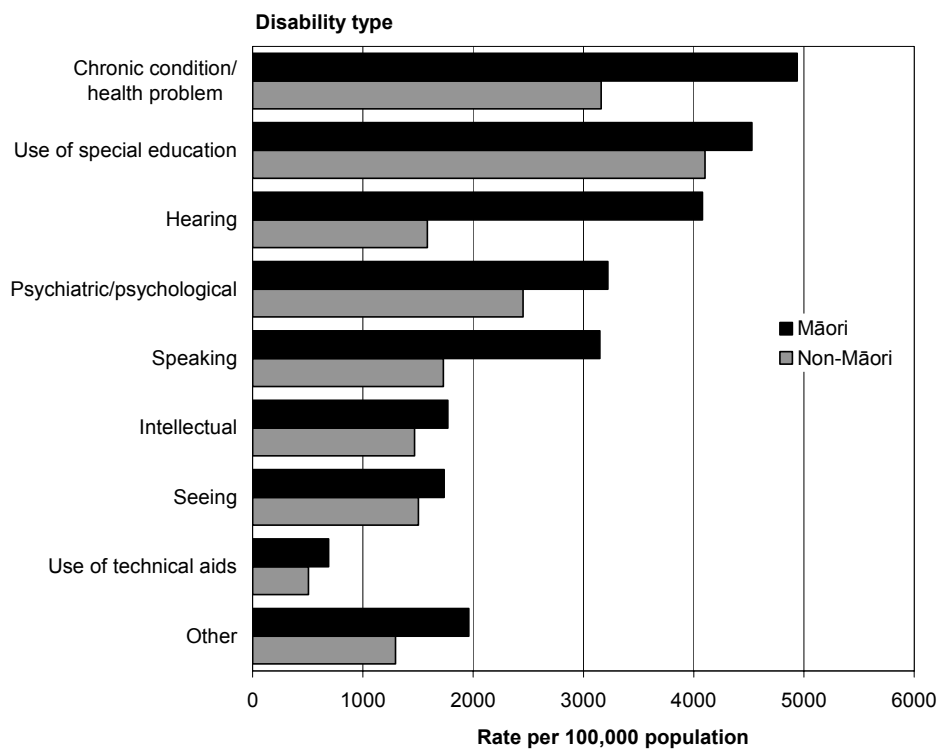


Māori suffer significantly higher rates of disability than do other New Zealanders (see Figure 7) (Ministry of Health 2004b). Māori have higher rates of disability across practically all disability types in both children and adults (see Figures 8 and 9).

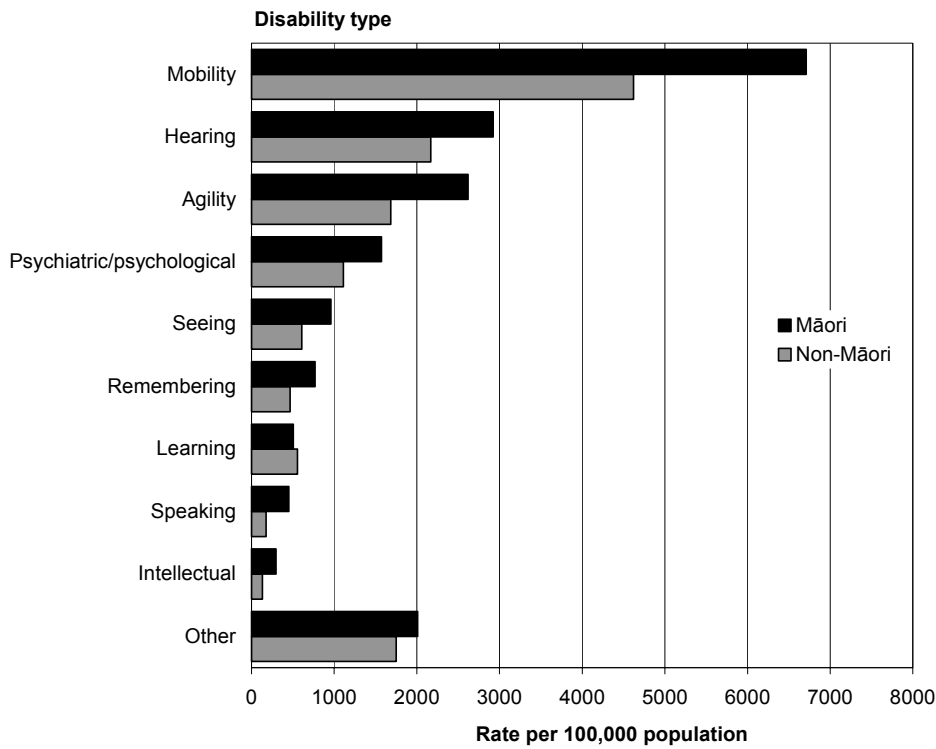
**Figure 7:** Prevalence of disability requiring assistance, 2001



**Figure 8:** Rates of different disability types for Māori and non-Māori children living in households, 2001

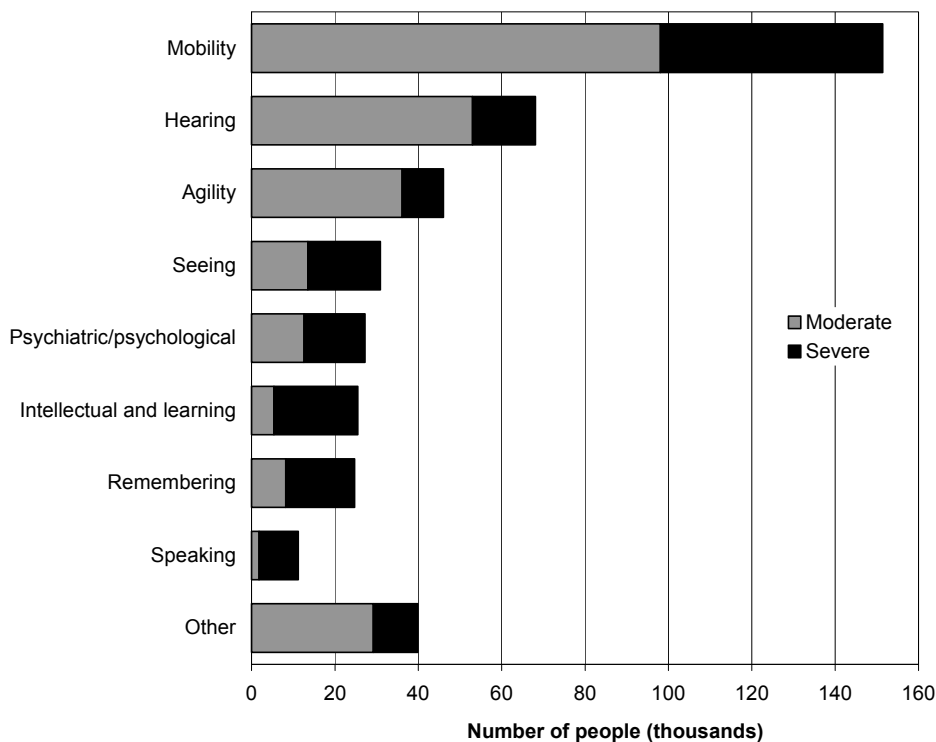


**Figure 9:** Age-standardised rates of different types of main disability for Māori and non-Māori adults living in households, 2001

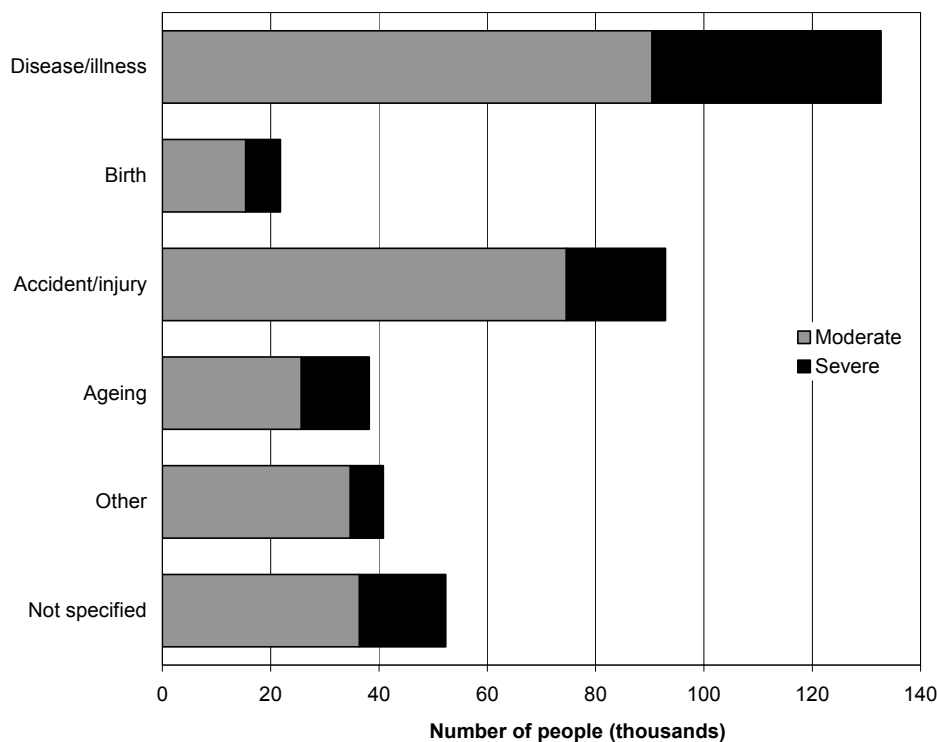


The prevalence of the various types of disability requiring assistance is shown in Figure 10, and the causes people attributed their main disability to in Figure 11.

**Figure 10:** Types of disability requiring assistance in adults



**Figure 11:** Causes of disability requiring assistance attributed to main disability, 2001



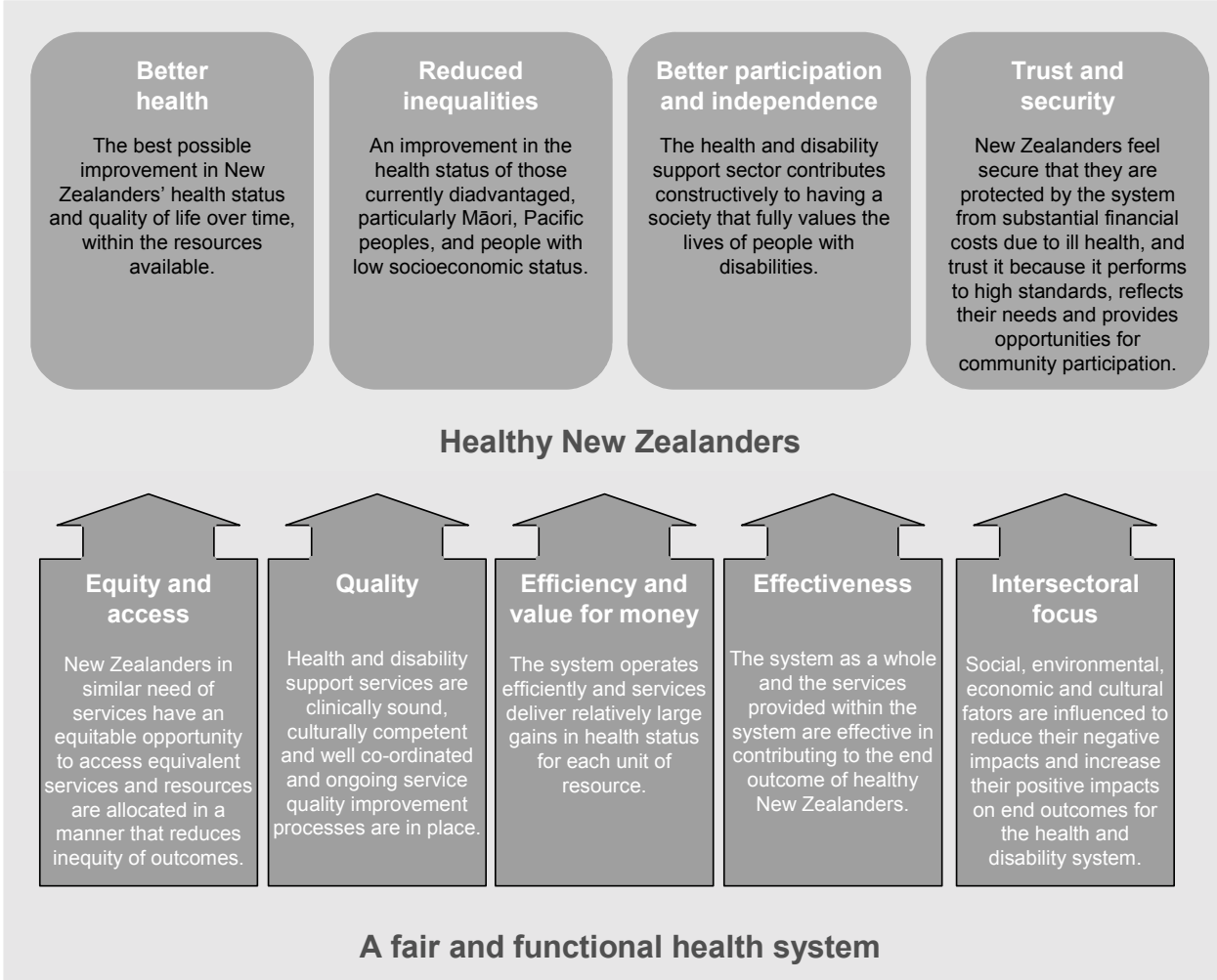
Systematic disability measurement in New Zealand began with the 1996 Census, so trend information is limited. The 1996 and 2001 surveys show similar results. Differences between countries in the definition and measurement of disability make international comparisons difficult.

### **Trust and security – health perceptions**

New Zealanders appear to perceive themselves as being in good health. Among OECD countries, our self-reporting of good health is second only to Luxembourg and, among over-65s, significantly higher than other OECD countries (The Commonwealth Fund 2004).

# How Healthy is Our Health and Disability Support System?

By international standards, New Zealand’s health and disability support system provides high quality, efficient and effective services that produce improving outcomes for New Zealanders. An intersectoral focus is growing. Improvements continue to be made across all of these system domains, with equity and access improvements most needed and most emphasised.



## Equity and access – use and responsiveness of the health system

The Commonwealth Fund study of five countries (Australia, Canada, New Zealand, United Kingdom and United States) found that New Zealanders reported the fewest problems accessing care on nights and weekends, getting same-day doctor appointments, and waiting for emergency care. They also reported the fewest co-ordination-of-care problems, good patient–doctor communication, and the highest overall physician responsiveness (The Commonwealth Fund 2004).

However, the same study reported uptake of some preventive measures, such as influenza and polio vaccinations and breast cancer screening, was relatively low.

There is also considerable, even stark, variation in access to health and disability support services. Māori access to cardiovascular treatments such as cardiac rehabilitation (after heart attack), coronary artery bypass graft and angioplasty has been only half that for non-Māori despite Māori being at close to double the risk of death, and three times the risk of death at age under 65 (Hay 2001). Although this access has improved in the last three years, it still remains below that for non-Māori despite substantially greater need by Māori (Ministry of Health 2004c).

Māori and Pacific peoples and those from more deprived communities have lower and/or later access to a whole range of services from preventive to specialist hospital services.

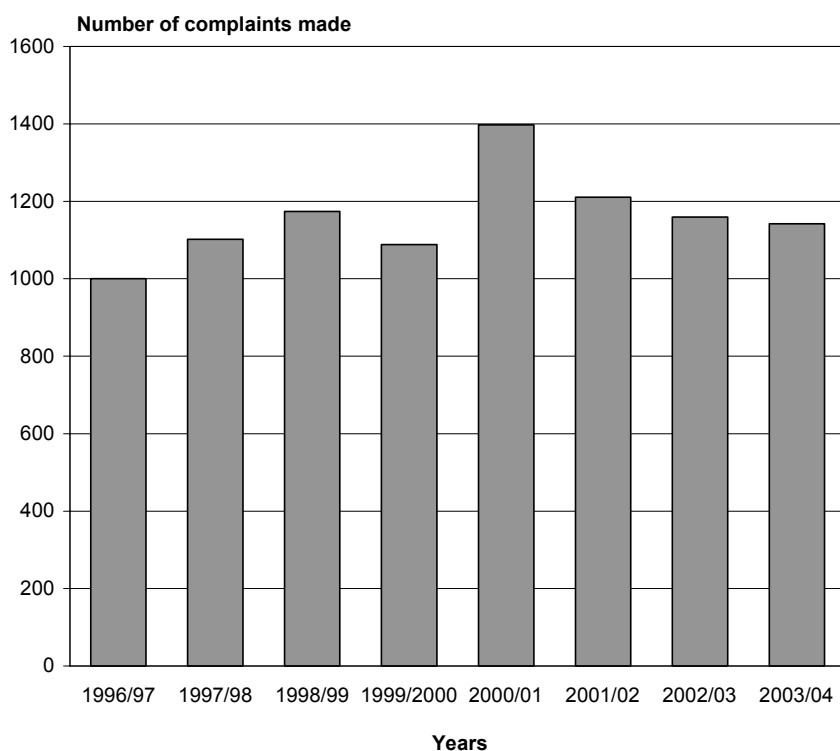
## Quality

Satisfaction ratings indicate how well services meet consumer expectations. As expectations change over time, satisfaction rating trends indicate the match between changing quality and changing expectations.

Consumer satisfaction with DHB hospital (including outpatient) services has been consistently high (rating good to very good) over the last three years, with only limited variation between DHBs (Ministry of Health 2002–05).

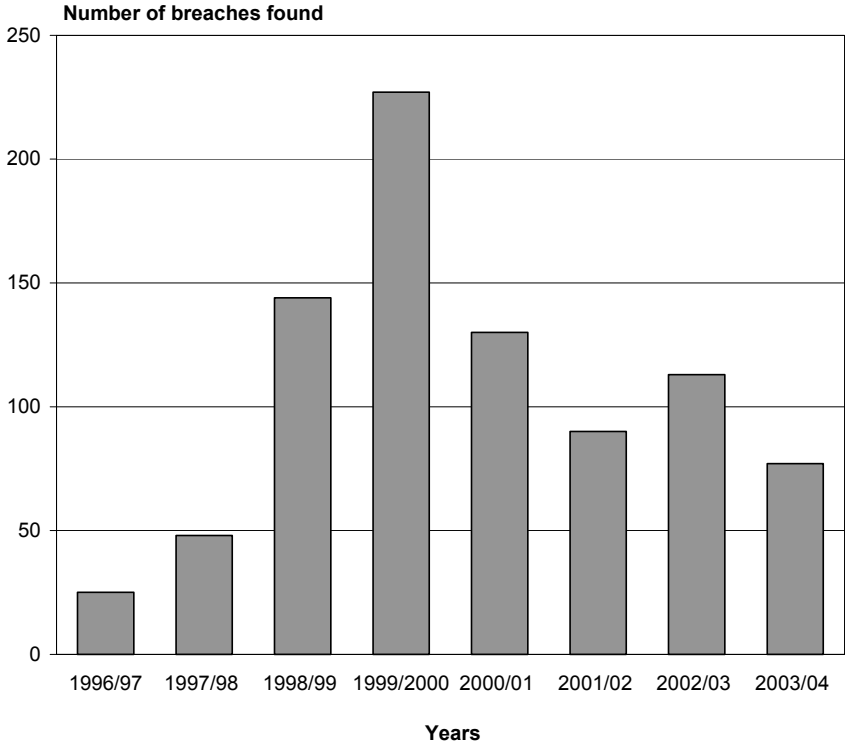
Complaints made to the Health and Disability Commissioner provide an indication of dissatisfaction with services. These appear to be becoming relatively stable over time (see Figure 12). (Health and Disability Commissioner 1996–2004).

**Figure 12:** Complaints to the Health and Disability Commissioner



Breaches of standards and codes of practice are another indicator of quality. Breaches of the Code of Health and Disability Consumers' Rights indicate where services have been below the bottom line of acceptability. Variation in breaches found, as shown in Figure 13, has occurred for a number of reasons, including multiple breaches by a single practitioner affecting a number of individuals.

**Figure 13:** Breaches of the Code of Health and Disability Consumers' Rights

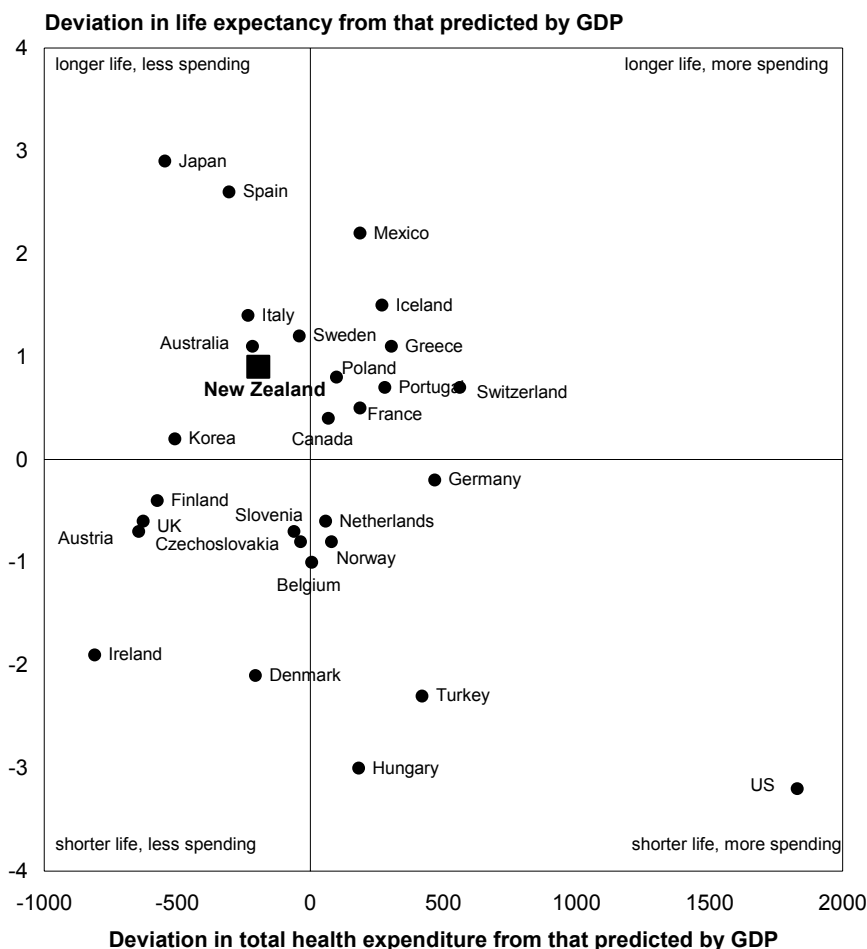


**Efficiency and value for money**

New Zealanders' reasonably good health is achieved while spending less than the OECD average (as a proportion of gross domestic product or GDP) on health services (see Figure 14) (Tobias 2005). New Zealand's health and disability support system appears to be relatively effective and efficient for the size of our economy.

Across the OECD, there is an association between national wealth (as GDP) and life expectancy. New Zealand has a somewhat better life expectancy than expected for a medium GDP. There is also an association between GDP and the proportion of GDP that is spent (by both government and private citizens combined) on health. New Zealand's spending on health is slightly under what would be expected based on these international observations.

**Figure 14:** Deviation from GDP-based predictions of life expectancy at birth and of total health expenditure, OECD countries except Luxembourg, 2002



Countries in the lower right quadrant of Figure 14 spend more than expected on health (given their GDPs), yet achieve a lower life expectancy than their GDP would lead us to expect – these countries therefore have relatively inefficient health systems.

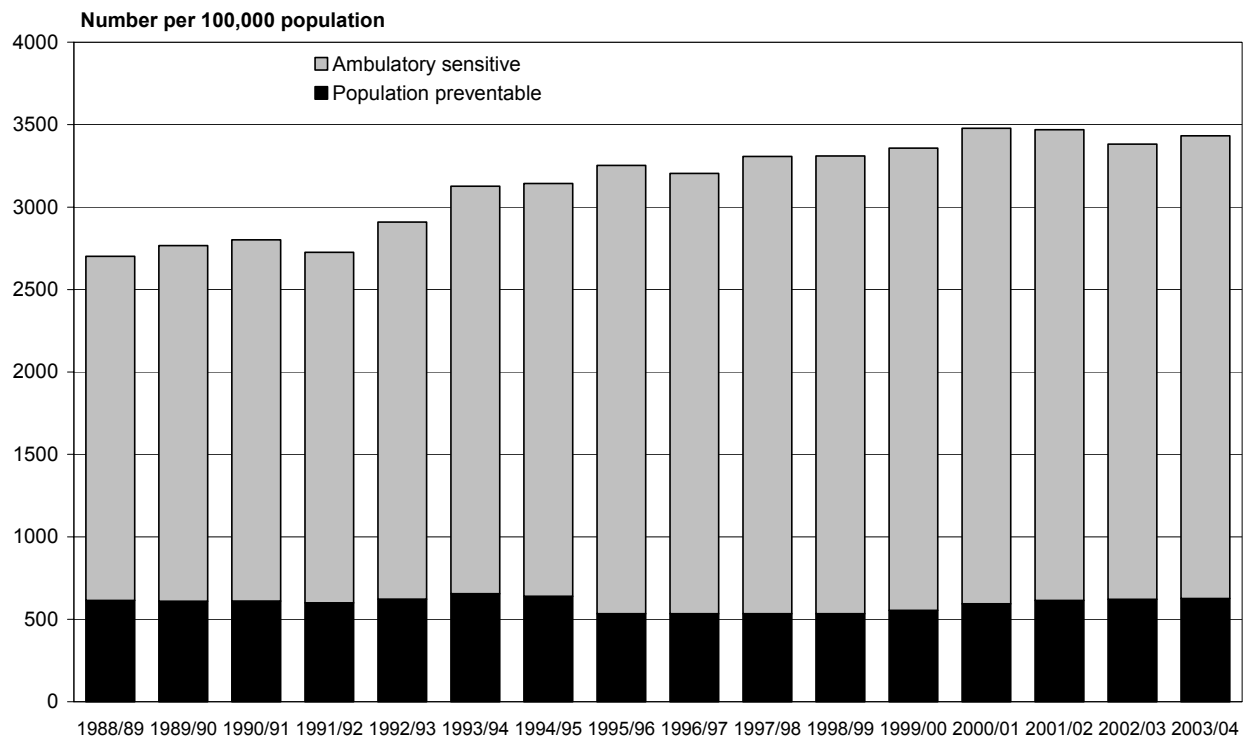
By contrast, countries in the upper left quadrant spend less than expected (given their GDPs) on health, yet achieve better survival than their GDPs would predict – these countries have the most efficient health systems.

Note that Figure 14 looks at relative efficiency rather than absolute achievement. While Figure 14 represents an attempt to compare the efficiency of national health systems, measuring this aspect of system performance is recognised as difficult and challenging internationally.

## Effectiveness

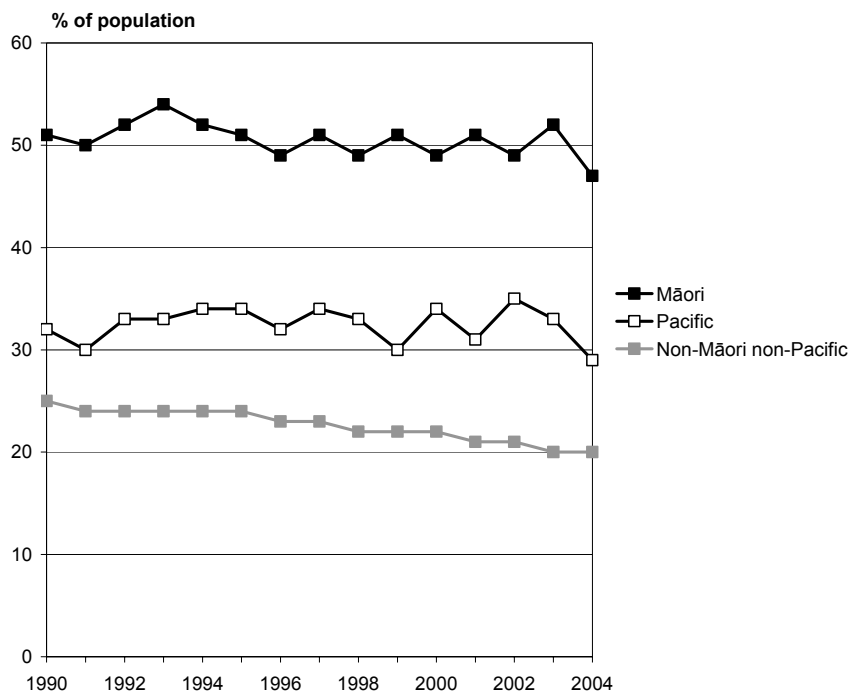
Avoidable hospitalisations, shown in Figure 15 (Ministry of Health 2004c), indicate the effectiveness of the health system in prevention and early identification and management of ill health. They include population preventable hospitalisations that could have been prevented by effective population health measures (such as health promotion to reduce smoking or obesity) and ambulatory sensitive hospitalisations that could have been prevented through effective primary health care.

**Figure 15:** Avoidable hospitalisations (estimated)



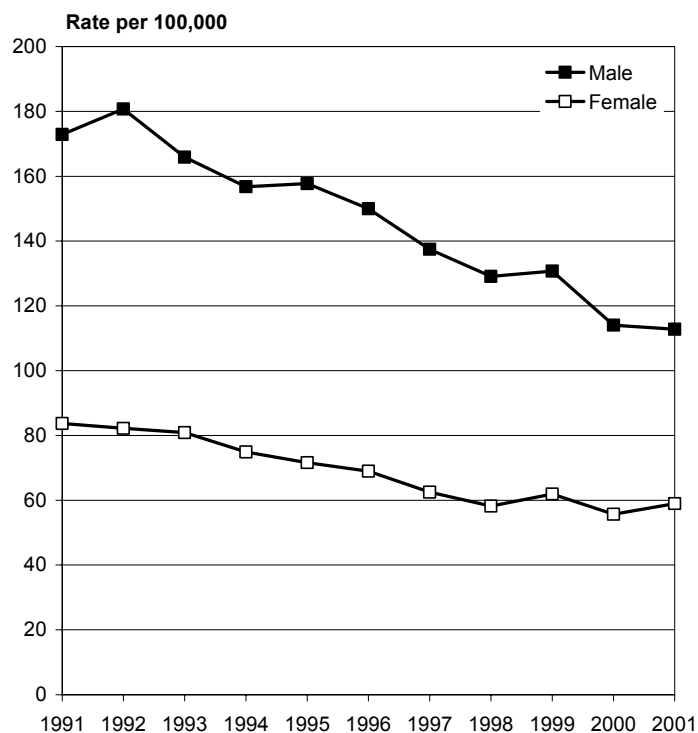
Tobacco smoking remains a key risk factor for illness and death, and reducing tobacco consumption is a major objective to improve health. Smoking by New Zealanders has declined steadily since the 1970s, though changes for Māori and Pacific peoples have been small in the last 15 years (see Figure 16). Tobacco consumption has reduced more than has smoking prevalence, indicating a reduced intake per smoker. Some 23 percent of New Zealanders aged 15 years or over smoke, on average, 11 to 12 cigarettes per day (Ministry of Health 2005a).

**Figure 16:** Cigarette smoking – prevalence in New Zealanders 15 years and over



Ischaemic heart disease is the leading cause of death for New Zealanders. Falling death rates indicate improvements across the health system, from prevention (eg, diet-related) to acute care management.

**Figure 17:** Death rates from ischaemic heart disease

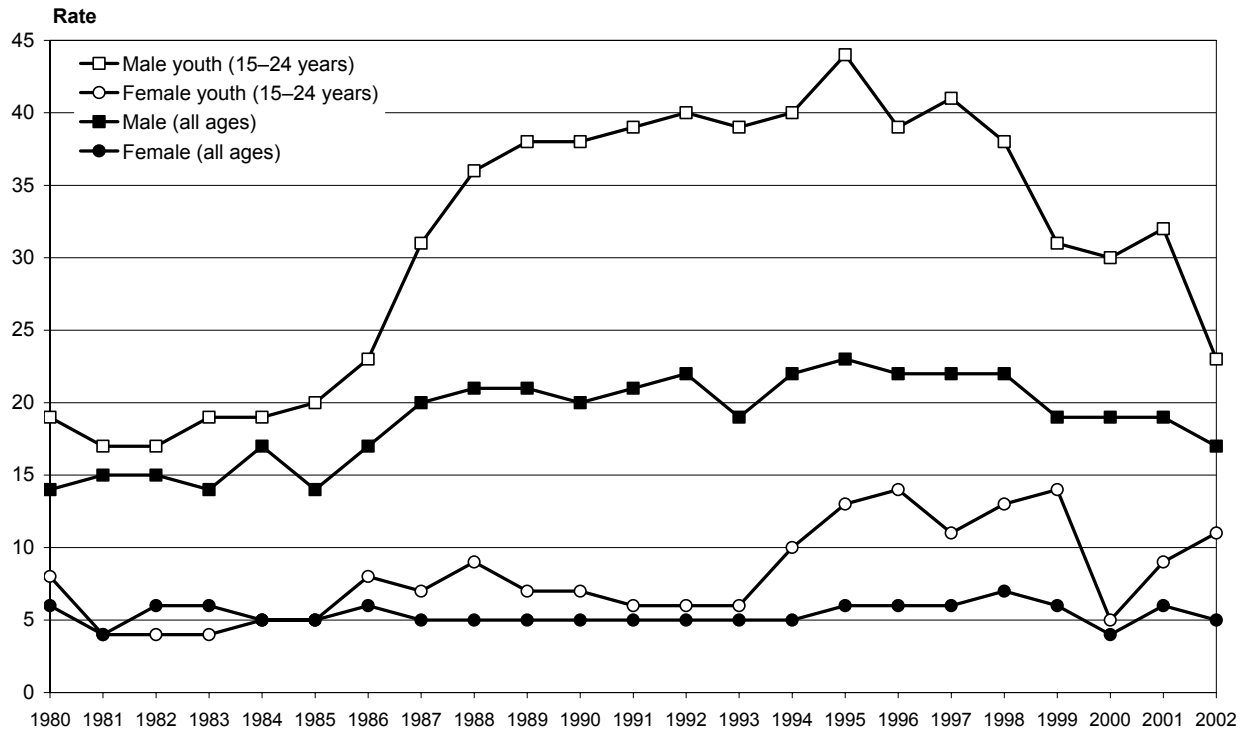


Data source: New Zealand Health Information Service.

## Intersectoral focus

New Zealand has high suicide rates, especially for young people, since the mid 1980s, with major intersectoral efforts to reduce these since the late 1990s. The overall suicide rate has fallen by 25 percent between 1998 and 2002. Our youth suicide rates remain high in comparison with most OECD countries despite significant reduction in male youth suicide rates (WHO 2005).

**Figure 18:** Suicide rates including youth suicide rates, 1980–2002



## Health and disability support – inevitably a complex system

In any developed country, delivery of health and disability support services – from health promotion through to intensive care, from hearing aids through to palliative care – is achieved through a complex adaptive human-activity system.

Particular features of health and disability support systems vary from country to country, but there are key common elements. These systems are all:

- **complicated** – the business of health is highly complicated and knowledge-intensive, with high degrees of professionalism, specialisation and sub-specialisation
- **valued** – high value is placed on health care, and this (along with decreased risk tolerance) tends to increase with increasing wealth
- **complex** – the knowledge requirements of health and disability support delivery make it not only complicated in linear ways (requiring increasing levels of specialisation), but also complex in interactive, lateral ways as the different parts of the system interact and produce more than the sum of the parts
- **adaptive** – when something changes, a whole series of adaptive changes ensue as the various parts of the system seek to continue with their goals (the system evolves to enable its continuance), and unexpected consequences are usual
- **human-activity-based** – a large proportion of costs are directly related to wages, salaries and fees, with practitioner decision-making exerting a high degree of control
- **resilient** – with people working in the system very committed to their work and the benefits it brings, and the system both resistant to and good at finding ways to get around external changes.

Key parts of the health and disability support system are:

- funding, regulatory and sector support agencies, including the Ministry of Health and its business units, District Health Boards (DHBs) and other Crown agents such as Pharmac and the Crown Health Financing Agency (publicly owned)
- primary and community health service providers, including Primary Health Organisations (PHOs), public health services, other independent practitioners and service providers, pharmacy and laboratory services (mostly privately owned)
- hospital and other specialist services (mostly owned by DHBs, some privately owned)
- home-based and residential care and support services (mostly privately owned, often not-for-profit).

All four parts of this system have undergone major upheaval and growth in the last 15–20 years. Three different philosophies, and associated structures, have been applied to the public funding and provision functions. The way the health system functions has been transformed, with many benefits. However, delays in service improvement have inevitably accompanied structural changes.

The major changes in the last 15–20 years have been:

- more explicit development of the ‘funder’ role in the system, with 80 percent of Vote Health funding now managed by DHBs as funders, to prioritise, plan and develop services to meet population needs

- emphasis on improving financial and performance accountability and management, assisted by firm government responses to deficits and more transparent capitated funding arrangements
- greater orientation and responsiveness to local concerns, with a high degree of local transparency
- growth of a more customer-centric and high-quality focus for services accompanied by more transparent and independent regulatory and complaints mechanisms.

Areas for ongoing development and improvement include:

- development of greater capability in the funding role
- effective management and containment of costs, while sustaining productivity
- deepening the capacity of the system to cope with unexpected pressures without the need for additional single-issue funding
- further development of collaborative regional and national planning approaches that engage practitioners as well as funders.

'Change fatigue' in the sector creates opportunities to capitalise on sector interest in addressing weaknesses in the current system in order to avoid restructuring.

The roles, functions and accountabilities of organisations in the health and disability support sector are described in the companion document (Ministry of Health 2005b).

Key organisations are discussed throughout this document.

- District Health Boards (DHBs) are key to improving the health of New Zealanders. These 21 Crown entities assess the health care needs of their populations, plan to address these needs and fund or deliver services.
- Non-governmental organisation (NGO) health and disability support providers, both not for profit and for profit, complement Crown providers.
- Primary Health Organisations (PHOs) are groups of primary health care providers that assist DHBs to 'get in front of ill health'.

## Trends and Pressures in the Next 10 to 20 Years

Immediate pressures facing the health and disability support system include:

- rapid increases in the cost of employing health practitioners, driven partly by an increasingly competitive international market and partly by moves towards social equity goals such as equivalent remuneration for roles predominantly filled by women
- a need to overhaul the pay and employment environment of support workers in both residential and home-based support work – the latter, formerly provided largely by volunteers, faces a shortage of volunteer workers and a steep increase in demand for home-based care
- rising expectations of access to newer equipment, pharmaceuticals and techniques, by both service users and practitioners
- growth in chronic illnesses with high ongoing costs of care (such as for renal dialysis)
- many organisations undertaking major change (eg, significant building and service reorganisation programmes at several DHBs), with the risk that managing change distracts them from service delivery issues.

### Population trends

- An ageing population results in more health care needs, more care and support needs, a changing tax base, a smaller total workforce in the 20–65 age group which requires technical efficiencies in other work areas in order to retain the required numbers in the health and caring workforce, and greater part-time work.
- There is a changing ethnic distribution with higher Asian, Māori and Pacific populations, changing age distributions and new ethnic populations leading to greater diversity; increased cultural literacy and competence requirements; increased opportunities for diverse cultural origins in the workforce; opportunities for developing niche workforce areas (eg, taking advantage of cultural orientations towards care, honour of older people).
- There are increasing social and economic inequities, with disadvantaged population groups experiencing increasing disparities and exclusion from social goods and these issues potentially becoming less amenable to interventions including public health interventions.

### Social climate and lifestyle trends

- Sedentary lifestyles, poor nutrition and increasing obesity are resulting in a greater prevalence of diabetes and cardiovascular disease (with huge downstream health care costs already impacting on some DHBs); an increase in some cancers; more coexisting depression, anxiety and substance-use disorders; growth in demand for health care with the potential to become exponential if not stemmed by investment in healthy public policy and programmes in areas such as transport, environment, education, social development and both public and primary health; and decreasing fertility, with more demand for assisted reproduction.

- Greater urbanisation, smaller families and a greater proportion of one-person households may be leading to a loss of social capital and increases in social isolation and the prevalence of depression, anxiety and substance-use disorders; increased care needs; dispersion of point of care with increasing home-based and local care; and opportunities for citizenship, urban design and public health initiatives to increase social capital and reverse the potential negative effects.
- There is a continuing trend for New Zealand to be seen as a lifestyle destination for those wishing for outdoors/environmental benefits and lower urban and industrial density than in many European and Asian locales.

## **Resources**

- Tightening energy supply will have flow-on effects to a wide range of costs including wages and salaries, and the ability to deliver services, especially those relying on transport.
- Pressures on funding will result in increasing calls for efficiencies and integration and to measure effect and effectiveness, with resulting pressure for quality information and research at all levels of health policy and delivery.

## **Technology development**

- Technological developments have provided an increasing ability to intervene to enable and prolong life; an increasing demand for available but very expensive treatments; and increasing specialisation in treatment delivery, with offshore delivery only for some very expensive and/or specialised treatments.
- Improvements in existing technology are enabling more efficient delivery, more outpatient and day-patient delivery, more remote delivery with high-resolution video links for diagnostics, interviews and specialist supervision, more local 'visiting' delivery along with more 'travel to specialist centre' short-stay delivery; changes in hospital business to become increasingly acute-care oriented, with higher acuity and complexity levels and greater centralisation; and smaller hospitals less able to deliver over time so that they evolve into emergency departments and convalescent and respite care providers.
- Improvements in research and development response times, such as for vaccines for emerging viral diseases, will make preventive treatments available with a huge demand potential (the entire well population) in response to the fear/threat of disease, with associated costs.

## **Labour market**

- Increasing costs of labour due to technology and productivity improvements outside the health sector that increase wealth for some members of the community and expectations that others will also share the benefits, coupled with scarcity as population ages, mean that any potential for off-set by immigration is probably undermined by higher prices for the health workforce internationally.

## **Rights and consumerism**

- There is a demand for more information and a greater say in the services available and/or delivered; greater time requirements to explain options, procedures, benefits and risks; more 'alternative' and second-opinion services; a rise in the use of health-lines and other triage-cum-information services; a rise in the reliance on internet-derived information; a demand for quality, reliable information direct to the consumer; and a greater proportion of specialist time spent in consumer interaction rather than technical delivery.
- There is an increasing demand for disability support services, dementia services and palliative care services; effective (but expensive) human care services such as psychotherapy, music and art therapy; and individualised services and packages tailored to individual preferences and needs.
- There is a continuing trend to litigiousness for both current and historical deficits in care.
- Equity-related challenges to funding and delivery prioritisation frameworks increase, and there is pressure for greater information on which to base increasingly individualised assessments of need and service priority.

## **International developments**

- The increase in inter-jurisdictional policy and regulatory activity will continue with increasing demand for global action in economic, social, health, education, civic, defence, environmental, conservation and other areas of government, leading to greater requirements for regulation, monitoring and management of treaty and other international commitments; and moves towards more joint-nation approaches with longer-term benefits and more immediate implementation costs and delays.
- There are increasing expectations for the ability to mobilise resources and personnel in response to international disasters and security issues.
- There are increasing expectations to provide aid to poorer nations, including health workforce training and development aid, together with moves to minimise 'poaching' of trained professionals from poorer nations.
- There has been an increase in international court decisions relating to access to health care and compensation for injuries to health.

## **Emerging communicable and environmental diseases**

- Epidemics and pandemics are increasingly likely, due to increasing international travel and trade, increasing population density and agricultural and horticultural intensification. Influenza pandemics are possible and inter-species virus transmission (eg, recent SARS and avian flu outbreaks) increasingly so.
- Increasing industrialisation and fuel-based economies bring associated increases in particulate and toxic environmental substances, as well as greater globalisation of terrorist activities.
- Pressures are put on health systems for responses, magnified by an increasing ability to identify emergent threats to health and associated public fear.

# Community and Government Working for Health and Participation

Health and participation are influenced by a wide range of factors beyond the health and disability support sector, and often outside the control of individuals. Various analyses of impacts on life expectancy and on gains in life expectancy have attributed between 10 and 30 percent to health services. Much greater impacts are attributed to environmental, social and behavioural factors (Public Health Advisory Committee 2004).

A wide range of government activities can impact positively (or negatively) on health and participation. Income, education level and employment status are all directly correlated with health in developed countries, including New Zealand. At more focused levels, communicable and lung disease rates are strongly influenced by the affordability and quality of housing and energy, and lifestyle factors related to health, such as physical activity and social connectedness; by urban design, transport policy and infrastructure; and by workplace policies and design.

Ensuring an active health and participation agenda in wider government is a key role for a Minister of Health.

Specific health protection, promotion and prevention programmes are well established in New Zealand. They account for a significant part of the Ministry's regulatory and programme delivery functions and for recent preventive health investment decisions by DHBs. These need to continue, and to evolve in response to changing community needs as well as to changes in the health sector, especially with the increasing role of PHOs in preventive health care.

Now, some of the biggest opportunities for health and participation gains are through aligned and combined policies and programmes across government and community. DHBs have crucial roles in aligning initiatives locally. Combined approaches may have specific health-related goals, such as reducing deaths and injuries from motor vehicle accidents, or reducing obesity. They may – and increasingly in future should – have broader goals that include health benefits, such as reducing family violence, or improving social outcomes for young people in contact with the justice system.

Typically, such approaches will employ a range of initiatives and programmes over a multi-year, often multi-decade, timeframe. They will be backed up by market research and other evaluation. To change social attitudes and behaviours requires a long-term commitment. Generalising the changes to sections of the community for whom there are greater barriers to change (often those where the potential impact is greatest), and developing ways to target high-risk groups, may take even longer. Nationwide approaches are generally supported by specific community action, especially in those communities with the greatest potential gains.

Here are three examples of cross-government programmes of activity led by the Ministry of Health.

- **Promoting healthy eating and healthy activity** – to improve nutrition, increase physical activity and reduce obesity; reduce the linked chronic diseases, depression and shorter life span; and increase participation in community and economy. This includes the Healthy Eating – Healthy Action strategy across the health, education, sport and recreation, transport, environment, social development and local government sectors.
- **Reducing tobacco, alcohol and other drug use** – to reduce smoking (which accounts for 17 percent of all deaths in New Zealand) and harmful use of alcohol and other drugs (which account for a number of fatal motor vehicle accidents and other deaths and have a wide range of adverse health, social and economic impacts). This includes the National Drug Policy and its associated action plans, involving the health, customs, police, justice, transport, education, social development, Māori development, and youth development sectors.
- **Protecting water for drinking, promoting drinking of water** – to improve the supply of safe drinking-water works across the health, education, tourism, environment, building and housing, and local government sectors as well as with industry. This helps make New Zealand a healthy place to live and to holiday in by reducing illness from contaminated drinking-water. Having safe and secure drinking-water supplies also contributes to other health and social goals – making outdoor recreation and good nutrition easier.

Across government, we now have good experience with such programmes or campaigns involving a small number of agencies co-ordinating their work to achieve specific, measurable changes over time. Our challenge is to jointly tackle some of the broader changes that are needed and for which responsibility extends over larger numbers of agencies. Effort here has enormous potential for synergy and added value.

The Ministry of Health is taking up this challenge with a change in orientation and capability development, both in the Ministry and throughout the health and disability support system. The Ministry has moved to gear itself towards policy, leadership, change facilitation and performance management roles. It has established a clear outcomes framework for the sector, and is a leading participant in a range of inter-agency projects and collaborations. But greater change will be needed. The management of the range of programmes and initiatives run by the Ministry, and of its business units that support the sector as a whole, is being refined and consolidated. This will free up time for the quite different attention and skills required for shared outcomes work across government.

Over the coming three years the Ministry will:

- prioritise its own work programme to free up resources for cross-agency work, including joint development of social and economic policy advice and of evaluation methodologies
- continue to build skills such as communication and networking, creativity and innovation, social and economic policy, evaluation and community development through internal development programmes and opportunities, support for joint state sector programmes, secondments between agencies at a range of levels in the organisation, and aligned recruitment and retention practices
- continue to review the funding responsibility and decision-making processes for district, regional and national services to ensure best fit for purpose with sector evolution and changing circumstances
- review responsibility for business units that support the sector as a whole, to ensure best alignment of business goals and accountabilities.

Key actions for the Minister of Health are to:

- ensure the impacts on health and participation are considered in all government policy areas
- recognise and support initiatives across government and communities that encourage better health and participation.

#### **The Healthy Housing Programme – 2005 Health Innovation Awards overall winner**

Communities with known high rates of overcrowding, and diseases related to overcrowding, are helped to access primary health services and facilities, to improve health and reduce overcrowding.

This programme was set up by Counties Manukau DHB, Housing NZ Corporation, Auckland Regional Public Health and the Auckland and Northland DHBs after research showed the most important risk factor for meningococcal disease among Auckland children was overcrowded homes.

## **Health and participation as part of a broader social investment**

Aligned and combined programmes to increase social capital, whether delivered to the whole population or to particular communities, increase people's (individual and community) competence and control over their life circumstances, including their health and health-related behaviours. DHBs, PHOs and local government will often have a combined role.

Examples of where health and participation are integrated with wider social and economic concerns, in response to community needs, are:

- education and skill development, parental involvement in children's education including health education, parenting, support for community education initiatives and assistance with individual information seeking
- work and employment, including unpaid and voluntary work and participation in community activities; and assistance to deal with barriers to participation (eg, health and disability barriers such as alcohol and other drug problems)
- financial management, including budgeting, saving, planning and investment; and assistance to deal with debt, gambling, smoking and other activities that impact on financial problems
- community support, including support for parenting, activities, social connection and inclusion (eg, for people with illnesses and disabilities); participation and coaching; assistance with information; youth development; and support for victims of bullying or family violence
- community development and decision-making, including involvement in local government; input to local planning and policy development; input to local services including schools, health services, libraries, sports and recreation facilities; crime prevention; and community safety, environment and employment
- physical activity, including safe environments and facilities; opportunities for organised sport and physical recreation for all ages and for parents; organisation, leadership and coaching
- food and nutrition, including health education and information; assistance with help-seeking, budgeting and shopping for food; food preparation and cooking; gardening and growing fruit and vegetables.

**Key recommendations to support community and government working for health and participation.**

Strengthen functionality and performance management of the sector so activity is fully aligned to outcomes:

- give priority to Ministry work in the two critical areas of intersectoral work on shared outcomes and improved evaluation of sector and system performance
- work towards the joint development of social and economic policy advice and evaluation of progress
- continue to review the balance of, and funding responsibilities for, district, regional and national services and business units, to ensure best fit for purpose as the sector evolves and circumstances change.

Increase opportunities to recognise and reward improvements so the wider system and communities can benefit from their spread and adaptation, leading to better health, reduced inequalities, better participation and independence, and trust and security.

## Delivering Services to Populations in Need

Our health and disability support system needs to work more effectively in order to keep delivering good health and participation for New Zealanders, in the face of a tight workforce supply and rising needs and expectations. In particular, it needs to improve delivery for those at greater risk of poor health and participation. Addressing the marked inequalities in health between Māori and Pacific peoples and other New Zealanders is one of the biggest challenges.

A key opportunity for a more productive sector hangs on the focus on population-based approaches. This is a key opportunity because:

- the major areas of growth in need for health and disability support services are in definable population groups (such as overweight and obese children and adults, people with type 2 diabetes, older people with chronic illness) – this growth is large enough that even isolated health practitioners naturally begin to think about common needs and how to address them
- another area of growth is in quite common conditions (such as depression or substance dependence) that have been under-recognised but are now being picked up in increasing numbers with improvements in primary health practice and a greater willingness of people to seek help
- effective ways to address the needs of groups of people are becoming known (such as better delivery of services for Māori, Pacific or refugee and migrant communities with multiple health needs)
- technology and service delivery improvements (such as screening and assessment tools, information technology and innovative service delivery models) are making it easier to identify groups of people in need and to provide effective early intervention, especially where the number of people likely to benefit is large.

Population approaches ‘ring true’ to health professionals as ways to get greater traction on improving health and participation outcomes. They can help design more effective and efficient programmes and services. Services will often still be delivered to individuals and whānau, but may be organised, resourced and monitored by the group or population of need.

There is a history of such population-focused innovation in New Zealand. Some has been in response to the needs of groups who for various reasons tended not to seek help from the usual sources (eg, Plunket, family planning centres, iwi-based hauora [health] services, remote-area services such as in the Hokianga, and those set up for people who could not afford traditional fees such as Union health centres).

Other population-focused innovations have included use of registries and recall systems to improve preventive and follow-up care. Booking systems for elective surgery improve clarity, timeliness and fairness in scheduling elective surgery for those who meet thresholds of need, with those having the greatest need being scheduled earliest. DHBs have a clear, legislated focus on the health and participation of their local populations.

As improvements are starting to be demonstrated and replicated, a culture change is gathering momentum in the health professions towards a focus on the needs of individuals in the context of the collective needs of a group of people. This leads to other changes that can only facilitate the development of better and fairer service delivery approaches from:

- a mainly reactive to a more proactive focus
- a focus on each individual to thinking about group needs as well
- individual health profession approaches to more joint collaborative approaches
- services provided to or for people to greater emphasis on working with people to improve their health and participation.

Most importantly, locally demonstrated improvements, whether they lead to better outcomes or similar outcomes delivered more efficiently, increase the momentum for further innovation and changes among those who need to implement them. They show that service delivery can change and that people can benefit. They facilitate leadership and capability development and transfer of ideas and improvements across the health and disability support system.

## **Primary Health Care Strategy**

Population-based approaches are one of the key directions of the Primary Health Care Strategy, introduced three years ago and still being rolled out. This is a very big change for primary health providers, communities and whānau, with potential to make significant improvements in New Zealanders' health and participation. It focuses on better health and reduced inequalities in health.

The strategy aims to pull together several major drivers for improved health and participation, including:

- better use of the full potential of the primary health care system and practitioners, with development of better care, better prevention and early intervention
- better application of government funds to where they are most effective, in preventive and early care and making this accessible and affordable
- better adaptation of services to local needs, with the active participation of community members in stewardship and governance of Primary Health Organisations (PHOs)
- better alignment within the wider health and disability support system, with a more active role for DHBs in steering primary health care.

PHOs are the vehicle to deliver the strategy.

Part of the strategy has been a big change in the financing of primary health care. Substantial increases in government funding are being rolled out, on a per-person rather than per-visit basis. This is enabling improvements in access to care and in the application of funds to population health needs. It is giving incentives for the prevention of illness and disability and for other productivity improvements. The funding has been rolled out faster for Access PHOs (those with at least half of their enrolled population in groups with poor historic access and high population health need).

More than 90 percent of New Zealanders are enrolled in one of 77 PHOs around New Zealand, and the first phase of evaluation indicates considerable goodwill and support for the strategy. Other indications are of improved access for some groups, optimism for better care for those with high or ongoing needs, planning for a range of new initiatives and for increasing the roles of non-medical health professionals, especially nurses (Health Services Research Centre 2005).

The degree of anxiety felt by private general practitioners about the longer-term financial implications for them and their practices appears to be declining as there is greater experience with the new funding arrangements.

However, there is concern that, after the roll-out of substantial additional funding, a number of providers are still charging fees that are a barrier to access for individuals and families. Some variation in fees can be expected, as can variation in the ways that increased funding is directed to improve services. But this variation should be modest. With nearly all Access PHOs and many other PHOs delivering services at the low fee levels envisaged, it is clear they are achievable with the new funding.

Work is under way on mechanisms to provide assurance that government funding flows through into reduced fees and that these fees can be maintained at a low level in future.

Improvements in the delivery of primary health care have been growing and should accelerate in the coming three to five years. As evidence that the strategy is successful the Ministry expects to see:

- more people receiving care, at earlier stages of risk or illness
- a wider range of health care workers contributing in effective team approaches
- greater community involvement in setting priorities
- improvements being promoted by key opinion leaders and replicated
- better treatment and management of chronic illnesses and diseases
- some outcome improvements (such as reduced deaths from cardiovascular causes) starting to appear.

## **Māori health and disability – major ongoing efforts required**

The most pressing population health issue for New Zealand is to address the poorer health status of Māori.

While health for all New Zealanders has improved, Māori health has improved more slowly than that of other New Zealanders in recent decades. There is a potential change in this trend of the last decades; life expectancy differences between Māori and non-Māori did not further widen in the most recent five-year measurement period (to 2001). This highlights the need for a continued focus on improving Māori health so that all New Zealanders can share equally in better health.

Addressing Māori health need is important; how to address it is a more difficult question. Approaches within the health and disability support sector have concentrated on making services more effective in reducing disparities between groups. Approaches across government have focussed on achieving better distribution of resources that contribute to health, such as education, employment and good housing, and ensuring health and disability support services support these efforts where needed.

Within the health sector, a major contributor to the difference in health status improvements appears to have been poor health service delivery to Māori. Historically, and continuing today, Māori have had lower access to many services, later access to acute services (presenting at a later stage of illness) and poor experiences of services.

Over the last 15 years, health and disability support services have been progressively developed to better respond to Māori. Changes have been made to improve Māori access to services, develop services that are relevant for Māori, focus on health gain priority areas and increase the participation of Māori in the decision-making and also in the delivery of services.

These changes are expressed in the health and disability support sector through the principles of the Treaty of Waitangi (derived from the Royal Commission on Social Policy 1988). They include:

- partnership – working with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and to develop appropriate health and disability support services
- participation at all levels – involving Māori at all levels of the sector in decision making on, planning for, developing and delivery of health and disability support services
- protection and improvement of Māori health status – working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values, and practices.

These principles are viewed widely throughout the sector as a constructive mechanism to maintain a focus on improving Māori health over time.

## **Pacific peoples' health and the health of other diverse groups**

Pacific peoples in New Zealand also experience significantly poorer health than non-Māori non-Pacific New Zealanders.

Many of the same principles and approaches to service improvement that underpin efforts to improve Māori health are equally important for Pacific peoples and other diverse groups with high health needs. Partnership with communities of need, participation at all levels in planning and delivering services, and a focus on improvement and responsiveness of services are key.

Further development of research and evaluation on aspects of health and disability for Pacific peoples and other diverse groups is needed.

**Key recommendations to work towards services delivering for populations in need.**

Strengthen functionality and performance management of the sector so activity is fully aligned to outcomes:

- continue and strengthen the emphasis on improving Māori and Pacific peoples' health
- increase useful and comparative information for the public on DHB and PHO service delivery and coverage, quality and outcomes
- tighten fee structure requirements for PHOs receiving planned funding increases, to more quickly achieve low-cost access to primary health care.

Increase opportunities to recognise and reward improvements so the wider system and communities can benefit from their spread and adaptation, leading to better health, reduced inequalities, better participation and independence, and trust and security.

## Services There for the People Who Need Them Most

Attention must be paid to the 'big wins', through interventions for populations with common disorders or conditions, in order to make the most effective and efficient use of health resources.

Attention also needs to be given to how resources are allocated across the system. Trust in the health and disability support system and in government can be undermined where people believe or fear that:

- people with high needs are not receiving services or have difficulty accessing them
- some people can access funding streams not available to others to receive services
- funding decisions seem to favour high-profile services rather than those for people who are more needy
- there is a perpetuation of past funding inequalities and poor outcomes.

Each of these problems can be found in our health and disability support system. They are often difficult to resolve because resources to increase services for one group may only be found by reducing services to another group. Inequities in access to care may be long-standing, especially where:

- there are previously unrecognised needs
- needs cut across sectoral and/or funding boundaries (eg, between health, accident, disability support, education and welfare)
- needs exist in groups that wider society tends to value less or identify with less
- there are service areas in which the main workforce as well as recipients of service have low social status or recognition.

In these situations there may be significant barriers to adequately assessing and prioritising such needs. Even attaining sufficient information may be difficult.

People with mental illness have been in this position, despite mental illnesses such as depression being common. Misunderstandings and fears of mental illness are now being replaced with more supportive and inclusive responses. A decade of visible commitment by successive governments to improving mental health services is making significant differences. The life prospects and contributions to the community and economy of people who experience mental illness are improving. Efforts to change social attitudes are under way (the Ministry's Like Minds, Like Mine programme has received many international awards for its work in this area). These efforts aim, with persistence, to change public behaviour as well as attitudes towards people who have experienced mental illness. This will lead to significant health and other gains for the community, but requires more than another decade of continued attention and service growth.

Other groups have not yet achieved this level of visibility and support. There are many examples: those with intellectual disabilities, autistic spectrum disorders and other disabilities including profound hearing and vision loss; those with dementia or requiring ongoing care; those with rare medical conditions or disabilities; and those with combined conditions such as diabetes, obesity, renal failure and reduced mobility together. Such groups sometimes have low access to or significant waits for health services (including specialised medical and surgical services as well as primary health care) and disability support services (including technical and environmental supports such as hearing aids).

There are many reasons for barriers to accessing care and support. Individuals with higher and more complex needs may require more complex and costly services. Specialised supports and communication may be required to assist access. Increasing the capability of health and support service workers to respond to the different needs of individuals, and providing access assistance where needed, is an important area of development.

There are historical reasons for resource inequities. Without active intervention it is unlikely that people in these groups will be able to access services that meet their needs.

This is a difficult issue to address. It requires prioritisation tools and mechanisms that work across different types of needs and different funding streams. It is not an area where a complete solution can be easily found. But it is important to make progress so that New Zealanders' confidence in the health and disability support system can be enhanced and maintained.

Over the last decade, separate funding mechanisms have been used to ensure that disability support services grow at the same rate as other services in the sector. However, it has become clearer in recent years that:

- the baseline quantity and quality of support, both for people with disabilities and for people with medical conditions that have associated support needs, have probably been low relative to other types of health service, perhaps similar to mental health services and primary health care services for Māori and Pacific peoples, both areas that are now being addressed with service increases
- there has been growth in recognition of need for services, and in expectations about what services should be provided and their quality and style
- the increased cost of new technical supports may have been proportionately greater in disability support
- opportunities for developing an understanding of the needs of people with some types of disabilities, the capability to address these needs, and the opportunities to actively engage in reducing discrimination in health services and in the wider community, may have been limited.

Working through these problems towards future provision in a transparent and equitable way is a major task for the Ministry and DHBs. With incomplete information, and the inevitable lag times involved in service increases or developments, there are likely to be interim arrangements and reviews involved in any recommended path forward.

There are clear differences in services available to people with similar needs where the origin of the need, and thus the funder, is different. The Accident Compensation Corporation (ACC) funds services for people whose needs result from accident or injury. ACC generally funds more services, and pays higher rates for the same services, than do other funders (DHBs or the Ministry of Health). The Ministry of Social Development funds additional health and disability support in some circumstances, such as to support increasing participation in employment.

DHBs tend to fund fewer services for people whose needs result from medical disorders or treatments than the Ministry funds for people whose needs relate to long-term disability. There has been some confusion on who funds what, and work is under way to address this.

Most of these funding differences and gaps are historic – not the result of active decisions made recently.

There are also differences between districts and regions in the relative funding and provision for different service groups. Greater consistency across the country has now been achieved for services funded by the Ministry for younger people with disabilities. However, different access continues where there are different funders and where people have similar needs arising from different causes. People with particularly high or complex needs may require integrated cross-funder responses to meet their needs.

The health and disability support system prioritises resource depending on both need and ability to benefit. Disability representative groups, on the other hand, favour rights-based approaches focused on broader entitlement. This view tends to be reinforced by the inequities in access and funding outlined above, and is highlighted by the ‘appeal’ routes people with disability have taken – predominantly to the Human Rights Commissioner or Human Rights Tribunal, rather than to the Health and Disability Commissioner.

Changes that might put at risk or erode the access of any group are likely to be vigorously debated. Thus clear pathways to fill gaps and prioritise funding to services that support participation, strong protections, and a commitment to meeting the needs of people with disabilities, will continue to be required.

## The way forward

A commitment to identify and address service gaps, especially those that substantially affect people with high health and disability support needs, is required. Such gaps are unlikely to be identified completely at one time, so commitment to an ongoing process of review will be necessary. However, substantial work to examine differences in access to services that occur because of different funders, and to assess their impacts and the feasibility of options to address them, should proceed without delay.

### **Key recommendations to ensure services are there for the people who need them most.**

Strengthen functionality and performance management of the sector so activity is fully aligned to outcomes:

- address gaps and inequities in the provision of services for people with high needs that can otherwise undermine confidence
- streamline DHB performance expectations and strengthen management frameworks around the core expectations, adding multi-year requirements for improvements in services for those with high needs, and in service user experiences.

## Planning and Funding for the Short and Long Term

In a system that is both complicated and complex, changes seldom happen quickly. A long-term approach is necessary, and one that steers and guides rather than one that expects a precise finely tuned response.

Directional but slow and imprecise steering is a product of a human activity system, especially one that faces workforce pressures and is expected to maintain or improve efficiency and effectiveness. Changes that require increased human resources (such as specialist theatre nurses or child psychologists) take years to achieve.

A degree of certainty around priorities and funding is required for DHBs and service providers to plan for the future. This is especially true where significant changes such as service increases are required.

The current health funding package arrangement has provided good baseline certainty for DHBs to plan effectively. Baseline funding is provided for three years in advance and rolled over each year to the next (third) outyear. Standard adjustments are made each year at rollover to provide for inflation in the wider economy, and components of the package allow for increased costs related to, for example, demographic growth and technology improvements. These components are carried over from earlier sustainability increases that were appropriated each year but based on a formula designed to provide for sustainability in the sector.

The three-year funding arrangement started in 2002 and has been rolled over twice, out to 2006/07. Its extension to 2007/08 has been deferred pending the outcome of a Ministry/Treasury review that will provide advice to the Ministers of Health and Finance by the end of November 2005 on:

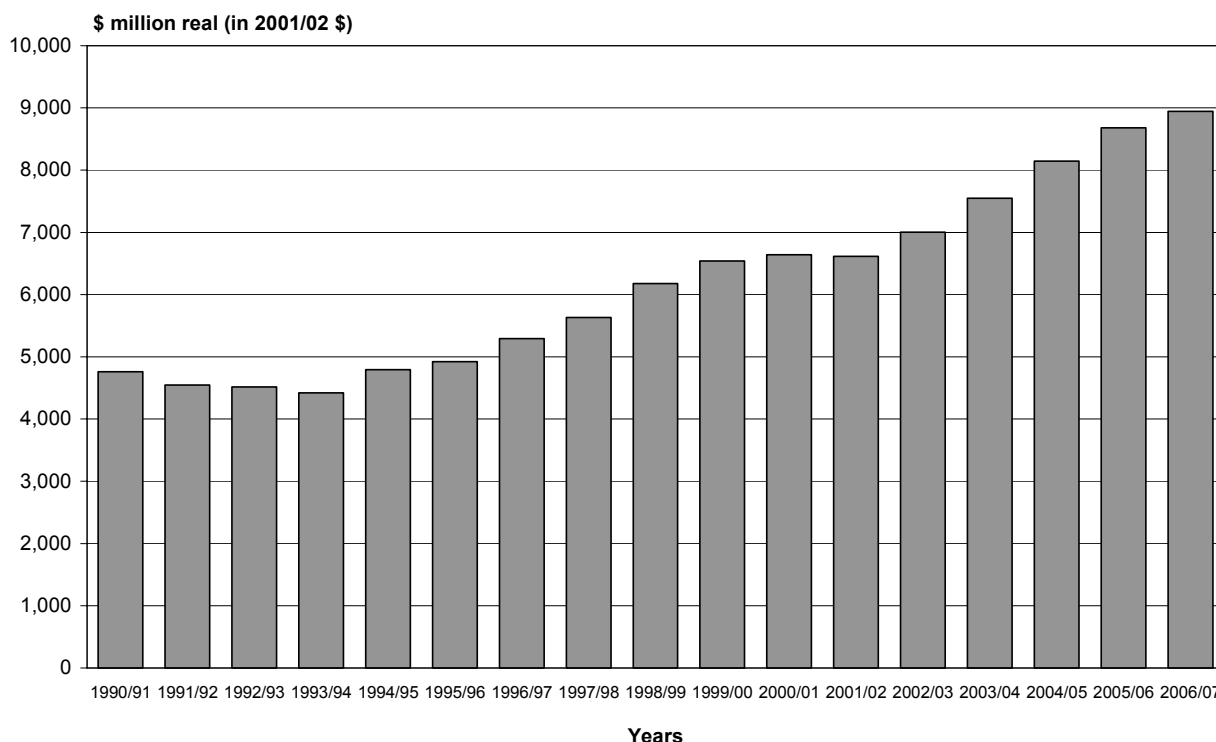
- a funding track for health that is both realistic in terms of health objectives and affordability
- options to strengthen the Government's ability to adhere to the planned funding track.

### Spending over time

Annual government health expenditure in New Zealand has increased from an estimated \$458 per head in 1950/51 to \$2103 per head in 2004, expressed in constant 2000/01 dollars. The average real increase in total Vote Health expenditure over the period 1990/91 to 2004/05 is 3.4 percent per year, or in nominal terms, 5.5 percent. Government spending on health care has also increased as a proportion of total government expenditure, from around 15 percent in 1975/76 to around 21 percent in 2005/06.

Figure 19 shows actual operating expenditure within Vote Health from 1990/91 to 2004/05, and planned expenditure for 2005/06, all in real terms.

**Figure 19:** Actual and planned expenditure for Vote Health in real terms (2001/02 base), \$ million



### The international context

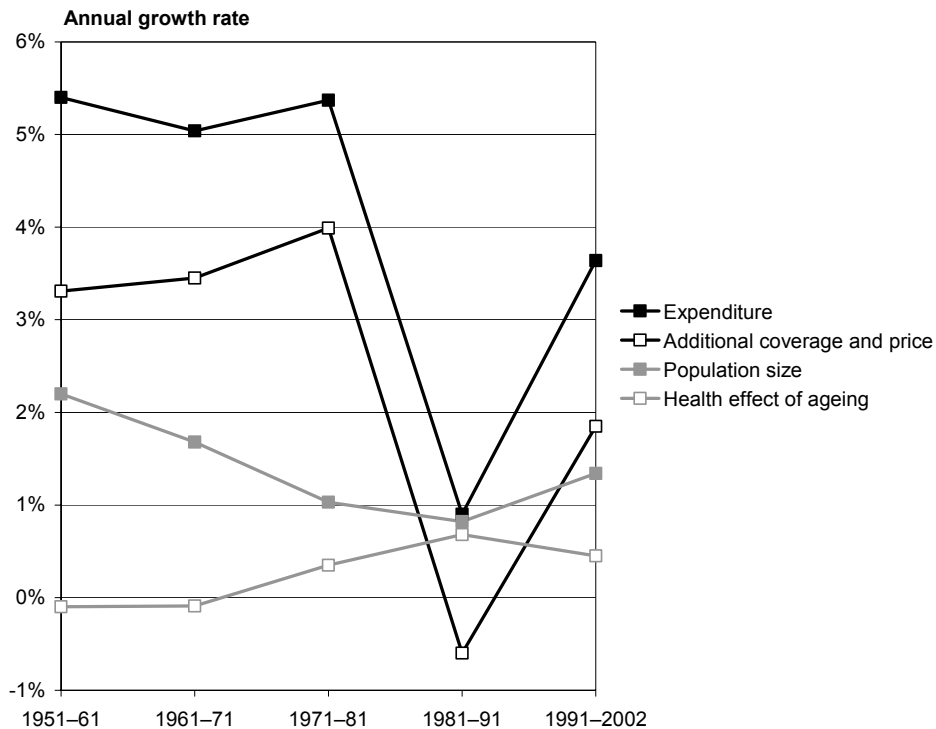
New Zealand’s experience with health spending is in line with OECD norms and trends. In 2002 New Zealand’s total health spending as a proportion of GDP (OECD definition) was 8.5 percent, ranking 16 out of 27 countries – 15 countries had a higher share of GDP devoted to Health. Most OECD countries, including New Zealand, have total health spending that falls somewhere between 7 percent and 9 percent of GDP.

New Zealand, like other OECD countries, has experienced health expenditure growth that has outstripped growth in GDP over the period since 1990. Real health spending per capita has grown at a little over 3 percent per annum and GDP per capita at around 1.5 percent per annum over the period. These relative growth rates are similar to those of Belgium, the Netherlands, Spain and the USA.

## What drives the increases in health expenditure?

Growth in GDP per capita is a strong driver of demand for health services. When individuals and countries become wealthier they tend to spend a greater proportion of their income on health care.

**Figure 20:** Factors contributing to growth in government health expenditure, 1951–2002



Non-demographic effects include paying more for inputs, as well as changes in outputs – due either to new technology and other service improvements or to explicit decisions to fund a broader range of services. Services not formerly available but now part of the public's basic expectations include:

- improvements in the treatment of cardiovascular disease, such as bypass surgery, angioplasty and cholesterol-lowering drugs
- joint replacement surgery (especially hips and knees)
- fertility treatment such as in vitro fertilisation
- increasingly sophisticated diagnosis and treatment of cancer.

Cost inflation appears from the table to have been strongly suppressed in the 1981–1991 decade. Some would argue this has resulted in subsequent catch-up requirements (eg, mental health funding increases).

Recent employment agreements have included both increased salaries and improved conditions for hospital-based practitioners that reflect international influences and may impact on staff numbers required for some service provision. At the same time, the pay of some other groups, particularly home support workers, has fallen below the rate of inflation.

Hospital-based care and interventions are increasingly intensive. Pharmaceutical and consumable costs have tended to rise faster than general inflation, partly because of quality and safety improvements.

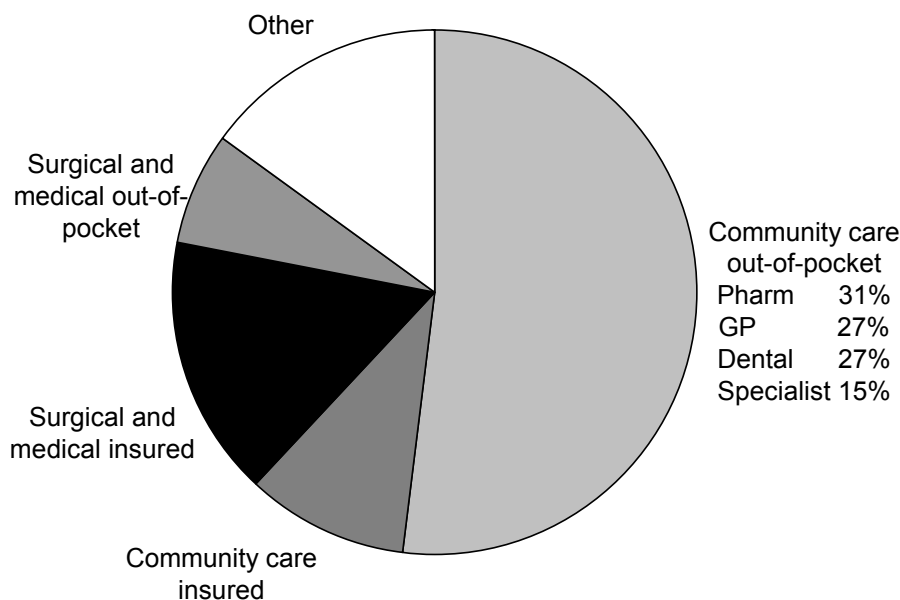
### The public–private balance

In New Zealand in 2002, 78 percent of total health spending was funded from public sources (this includes accident compensation and rehabilitation). This put us 10th out of 26 OECD countries – nine countries had a higher publicly funded share of health spending.

The strong growth seen in public expenditure on health has been outstripped by even stronger growth in private health spending – the private share has increased from 12 percent in 1980 to 22.1 percent of total health expenditure in 2001/02.

As shown in Figure 21, much of this private spending is out-of-pocket spending on co-payments for medicines and services, including some such as dental services covered by the public health system only for defined groups (Ministry of Health 2004d).

**Figure 21:** Private spending on health, 2001/02



The fact that over one-fifth of health spending now comes from private sources has a number of implications.

- Privately funded health services are accessed disproportionately by those on higher incomes, raising equity concerns.
- Increasing private demand may raise questions about the comprehensiveness and timeliness of the public system.
- As the private sector grows, health professionals are increasingly attracted there by the higher rates of remuneration, and this reduces the capacity of the public sector to deliver.
- Potential conflict of interest arises for the 48 percent of public hospital specialists who are also engaged in private sector work.
- The willingness of the public to pay to access elective services quickly in the private sector (when the alternative is a free service with a longer wait) is indicative of the high costs incurred by people waiting, and the correspondingly high value placed on timely health services.

Three current initiatives should lead to the private share of total health spending falling. The Primary Health Care Strategy and reducing income and asset-based co-payments for residential care for older people are both shifting the balance back towards public funding. At the same time, the additional resources going into elective surgery both increase public funding directly, and reduce the demand for surgery to be done privately. These developments make the public health and disability system more comprehensive and timely; they should therefore increase public confidence that services will be there when needed.

## **The way forward**

The importance of continuing with a three-to-four-year advance funding track for Health is well supported by DHBs, Treasury and the Ministry. It gives certainty to DHBs for efficient and effective planning and funding.

A funding track should include, at a minimum, an allowance for inflation, population change, the gradual introduction and spread of health technology, and achievement of long-term service increase plans such as for mental health services. Advance planning for capital developments may also take several years, and is assisted by knowledge of Crown funds for capital investment.

For the sector's part, continuing with a disciplined approach to adhere to allocated funding is critical. Failure to do so risks losing the ability to plan and returning to ad hoc funding injections in response to crises.

To assure Ministers and the public that increasing health expenditure is delivering value for money, work is under way to develop better performance measurement and improved accountability mechanisms for both DHBs and their PHOs.

Further, as part of our Vote Health expenditure review work, the Ministry and Treasury will report on ways to ensure progress across the sector in managing the assessment and introduction of service changes and new initiatives and technologies. Decisions about such changes should support key strategic outcome goals, provide value for money, improve consistency and equity across the country, spread best practice and evidence based approaches and allow progressively more information for the public on what they can expect from the system.

**Key recommendations to enable planning and funding for the short and long term.**

Ensure a long-term planning horizon with at least a three-to-four year funding stream to give baseline certainty for service planning, including in this stream allowance for inflation and population change, multi-year service increases (such as mental health funding) and capital provision.

Strengthen functionality and performance management of the sector so activity is fully aligned to outcomes:

- streamline DHB performance expectations and strengthen management frameworks around the core expectations, continuing those relating to fiscal responsibility and adding multi-year requirements for improvements in productivity.

# Capability to Deliver what New Zealanders Expect

For our health and disability support system to meet public expectations and deliver better health and participation in the face of the trends and pressures outlined above, it will need to achieve better outcomes for each worker in the system.

There are three areas of challenge where the future capability of the system can stand or fall, all of which require long-term commitment:

- to secure the right people in sufficient numbers to run the system
- to build information systems that enable those people to use their time to best effect and that enhance the quality and safety of service delivery
- to build collaboration and coherence so that the different organisations in the sector share their expertise, innovation and planning.

## The right people in sufficient numbers

**Vision:** a well-motivated and skilled workforce able to deal with increasing demand and innovations in service delivery through teamwork, flexible working practices in multi-disciplinary teams and the ability to retrain quickly to meet new challenges.

The biggest input into health and disability support services is skilled people. Those people are critically important to the delivery of better health and participation outcomes for New Zealanders.

Improvements in technology will, over time, change what skilled manual work is required and at what point in the delivery of care (especially in diagnostics, medical devices and surgical procedures). Improvements in information technology and communications will enable much information and advice to be provided distantly, and available when and where individual health care users seek it. However, health care and disability support will continue to rely on a highly skilled human workforce.

With a lower 'working-age' population and greater demands on health services due to increasing chronic illnesses and diseases, health care is likely to require a larger proportion of the total labour force in all developed countries in future, even with technical improvements and efficiencies. New Zealand is already competing internationally for health workforce.

We are vulnerable to small fluctuations in the number of workers in key specialty areas, such as radiotherapy, radiation technology, child and adolescent psychiatry and psychology, because we need a relatively small number of people who take a long time to train.

We need to work with employers, professional bodies and education providers to enable new work roles requiring a lower level of training, and to facilitate and speed changes in career between different areas of health. New roles such as 'physician assistant' or 'pathology technician' face major investment and recruitment hurdles at the start as educators, employers and future supervisors and co-workers must all commit to the change. The health professions have tended to be concerned about such changes, and government may need to take a lead in promoting their development and evaluation.

We also need to attract more people into home support as the number of people with chronic illnesses and disabilities rises and their care can increasingly be delivered at home. Opportunities to do so include reducing financial disincentives (eg, those related to travel costs and to abatement rates for income support beneficiaries who may work part time) and the development of qualifications and career paths in this work area to improve the quality and productivity of work and to enhance recruitment and retention.

To attract potential workers (including migrants) into the health and disability sector workforce, the New Zealand Government needs to:

- show that work in primary and preventive health care, and intersectoral and public health initiatives, is valued through continued investment
- continue to facilitate steady economic growth and energy efficiency
- invest in education and increase the focus on key skill areas of communication and collaboration, leadership and discernment, and on key orientations towards perspective and culture, quality improvement and learning
- address financial disincentives to work (including part-time work).

To improve the capability and effectiveness of the health and disability support workforce, the Government also needs to work with the key health professions and education providers to:

- develop leadership, innovation, and collaborative and inter-disciplinary working approaches
- enhance personal choice and enable skill shortages to be addressed faster by developing career paths that allow greater flexibility at entry, and greater opportunities to move between health careers and recognise prior learning
- facilitate change and innovation in education and workplaces, including ways to re-examine and re-design work and work roles, and improve work processes and outcomes.

A range of initiatives is already under way in priority workforce development areas such as mental health. Common first-year training across health sciences/professions at some universities is already helping to establish broader pathways into health careers. The Minister of Health will have a key role in encouraging a more collaborative approach among the health professions, educators and employers to foster more flexible approaches to education and career development in health and disability support.

## Information systems enabling people to use knowledge to best effect

**Vision:** effective use of information to improve health and participation outcomes, including:

- service providers with ready access to relevant information to help service users (patient records, scans, lab results, diagnostic tools, latest information on effective treatments)
- effective administration of appointments, payments and other processes to make the most effective use of support staff
- excellent data collection at the aggregate level to enable planning, evaluation and improvement of services.

Achieving this vision requires investment across the system to address gaps in infrastructure, communication and connectivity support so that all providers use electronic health records and have access to information to benefit individual users of their services. Detailed implementation planning for the Health Information Strategy for New Zealand is currently under way with recommendations, including timing and resourcing, expected by the end of the calendar year. The goal of the strategy is to ensure that all relevant organisations achieve at least a minimum level of capability without preventing individual organisations from introducing further innovation.

Worldwide there is huge activity in generating and disseminating knowledge about health conditions and improvements in health care. Increasingly, there are shared networks and collaborations to collect and make available the state of knowledge, recommendations and guidance on a huge range of topics. It is easier than ever before to obtain information, but the volume of material can make the task of assimilating it and applying it in practice overwhelming.

Tools to enable constant updating of knowledge and revision of health delivery are also developing rapidly. Web-based systems that integrate a range of different functions and data sources, including individual practice sources, can increasingly filter, prioritise and present usable information when and where it is needed.

New Zealanders have taken up information-sharing technology well, and health professionals are no exception, with primary care practitioners in particular adopting computer-assisted practice management systems and patient care systems at a high rate. There is some lag in infrastructure support in the hospital sector and the not-for-profit sector, with capital requirements a barrier. However, web-based services and other developments have had very good uptake among individual health professionals where they see direct benefits to their practice and to users of their services.

As well as speedier access to individual health records or administrative data, health practitioners can use knowledge to improve health and participation outcomes by:

- acquiring and using outside knowledge such as diagnostic tools, information on effective treatment options and benchmarks – this is fairly well understood by practitioners
- generating and using local knowledge and combining it with outside knowledge (eg, assessing the impact of disorders or risk factors on a local population) – this is less well-understood by practitioners and less supported by current information systems.

New Zealand has some well-established and highly valuable collections of health information. The National Minimum Data Set collection of hospital health data has been an enormous asset, in combination with other data sources in the health and wider government sectors. The Mental Health Information National Collection has paved the way for the introduction of outcomes measurement, even though roll-out to non-government providers was delayed and improvements in data collection are required.

The history of rather reluctant investment in information systems across New Zealand's health and disability support sector now creates an opportunity to use newer technologies at lower cost to address the current gaps in information collection and provision.

Primary health care and community-based disability support and specialist care services need urgent investment in information systems if they are to improve the delivery and effectiveness of service provision. Although many providers have good stand-alone practice management systems, greater connectivity with other providers' systems can have a significant impact – immediately on such things as the timeliness of advice (eg, receiving laboratory and scan results electronically), and in time on broader aspirations such as the ability to plan effective programmes to meet population health needs.

In the early stages of DHB development, planning and funding personnel have had limited time and resources to distil, consider and use much of the available information. New collaborative arrangements, such as those for considering prioritisation of service and technology improvements, are providing greater accessibility for DHBs to a wider range of useable information.

Greater connectivity has enormous potential to improve care delivery and the productivity of the health and disability support system, particularly systems that can combine rich local and individual information with wider sources.

## Collaboration and coherence

**Vision:** a well-co-ordinated health and disability support system that provides users with a seamless service and in which organisations share information and expertise and plan collaboratively to meet major challenges.

New Zealand is a small country. Local connection and responsiveness enhances effective service delivery. However, where we split and duplicate our efforts around the country we may forego opportunities for more or better service delivery.

Emerging challenges – whether they be new health needs, critical shortages in particular areas or advances in service delivery – demand adaptation locally and nationally. At the same time, continuity is needed over the range of health and disability support services. Forging and strengthening links throughout the system will enable better adaptation to changing needs and conditions across the whole country.

There will always be tensions between local needs and resource commitments and those of wider regions and the country as a whole. To establish coherence and collaboration, organisations must be able to adapt, arrive at consensus and accept and implement change, whether at the local, regional or national level.

Planning and funding responsibilities for New Zealand's health and disability support system are spread over 22 organisations (DHBs and the Ministry of Health), with service delivery by an even wider range of organisations, including PHOs. The DHB structure enhances local responsiveness and coherence and allows for innovation and pilot approaches. But it also requires collaboration between DHBs to minimise potential barriers to improvement and adaptation.

Collaborative approaches between DHBs at the local, regional and national levels, and between the Ministry and DHBs, are under way and will be further developed. However, collaboration at the organisational level is not sufficient to enable timely and effective responses throughout the system. Networks of people across the system – including professional, specialty and interest area networks (local, regional, national and international) – facilitate the rapid transfer of information as well as responses to new information and the ability to implement changes.

Different types of challenge demand different types of response leadership and co-ordination. An effective, adaptive, resilient system will plan for responses in the most effective ways for a particular challenge. Co-ordination may be required at local, regional, national and international levels, and the locus of control and responsibility needs to match the rapidity, spread and impact of the particular challenge.

## **International challenge**

Preparation for response to an influenza pandemic is co-ordinated internationally by the World Health Organization (WHO), which is currently on alert after a series of human deaths in Asia from an avian flu virus. If human-to-human transmission of such a new and virulent strain became established, it could spread quickly and have enormous impacts – the 1918 Spanish influenza pandemic is believed to have killed more people than World War I.

In New Zealand, the Ministry of Health is leading preparations by raising awareness, buying bulk supplies of pharmaceuticals, establishing responsibilities and chains of command for activation, and co-ordinating planning by other government agencies, local and regional authorities, DHBs and medical officers of health. DHBs are planning local and regional responses to such a potential emergency, to maximise benefit to affected communities and protection for staff who need to stay well to respond and to continue other essential services.

## **National challenge**

Collaborative decision-making is advantageous for many service changes, whether they are new health interventions or service reconfigurations (introduction of a new service, cessation of a service, service expansion, quality change, change of providers). Without collective efforts, individual DHBs can sometimes be compromised by the decisions of other DHBs or the Ministry. They also have limited capacity to collect and assess the evidence supporting changes, and may require technical assistance.

A new approach set up by DHBs, the Ministry and DHBNZ provides for decision making at the best level for the particular issue, clear processes and decision-making responsibilities and support such as horizon scanning and analysis. It has been piloted with decisions about the best locations and number of facilities for high-dose brachytherapy (a form of radiation treatment for cervical cancer which requires specialist equipment).

## **Regional challenge**

Good acute and emergency care is one of the fundamental expectations of our health system. Because acute and emergency care needs are essentially unpredictable, it can be difficult to sustain a programme of planned (including elective) services, particularly in smaller hospitals. The proportion of acute to planned inpatient services is also increasing as diagnostic, assessment, surgical and palliative care services are increasingly delivered in the community or with shorter hospital stays.

There are two aspects to this challenge. One is to continue service delivery when there are peaks and troughs in demand and in supply (eg, where there are crucial workforce gaps). The other is to plan effectively for overall provision of services and use of resources. This planning is needed to ensure that good acute and emergency care is available to all, including people in smaller centres and more remote areas and that planned care is disrupted as little as possible, especially for those with the highest needs.

Both aspects of this challenge require providers to work more closely together. DHB managers and clinical leaders need to understand the other facilities they may be able to call upon, or support. They need to make joint decisions about what services should be provided where, and how key generalist practitioners can be supported by leading specialists to deliver competent care in smaller centres. An ability to share planning, records, staffing and other resources to collaborate across units and teams will help to deliver resources to where people needing services are, or vice versa.

DHBs have shown increasing willingness to contract elective services to other providers where they have been unable to provide certainty. All providers need to be willing and able to take a wider view than the organisation's own at all levels, irrespective of the details of the governance and funding structures within which they operate.

**Key recommendations to ensure the system's capability to deliver what New Zealanders expect.**

Invest in critical capability development that will improve effectiveness and productivity:

- support early implementation of the Health Information Strategy for New Zealand and work towards better information across the sector on intermediate health outcomes
- reward developments in health workforce education that support broader and more flexible pathways into and between health practitioner careers, and new health careers
- increase collaboration and coherence throughout the system, both formal and informal, to build effective, adaptive and resilient response capability for a variety of challenges.

Strengthen functionality and performance management of the sector so activity is fully aligned to outcomes:

- continue to review the balance of, and funding responsibilities for, district, regional and national services and business units, to ensure best fit for purpose as the sector evolves and circumstances change
- streamline DHB performance expectations and strengthen management frameworks around the core expectations, adding multi-year requirements for increasing collaboration with other DHBs.

## Putting It Together – Key Challenges

In order to meet the challenges facing our health and participation, we need:

- active people, actively participating in communities:
  - active physically
  - able to make active life choices
  - participating and including others
  - active in their whānau and communities
- active health professionals and services:
  - focused on outcomes for people and populations
  - active in learning
  - involved in shaping and improving services and systems
- active District Health Boards:
  - identifying population needs
  - collaborating to meet those needs
  - using evidence and information
  - preparing to meet future challenges and opportunities
- active government:
  - clear direction setting for health and participation
  - active enabling and barrier removal
  - investment and capability building
  - ongoing evaluation.

It is a significant challenge – for New Zealand as well as for the rest of the developed world – to engage our whole population in action for health in time to make a significant impact on future health and participation, on need for health and disability support services, and on the funding required.

This level of engagement and activity can only be achieved if government:

- moves consistently in those directions
- provides clarity about expectations and recognises achievement
- supports efforts that will improve outcomes for people – especially efforts directed to those most at risk of poor outcomes
- builds the infrastructure (information systems, evaluation processes) needed, both to deliver better services and to learn about and extend what is working
- invests in capability and active evaluation.

## **A step up for the sector**

All New Zealanders, and all parts of the health and disability support system, can contribute to better health and participation by being active in the right directions.

Recognising, reinforcing, inspiring and spreading those actions is a leadership role for a Minister of Health. Being clear about the outcomes needed, and providing the conditions that enable those involved to devise and implement ways to achieve them, is the best strategy for success in the medium to long term.

This is a challenging strategy. It requires setting directions and boundaries, then delegating the decision-making; being tolerant of innovation, a level of inconsistency and some failures; supporting learning from both successes and failures; and resisting intervention unless boundaries are clearly crossed. It acknowledges that the organisations and systems now in place, while not perfect, are sufficiently mature and able to get on with the job of securing health and participation for New Zealanders into the future. It accepts that better gains will be made by fostering active involvement and active learning at all levels, and allowing evolution over time.

With this challenge also come opportunities:

- to further develop the outcomes framework for health and participation, and for the health and disability support sector, with evaluation frameworks, infrastructure and processes to assess progress over time
- to focus on wider activities in government and communities that can work for health and participation, including building the capability to work across organisations and traditional accountability structures
- to clarify directions and move forward on addressing inequities and unmet needs that could undermine confidence in the system.

## The Way Forward – Recommendations

Over the coming three years, the Ministry recommends the following key actions to take the health and disability support system forward.

- **Strengthen functionality and performance management** of the sector so activity is fully aligned to outcomes:
  - address gaps and inequities in the provision of services for people with high needs that can otherwise undermine confidence
  - continue and strengthen the emphasis on improving Māori and Pacific peoples' health
  - give priority to Ministry work in the two critical areas of intersectoral work on shared outcomes and improved evaluation of sector and system performance
  - work towards the joint development of social and economic policy advice and evaluation of progress
  - streamline DHB performance expectations and strengthen management frameworks around the core expectations, continuing those relating to fiscal responsibility and adding multi-year requirements for increasing collaboration with other DHBs, and for improvements in productivity, in services for those with high needs, and in service user experiences
  - continue to review the balance of, and funding responsibilities for, district, regional and national services and business units, to ensure best fit for purpose as the sector evolves and circumstances change
  - increase useful and comparative information for the public on DHB and PHO service delivery and coverage, quality and outcomes
  - tighten fee structure requirements for PHOs receiving planned funding increases, to more quickly achieve low-cost access to primary health care.
- **Invest in critical capability development** that will improve effectiveness and productivity:
  - support early implementation of the Health Information Strategy for New Zealand and work towards better information across the sector on intermediate health outcomes
  - reward developments in health workforce education that support broader and more flexible pathways into and between health practitioner careers, and new health careers
  - increase collaboration and coherence throughout the system, both formal and informal, to build effective, adaptive and resilient response capability for a variety of challenges.
- **Increase opportunities to recognise and reward improvements** so the wider system and communities can benefit from their spread and adaptation, leading to better health, reduced inequalities, better participation and independence, and trust and security.

- **Ensure a long-term planning horizon**, with at least a three-to-four-year funding stream to give baseline certainty to DHBs, including in this stream allowance for inflation, population change, multi-year service increases (such as mental health funding) and capital provision.
- **Provide stability in overall settings and structures** for the health and disability support system, allowing evolution and further development that supports better health, reduced inequalities, better participation and independence, and trust and security.

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