

# **Healthy Opportunities:**

**Leading in Health  
and Disability**

Briefing for the incoming  
Minister of Health  
1999



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# Welcome to the health portfolio

In this briefing we set out our advice on where you, as Minister of Health, can make a difference. People needing services, both as individuals and as populations, are at the heart of the portfolio. Services are delivered through a complex system of public and private health and disability service providers, funders and other organisations.

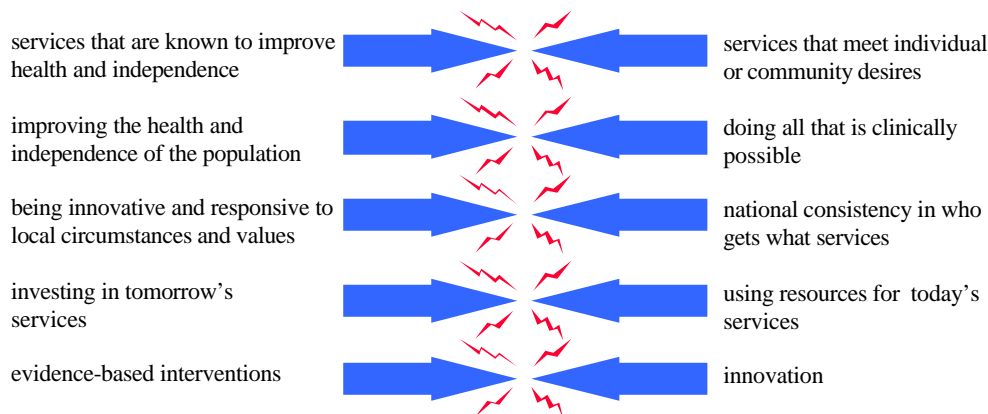
The challenge is to achieve, now and into the future:

- very good health and independence for all New Zealanders, and lower disparities in health and disability outcomes
- access for all New Zealanders to an acceptable range of health care and disability support services, regardless of ability to pay
- a high-performing system in which people have confidence.

The Ministry of Health’s aim is for ‘Healthy New Zealanders’.

This paper provides you with an overview of the health and disability system, and its key challenges and pressures. Some of the challenges ahead will involve fostering solutions to old and new problems; others involve managing the ‘irresolvable’ tensions and pressures of any health and disability system (see Figure 1).

**Figure 1. Fundamental tensions in health and disability support**



Health and the ability to participate in society are fundamental to people’s wellbeing. Decisions on what health and disability support services are provided and for whom, within the public funding available, affect everyone in a very personal way. At times, some people will find these funding or clinical decisions hard to accept. The broader benefits may not be apparent in the short term. To help manage the resulting pressure, it is important there are clear government priorities.

We offer practical solutions on what you can do in the years ahead to manage the pressures and risks of the New Zealand health system, improve health and disability support services for all New Zealanders, and secure some real health gains.

*For an overview of the roles and responsibilities of organisations, see the accompanying Facts about Health and Disability in New Zealand.*

*‘Independence’ refers to the concept of supporting and empowering people with disabilities to live as independently as possible within the community. It recognises that people have diverse needs, and that some will require more assistance than others.*

*Appendix Two explains why health care and disability support services are different to other services.*

**Note:** The appendices and references to key publications provide you with more detail on specific issues. We can provide further briefings on any other aspect that you indicate.

# Executive summary

The Health portfolio is about securing the best possible health for the population and support for people with disabilities, ensuring access to an acceptable range of services for all New Zealanders, and creating an environment that drives effective effort. The areas of action suggested in this briefing build on the current strategic framework and the achievements to date. We assess where there are gaps in performance and offer solutions to build forward.

Effective public health strategies are critical in achieving the three goals set out below, as they can reduce disparities and achieve overall health gain. The ability of the sector to provide appropriate service coverage in the future depends on the ability of public health services to reduce the burden of disease. Accordingly, population health approaches are a common theme throughout the document.

**Goal 1: Very good health and independence for all New Zealanders, with a focus on reducing disparities in health and disability outcomes**

Māori, Pacific people, and people in lower socioeconomic groups continue to have much poorer health and more disability than other New Zealanders. Improving outcomes for these groups must remain a priority to reduce the unacceptable differences and to significantly improve the *quality* and extend the *length* of life for the population as a whole. Services must get better at reaching population groups that have, or are at high risk of, poor outcomes. The strong associations between health status and socioeconomic indicators, such as education and income, show effective linkages between health, education, welfare and other social services are needed. Burden of disease projections strongly indicate a rising prevalence of chronic disabling conditions. To achieve better outcomes, there must be shifts in the focus of service provision and resources, and innovative ways of delivering services.

To achieve Goal 1 we need to:

- target resources and services at Māori, Pacific people, and people in lower socioeconomic groups to decrease inequalities in health and independence
- make more effective links and further develop common policy approaches between health, education, welfare and other social services, to tackle the socioeconomic determinants of health
- encourage models of delivery and funding that support service co-ordination and reach out to populations
- focus on key avoidable and modifiable diseases and injuries (such as cardiovascular disease, cancer, mental illness, injury, respiratory disease, diabetes, and immunisation-preventable diseases), and the underlying risk factors, such as smoking, lack of exercise, diet, drugs and alcohol
- enhance consumer and community roles in promoting people's own health and independence, and managing some of their own illnesses

- continue to promote healthy environments.

**Goal 2: Access for all New Zealanders to an acceptable range of health care and disability support services, regardless of ability to pay**

New Zealanders want to be confident that they have access to needed quality services. But there will always be a gap between what services the public expect and what the country can afford. To help manage the resulting pressures, it is for priorities to be clear. The current funding levels and funding growth path are sustainable as long as economic growth is maintained. Overall, the level and range of publicly funded health care and disability support appears reasonable given the size of our country and our population, and our level of wealth. But access is not always equitable across the country or between population groups, and the level of some services, particularly mental health services, needs to be increased.

To achieve Goal 2 we need to:

- manage pressures, by clarifying what publicly funded health and disability support services will be available, by developing a public understanding about what services can and cannot do, and by reflecting local community and consumer views in the difficult trade-offs that have to be made
- continue to develop effective and acceptable prioritisation approaches that focus on health or disability need and ability to benefit
- retain the Sustainable Funding Path, to assist service planning and as a process to manage fiscal pressures within predictable fiscal growth
- lower access barriers for Māori, Pacific people, people in lower socioeconomic groups, and rural communities
- continue to increase the level of some services, particularly some mental health and disability support services.

### **Goal 3: A high-performing system in which people have confidence**

All participants in the system (patients, people with disability, the health and disability support workforce, managers, community organisations, and policy makers) work towards increasing the health of New Zealanders and providing better disability support services. Positive relationships based on good communication, common understanding and trust are crucial for improving performance and building public confidence. Over the last six years, one of the key gains has been better information on volumes and costs of services. This has increased the Government's ability to specify the quality and quantity of services. But poor incentives and some outdated regulations are contributing to sluggish changes in desirable service patterns. The health and disability workforce must be able to adapt its roles, activities and orientation so that labour with the right skills, knowledge and attitudes is available. In addition, the current annual cycle of contracting takes an enormous amount of effort up front, and may prevent providers and the funder from building up more positive relationships and working together to seek out the most effective services for patients and consumers. The monitoring of contracts may also suffer. There are also gaps in information and quality practices that are necessary to achieve a high-performing system that consistently delivers health gain.

To achieve Goal 3 we need to:

- promote trust and collaboration, between agencies and between professional groups; this includes engaging clinicians and other providers in changing service patterns to achieve shared health and disability outcome objectives
- remove regulatory and cultural obstacles to desirable change in where and by whom services are delivered
- strengthen incentives that encourage community- and hospital-based services to work together to provide seamless care (for example, stepping up to longer-term contracting approaches)
- support devolution of responsibility with a strong national framework of incentives, accountability, and regulation
- champion a quality culture, with a system-wide risk-management approach to reducing preventable harm and achieving consistency of practice through shared learning, benchmarking, and clinical governance within a national standards framework
- develop a health information infrastructure and national information standards to enhance system-wide access to and sharing of information among the health and disability workforce and consumers, in a manner that complies with privacy principles.

# Introduction

The Health portfolio is about taking effective action where possible, and balancing the irresolvable tensions that exist in any health and disability support system. This briefing points to a number of areas where action would be beneficial for health and independence.

Many of the issues and pressures described are not new. We suggest how to build forward on the policy framework in an ongoing effort to find approaches that work better for patients, consumers, and population groups, and manage the drivers of change (see below). Transitions take time and effort, however, and uncertainty can divert attention from the key task: improving the health and independence of New Zealanders. Leading change by engaging the public and clinicians alike and by building on achievements to date is the key to creating confidence and achieving success.

## **Key drivers and trends that will change the health and disability sector in New Zealand**

**Expectations:** better informed and more articulate taxpayers, consumers, and the general public will increasingly expect access to new technologies, the highest performance standards, value for money, and accountability for outcomes.

**Demographic and social trends:** globalisation, an ageing population, increasing proportions of Māori, Pacific and Asian people, and changes in family structures will impact on how health and disability support services are best financed and delivered.

**Epidemiological trends:** there will be a higher incidence of infectious diseases and risks of antibiotic resistance, more ageing-related diseases, and growing numbers of people with a high degree of disability and chronic illness, mental illness, diabetes, and some cancers.

**Information and technological innovation:** information technology, imaging for diagnosis and therapy, robotics, advanced assistive technologies, and genetic engineering will change how, when, where and by whom services can be delivered. Some of the technology will make currently high-cost and complex interventions more routine, cheap and thus more accessible, and will assist in meeting the challenges posed by the shift in expectations and demographic and epidemiological trends.

**Economic performance:** in face of future pressures, the ability to sustain an acceptable level of services will depend crucially on New Zealand's economic performance. Research on the determinants of health status show that the level of personal income, as well as its distribution, is important.

Source: Kriebler & Middleton (eds) *Health Futures: 2020 visions*, Institute of Policy Studies. Victoria University Press 1997.

## Goal 1. Very good health and independence for all New Zealanders, and lower disparities in health and disability outcomes

Better health and independence outcomes can be achieved through promoting healthier lifestyles along with effective health care interventions and disability support, and action in other sectors, given the relationship between socioeconomic factors and health and disability outcomes. In this section we set out how you, as Minister, can drive further gains by enabling funding and service delivery to shift more to early intervention, prevention and health promotion activities, with a particular emphasis on raising the health and independence of Māori, Pacific peoples, and people in lower socioeconomic groups. Co-ordination with social services from other sectors is critical to making a difference.

### 1.1 Brief assessment

- From 1950/52 to 1995/97, life expectancy at birth in New Zealand increased from 71.3 to 79.6 years for females, and from 67.2 to 74.3 years for males. But these gains in New Zealand lag behind those of more affluent countries such as Canada, Australia, and the UK .
- The length and quality of life of Māori, Pacific people and people in lower socioeconomic groups is significantly lower than that of other groups.
- In 1996/97 life expectancy at birth for Māori was 69.4 years, compared to 78.0 for non-Māori. The gap between Māori and non-Māori has narrowed quickly over the last 40 years, but remains unacceptably large.
- The three leading disorders reducing the quality and length of life of New Zealanders are cardiovascular disease, cancer and mental disorders.
- About one in five New Zealanders has a disability resulting in functional or role limitation, and about 11 percent need assistance either intermittently or continuously.
- There has been good progress in reducing ischaemic heart disease, SIDS, road traffic injuries, alcohol-related harm, and cervical cancer.
- Rates for diabetes, rheumatic fever, and youth suicide have deteriorated. Māori and Pacific people are more than twice as likely to be diagnosed with diabetes than Pākehā.
- Compared with other OECD countries, New Zealand does relatively poorly in terms of infant mortality and immunisation rates. Rates are more comparable for non-Māori.
- The New Zealand youth suicide rate is among the highest in the OECD.
- Almost 80 percent of avoidable deaths occur in the 45–74 age group, and are dominated by ischaemic heart disease, diabetes, and smoking-related causes. Road traffic accidents and suicide are the leading causes of avoidable death among younger people.

*Full details can be found in Our Health Our Future: The health of New Zealanders 1999, Ministry of Health in press.*

*Progress on Health Outcome Targets, Ministry of Health 1998.*

*Disability in New Zealand: Overview of the 1996/97 Surveys, Health Funding Authority and Ministry of Health.*

*'Avoidable' means modifiable by interventions, such as prevention, early diagnosis, treatment, or action in other sectors.*

## 1.2 Policy issues

### Why are there differences in health status?

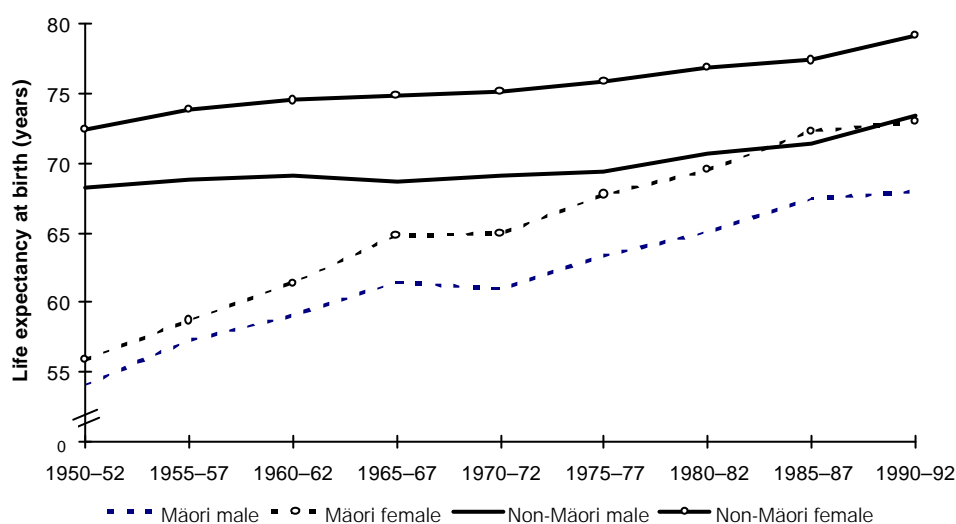
Māori, Pacific people, and people in lower socioeconomic groups have poorer health status and a higher incidence of disability than the general population (see Figures 2 and 3). The exact reasons are not always well understood, but are related to differences in:

- uptake of health and disability support services
- lifestyle behaviours (particularly smoking, inappropriate diet, alcohol consumption, and lack of exercise)
- physiological risk factors (obesity, diabetes, high blood pressure)
- socioeconomic circumstances, such as income and labour-force participation, education, and housing.

The Social, Cultural and Economic Determinants of Health in New Zealand: Action to improve health, National Health Committee 1998

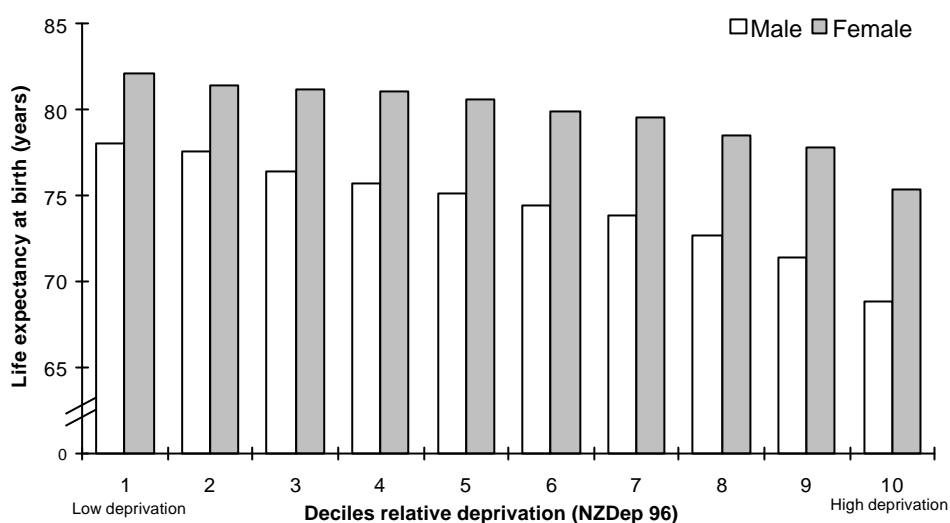
*A change in the ethnicity question in the 1996 census means that 1995–97 data start a new series and cannot be readily compared with historical data. The new series starts at a somewhat lower base for Māori, but no conclusions*

Figure 2: Life expectancy at birth, by gender and ethnicity, 1950–52 to 1990–92



Source: *Our Health Our Future: The health of New Zealanders 1999*, Ministry of Health in press.

**Figure 3: Socioeconomic status and life expectancy, 1996–97**

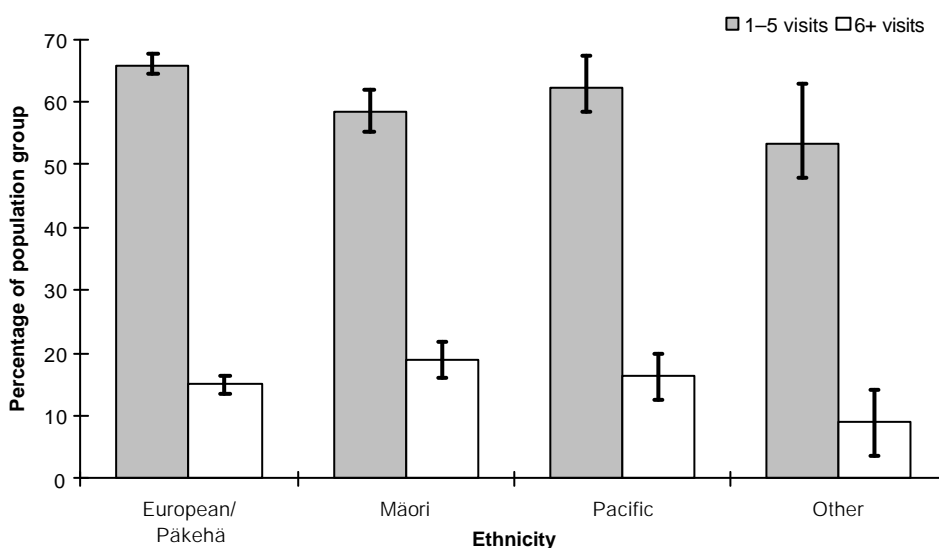


Source: *Our Health Our Future: The health of New Zealanders 1999*, Ministry of Health in press.

Māori and people with low family incomes are more likely to visit their GP six or more times per year compared to the rest of the population (see Figure 4). But once the figures are adjusted for socioeconomic status (as a proxy for need), Māori and Pacific people are shown to use primary, secondary and disability support services less than the rest of the population. This is surprising, given the significantly worse health status of these population groups. When combined with the high acute hospital admission rates, particularly in areas such as South Auckland and Porirua-Kapiti, it suggests that primary care services are not reaching some Māori, Pacific people and people in lower socioeconomic groups, or are not providing the same benefits to those groups.

Taking the Pulse: The New Zealand Health Survey, Ministry of Health 1999.

**Figure 4: GP visits by ethnic group, 1996–97**



Source: *Taking the Pulse: New Zealand Health Survey*, Ministry of Health 1999

Taking the Pulse, Ministry of Health 1999, shows that the number of Māori who said they needed to see a GP but did not is one-and-a-half times greater than non-Māori. Nearly one in eight adults gave this response, and just under half of these gave cost as the reason.

Progress on Health Outcome Targets 1998, Ministry of Health 1998.

*The link between socioeconomic status and health and independence goes both ways: low socioeconomic status is associated with poor health and disability outcomes; poor health and disability reduce the ability to earn money or get an education.*

*There are several provider initiatives designed to improve outreach, support and management of*

There is a significant gap in immunisation rates between Māori and Pacific children and other children. The New Zealand Health Survey shows that Māori and people in lower socioeconomic groups are more likely to be smokers, and are most likely to consume alcohol in a way that puts health at risk.

As in other OECD countries, a large share of the difference in health status between groups is linked to socioeconomic indicators, particularly differences in family income, employment, education, and housing conditions. Ethnic differences in mortality, disability and self-rated health status are reduced but not eliminated by adjusting for socioeconomic status.

Diabetes highlights some of the issues. Diabetes is a significant cause of reduced quality and length of life. It is a chronic disease with potential complications resulting in blindness, kidney failure, heart disease and limb amputations. Health services do not seem to be able to effectively reach all those with diabetes. As with any chronic disease, effective management depends on self-management supported by good-quality primary care. We suspect that there is a large group of people who do not know they have diabetes. Innovative, culturally empathetic, integrated systems are needed that reach out to people for better access to primary care services (including nurses and Māori providers) and for better outcomes.

### **Where can the greatest gains in health and independence be made?**

The Ministry's forthcoming report entitled *Our Health Our Future: The health of New Zealanders 1999* will provide the most up-to-date and comprehensive study of New Zealand epidemiological data. This study shows that chronic disabling conditions will become more prevalent in the future, particularly because of the ageing of the population.

The report has analysed what contribution various conditions make to premature mortality and disability outcomes, measured as disability adjusted life years (or DALYs). The top 15 diseases and conditions account for about 59 percent of the total disability adjusted life years lost (see Table 1).

Much of this burden of disease – and much of the inequality in the burden of disease falling on different population subgroups – can be attributed to modifiable risk factors, including lifestyle behaviours (smoking, alcohol, diet and exercise) and physiological risk factors (diabetes, obesity, high blood pressure, and high blood cholesterol).

**Table 1: Conditions causing at least 10,000 DALYs, 1996**

Cause group	Condition	DALYs lost	% total DALY	Major modifiable risk factors
Cardiovascular disease	Ischaemic heart disease	74,411	13.6	Smoking, high blood pressure, high blood cholesterol, physical inactivity, obesity, high-fat low-vegetable diet, diabetes
	Stroke	29,511	5.4	High blood pressure, diabetes, smoking, physical inactivity
Respiratory disease	Chronic obstructive pulmonary disease	26,915	4.9	Smoking
	Asthma	18,778	3.4	(Passive) smoking
	Lower respiratory tract infection	10,497	1.9	Lack of vaccination (pneumonia, influenza)
Diabetes	Diabetes	20,980	3.8	Physical inactivity, obesity
Cancers	Lung cancer	17,291	3.2	Smoking, low-vegetable diet, physical inactivity
	Colorectal cancer	15,722	2.9	Low-vegetable diet, physical inactivity
	Breast cancer	13,330	2.4	Lack of mammography screening
Mental illness	Depression	20,497	3.7	Stress, physical inactivity
	Anxiety disorder	17,930	3.3	Stress
	Dementia	14,693	2.7	Physical inactivity, other stroke risk factors
Injury	Road traffic injury	17,500	3.2	Speed, alcohol, non seat belt use
	Suicide	12,878	2.4	Depression, stress
Osteoarthritis	Osteoarthritis	11,264	2.1	Obesity, physical inactivity

Source: *Our Health Our Future: The health of New Zealanders 1999*, Ministry of Health in press. Data are provisional.

It is estimated that about 70 percent of premature deaths and a great proportion of morbidity in the 0–74 age group is avoidable, including a third (100,000 in 1997/98) of total hospitalisations.

These avoidable conditions present opportunities for improvements in health and independence and reductions in inequalities. We can realise many of these opportunities within the available budget, through effective primary care, health promotion and disease prevention, and effective integration of services. At the same time, this approach needs to be balanced with the objective to provide access to an acceptable range of services to all New Zealanders, even when these services contribute only small gains in health or independence.

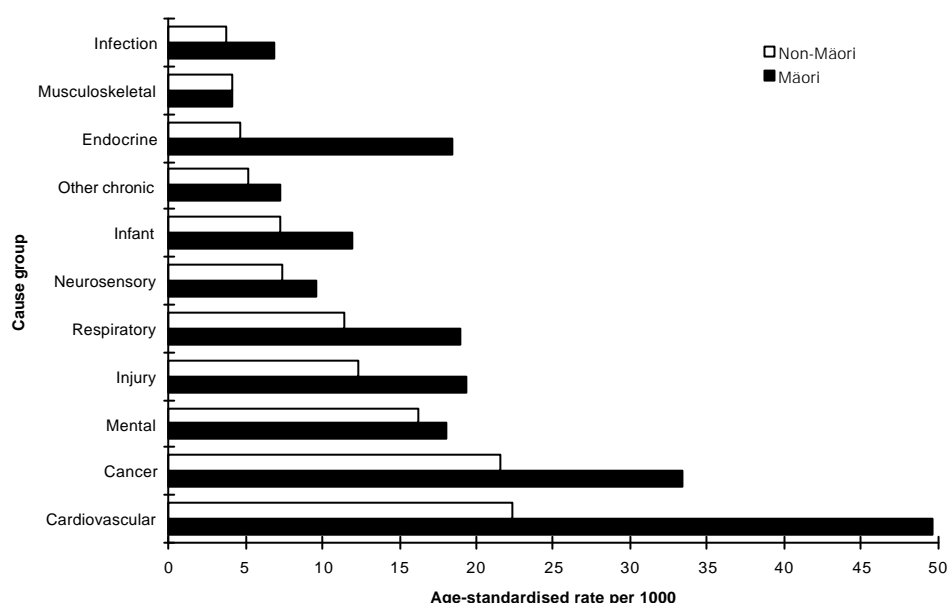
### 1.3 Solutions

#### Focus on population groups with the greatest inequalities

- **Reduce inequalities by targeting Māori health more**

Māori health is a clear priority for health gain initiatives. Māori suffer a greater burden of disease, relative to non-Māori (see Figure 5). After eliminating variations caused by age and gender, it is clear that Māori experience a higher prevalence of most disease groups, but especially of diabetes (endocrine), cardiovascular disease, cancer and respiratory diseases, as well as infectious diseases such as meningitis, rheumatic fever, hepatitis B, and tuberculosis. While broader socioeconomic factors play a key role in these disparities, improved service delivery is also significant for health gain.

Figure 5: Disability adjusted life years lost, by cause group and ethnicity, 1996



Source: *Our Health Our Future: The health of New Zealanders 1999*, Ministry of Health in press

Over the last five years, Māori health policy has focused on a range of approaches aimed at building up the capability and responsiveness of the health and disability sector to improve Māori health and independence, with a focus on Māori provider development and mainstream enhancement.

There is not yet clear evidence about what works best, but anecdotal feedback and the few existing studies are positive. The Ministry, therefore, favours continuing to trial different approaches, assessing their impacts, and extending those that prove successful. This would include continuing to:

- invest in Māori providers (as key players in reducing access barriers and improving the acceptability, effectiveness and appropriateness of services for Māori)

- increase financial certainty for those providers through better contracting and funding approaches
- extend Māori workforce development initiatives
- develop requirements for mainstream providers to increase their capacity to provide services that are more acceptable and effective for Māori, including encouraging arrangements that allow effective linkages between Māori providers and mainstream providers
- increase Māori participation at all levels of the health sector, including policy and purchasing
- work with other social sectors to develop intersectoral approaches.

In addition, the Ministry would favour:

- refocusing the primary care sector on achieving population health in addition to delivering personal health services
- targeting both resources and service co-ordination efforts to geographic and other areas of high need
- creating a sense of urgency among all providers in addressing diabetes, cardiovascular disease, respiratory illnesses and infectious diseases for Māori.
- ***Place further emphasis on the health of Pacific people***

The health status of Pacific people lies between that of Māori and the total population. The key issues for Pacific people are diabetes, cardiovascular and respiratory diseases, and childhood diseases such as rheumatic fever, hearing loss and infectious diseases (such as meningitis). Most of these are preventable or modifiable by better and earlier access to primary care, including preventative services, and good integration with other levels of care.

The Ministry believes that raising the health status of Pacific people must be a priority area for the sector, building on the greater emphasis that has been placed on Pacific health in recent years.

A lot has been achieved, but to make further gains in improving Pacific people's access to effective services we need to:

- improve the responsiveness of mainstream services to Pacific people, including sharing best practice, such as through dedicated Pacific teams
- continue to develop Pacific primary care services, including mobile services and other methods to reach into Pacific communities
- improve participation by Pacific people in the health workforce
- improve the linkages between primary and secondary services, and the links between mainstream and 'by-Pacific-for-Pacific' services

- develop intersectoral approaches
- create a sense of urgency among all providers in addressing diabetes, cardiovascular and respiratory illnesses, and infectious diseases for Pacific people.

The Pacific Vision Conference held earlier this year has been successful in bringing Pacific communities, sector agencies and government departments together to address the health status and wellbeing of Pacific people with fresh impetus.

- **Target people with multiple disadvantages, especially children**

People with low socioeconomic status is a third group who experience poor health and disability outcomes. The Child Health Strategy has focused particularly on children from families with multiple socioeconomic disadvantages, with high health and disability support needs, tamariki Māori, and Pacific children. It is important that the Child Health Strategy continues to be implemented. This includes promotion, prevention and early intervention approaches (including preventing SIDS, and improving immunisation rates), and working with other providers and key agencies in other sectors. We need to further engage providers of child health services to find ways of giving this greater momentum.

### **Intersectoral approaches are essential**

Health care and disability support services and regulation alone are not enough to promote, protect, and improve the health and independence of New Zealanders. Actions that address socioeconomic risk factors (such as low income, unemployment, low achievement in education and overcrowded housing) are also needed to improve health status.

Early feedback from local, intersectoral initiatives under the Strengthening Families umbrella points to successful outcomes of such approaches for children of families at risk. This, and early results from other intersectoral initiatives such as Health Action Zones in the United Kingdom, indicates that intersectoral initiatives are more effective for high-risk families than separate interventions, and may avoid duplication and people falling through gaps. An intersectoral approach is integral to the public health framework where co-ordination across central and local government agencies is crucial to achieve our health goals.

Our conclusion is that intersectoral approaches should be extended at the policy, funding and delivery levels for different population groups, such as Māori, Pacific people and people in low socioeconomic groups, and people with disabilities. Strengthening Families provides a platform for launching such initiatives.

### **Reorient health and disability support services**

- **Strengthen primary care, and prevention and health promotion**

An ageing population, coupled with more effective treatments for many acute conditions, means that an increasing share of need will come from chronic, long-term

The Child Health Strategy, Ministry of Health 1998.

The Children's Nutrition Survey will provide information on key determinants of child health status, including diet, physical activity and food

Strengthening Public Health Action: The strategic direction to improve, promote and protect public health. Ministry of Health

The New Zealand Youth Suicide Prevention Strategy, and the National Drug Policy are examples of multi-sectoral approaches.

conditions. Services will need to provide more ongoing support, advice and interventions, often involving a variety of different providers over extended periods of time. Services also need to become more proactive, providing prevention and health promotion, targeting areas of needs and risk factors for specific population groups, and linking up with other services for continuity of care across episodes and levels of care.

The way forward is to give providers incentives to be proactive in identifying and managing the needs and risk factors of affiliated populations. This can be progressed particularly by developing contracts with primary care providers who are often the first contact with the health and disability support system: there are well over 50,000 contacts daily with primary care services (such as those provided by general practitioners, nurse practitioners and midwives through a range of primary care organisations including Māori providers, community health services, independent practice associations, and other non-government organisations).

Some primary care organisations are already taking greater responsibility for improving the health status of affiliated populations by building relationships with public health services, and by carrying out their own population-focused programmes, such as immunisation and screening. This builds on the shift of focus in primary care organisations (which represent about 84 percent of GPs) from contract negotiations to management, support and monitoring of clinical activity and quality, the sharing of information, and closer co-ordination with secondary care services. Community-based Māori providers are increasingly playing an important role in reaching and providing services for Māori.

To build on these desirable changes, primary care providers could be made responsible to not only deliver services themselves, but also to work with other providers to achieve good health outcomes for their local communities, and to facilitate individuals to live healthier lifestyles. Key elements would be:

- population-based funding, such as capitation and other funding methods that include elements of risk-sharing to sharpen incentives (fee-for-service does often not give good incentives for managing the health of a population)
- affiliation, with a choice as to which provider to affiliate with: this would assist (along with other approaches, such as bench-marking and outcome monitoring) in managing risks of under-servicing that may arise with approaches such as capitation.

Along with financial incentives, information technology has the potential to back up change in two ways: good monitoring by the funder of care and referral patterns, and focusing of providers from not only providing individual health services but also addressing the needs of population groups. Taking responsibility for changing patterns of population health status will help motivate health care professionals.

The benefits of a reorientation to primary care, prevention and health promotion was reflected at the 1998 Action for Health and Independence conference. Common factors to successful, sector-led initiatives were: service providers who understand

*See L Malcolm, L Wright, P Barnett, The Development of Primary Care Organisations in New Zealand: A review undertaken for Treasury and the Ministry of Health, unpublished, October 1999.*

*See Draft Primary Care Strategy Consultation Document (in preparation), Ministry of Health, December 1999.*

their affiliated population, services focused on areas of health gain, evidence-based interventions, advocacy for action in other sectors, and sharing of information.

### **Lead the difficult shift in thinking about health**

Achieving a shift in the emphasis of services (and resources) to areas of the highest health gains will be difficult: it requires a shift in thinking by providers and the public, and it will mean making trade-offs at the margin on the level of some of the services that are currently being delivered. Coherence and consistency of prioritisation at all levels will be important – from decisions at the Ministerial level down to those made by clinicians, other providers and needs assessors.

- ***Tackle the top causes and risks that give most gain for money***

As a way to lead the shift in thinking about health care and disability support, the Ministry believes that it would be useful to concentrate some resources on a small number of key conditions, and their risk factors, that would:

- achieve considerable improvements in health and independence
- address inequalities in health and independence
- be able to be modified or prevented by cost-effective interventions, including population health, disability support, or personal health services
- allow progress to be measured.

For the past six years, 88 health outcome targets under each of 41 objectives have been tracked. This gives valuable, comprehensive information on how New Zealand is making progress on risk factors and population health outcomes. A disadvantage is the breadth of focus. There is an opportunity to focus effort on a small group of high impact diseases and/or risk factors while maintaining the breadth of monitoring to check that other diseases do not slip out of control.

Table 1 in section 1.2 takes a first step in choosing a small list of objectives for action and targets by ranking the top 15 conditions by their impact on the total burden of disease (particularly cardiovascular disease, cancer, mental illness, injury, respiratory disease, and diabetes). But before it is converted into a list of objectives and targets it would need to be modified by:

- incorporating the Government's social objectives. For example, the Government may wish to put greater weight on improving health outcomes for Māori, Pacific people and children from specific population subgroups, to reduce inequalities; this could change the ranking and composition of conditions, although the top 15 conditions have a large impact on Māori and Pacific people
- undertaking consultation with health professionals and providers, communities, and other sectors where action may be taken (for example, transport); this is important as a means to ensure that objectives and associated targets are realistic and have enduring support

- considering what cost-effective interventions are available at any level of care and the resource implications of any targets, to assure the targets are realistic and will achieve real gains.

## Goal 2. Access for all New Zealanders to an acceptable range of health care and disability support services, regardless of ability to pay

Health and the ability to participate in society are fundamental to people's wellbeing. Often individuals are most vulnerable when they or their families need health care or disability support most. Security of access to needed quality services, regardless of ability to pay, is therefore a key issue for the public.

In this section, we explain what lies behind some of the public's concerns and suggest how public expectations can be managed, why it is important to further refine prioritisation tools, and how barriers to accessing services can be addressed.

### 2.1 Brief assessment

Is New Zealand delivering an acceptable range and level of services to its population? The answer depends on what people consider acceptable: we all value our own health and that of others, but each individual values health and the availability of health care and disability support differently.

It is very difficult to draw conclusions by comparing New Zealand to other countries, because of differences in social and economic circumstances and data definitions. The relationship between funding, services and health status measures is complex. What seems to matter most are the level of wealth of the country (GDP), the extent of income inequality between population groups, education levels, and how well public spending on health is used.

- Of the people who used health care services in the last 12 months, 90 percent were satisfied or very satisfied with their overall care.
- The public's key concerns in New Zealand (and countries such as Australia, Canada, the United Kingdom, and the United States) are waiting times, affordability, and availability of services.
- Ninety percent of people live within 30 minutes (95 percent within one hour) of general primary care, and 90 percent live within one hour of basic hospital services.
- In 1999/00 Vote Health is \$6,674 million. Public funding makes up 78 percent of all spending on health care and disability support services.
- Between 1979/80 and 1997/98, inflation-adjusted public spending on health per head of population increased by about 2.1 percent per annum to \$1,631. In 1997/98 private spending was \$483 per capita.
- The range and volumes of publicly funded health care and disability support have also increased (see Table 2).
- With some exceptions, the level and range of publicly funded health care and disability support appears reasonable given the size of our country, our population, and our level of wealth.

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- Some barriers in access to services remain for Māori, Pacific people, and people in lower socioeconomic groups and rural areas.

## 2.2 Policy issues

### Health expenditure is in line with New Zealand's level of wealth

The public has concerns about waiting times, and the affordability and availability of services. Over the past ten years, the number of services has increased well above the increase in population (see Table 2), but public concerns feed into concerns about whether government spending on health is enough. In 1999/00 Vote Health is \$6,674 million, and with other public funding on health (such as ACC), represents around 78 percent of all spending on health care and disability support in New Zealand.

**Table 2: Changes in volumes of selected services**

	1988/89	1997/98	Change per annum (%)
Population <sup>1</sup>	3.3 m	3.8 m	1.5
Hospital inpatients discharges <sup>2</sup>	362,916	490,972	3.4
Hospital day patients discharges <sup>2</sup>	17,649	82,438	18.7
Medical surgical volumes <sup>3</sup>	660	839	2.7
Surgical volumes <sup>3</sup>	523	679	2.9
Elective surgery volumes	82,283	122,035	4.5
Average length of stay (days)	6.5	3.9	-5.4
Number of laboratory tests	6 m	13.5 m	6.6
Number of beds in public hospitals <sup>4</sup>	22,537	14,298	-4.1
Number of beds in private hospitals <sup>4</sup>	7,855	9,156	1.8

1 Change in measure: 1988/89 de facto population, 1997/98 resident population

2 Filtered and case-mix adjusted

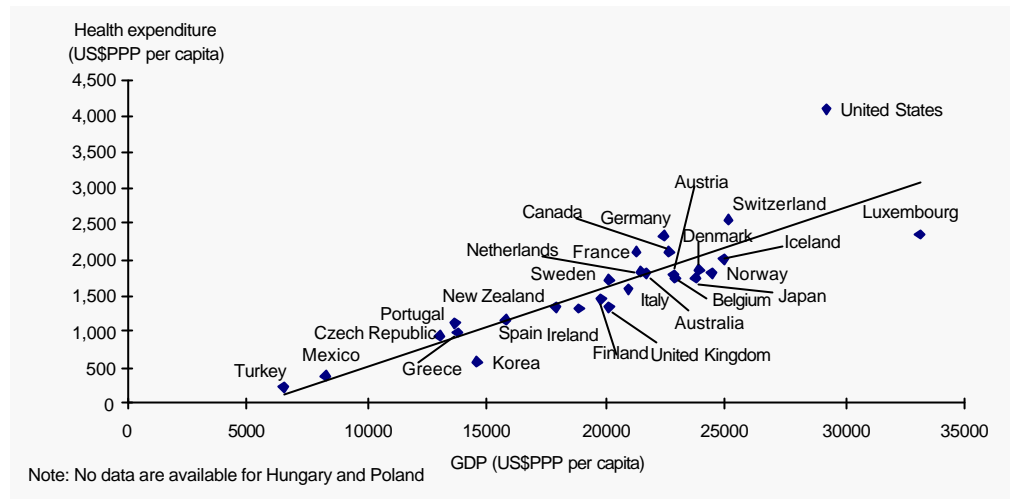
3 Standardised rate per 100,000 population

4 *New Zealand Official Yearbook 1992* and New Zealand Health Information Service

New Zealand spends about as much on health as would be expected for a developed nation with our level of national income (see Figure 6). Having said this, there is no 'right' level of health spending for New Zealand's population size, for our level of health need, or for our level of national income. Public opinion surveys in nations with higher GDP per capita and higher levels of spending on health indicate similar concerns about access and organisation.

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**Figure 6: Relationship between health expenditure and GDP in the OECD (1997)**



Source: *Health Expenditure Trends in New Zealand 1980–1998*, Ministry of Health 1999

**But there are access barriers**

Progress has been made in Māori health, child health and mental health. But some population groups still face some access barriers, particularly Māori, Pacific people, people in lower socioeconomic groups, and those living in rural areas. There are also differences in intervention rates between regions, which may point to access inequities (historical patterns of provision remain influential in service delivery), and inconsistent practices.

As described earlier, Māori and Pacific people have somewhat lower levels of contact with primary care providers, which is surprising given the significantly worse health status of these population groups. Māori and Pacific people tend to present late in the course of a condition and do not appear to derive the same benefits from the services, compared to the rest of the population. Possible reasons include cost to the individual, cultural barriers, language barriers, and problems with following through (for example, the cost of filling prescriptions).

See section

There has been success in increasing the number of Māori provider organisations – from 23 in 1993 to over 240 in 1998. But coverage of the relevant populations with providers that are appropriate to specific community groups is incomplete. Participation by Māori and by Pacific people in the health workforce remains low. Mainstream providers of publicly funded services are required to offer culturally appropriate services, but there remains scope to further develop such services.

The costs of accessing primary care services may be another reason. The RAND Experiment in the United States showed that a 5 percent increase in out-of-pocket costs did reduce total expenditure on health services by 25 percent, but that this had little or no effect on the health of the average person. Health among the sick poor, however, was affected. Low-income people or high users of health services qualify for Community Services Cards and High Use Health Cards, which reduce out of pocket expenses. But these cards do not address other costs, such as transport, and

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there are still differences with support for transport to enable access to services nationally. On average, Māori and Pacific people have lower household incomes than the rest of the population.

An evaluation of the free-under-sixes policy indicates that a reduction of user-charges did increase the number of children visiting GPs and the number of GP consultations. It could not show whether it increased service use by people with low income, by Māori, or by Pacific people. (It should also be noted that there are after-hours charges for children under six, and this may confuse some users.) When people do not access health services early it reduces opportunities to prevent illness and disability, or to intervene early and avoid hospitalisation.

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Although, on average, people in rural areas enjoy better health and independence than their urban counterparts, rural communities find it harder to attract and keep health professionals. People generally have to travel greater distances to access services such as GPs and primary care nurses. The Health Funding Authority is improving the consistency of the travel and accommodation policy across the nation. Disability support services have traditionally been in short supply in rural areas.

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There has been a significant increase in both the quantity and quality of mental health services especially over the last five years. This is a result of increased funding, pharmaceutical improvements and a clear strategic direction aimed at the provision of more and better services for the 3 percent of the population with the most serious mental health problems.

Despite these gains, we estimate that so far only about half to two-thirds of the 3 percent group access the appropriate services, and that more can be done to prevent people becoming seriously unwell. There are particular service gaps for children, youth and Māori. Stigmatisation and a shortage of an appropriately trained workforce are major barriers to accessing and providing mental health services.

People with disabilities, in particular people with multiple disabilities or high and complex support needs (such as dual intellectual and physical disability or highly challenging behaviour) face particular access issues. Key issues for the future are how to ensure that resources are re-allocated to meet the projected increase in (primarily physiological or age-related) disability, how to manage the associated fiscal risks, and how to overcome barriers when complex disabilities require co-ordinated health and disability support services.

### **Public expectations will continue to exceed what the country can afford**

Public expectations are fuelled in part by seeing in the media the range of services and technologies that are now available (particularly in other, more affluent countries), by concerns about quality, and by what is available privately. While the overall level and mix of services continues to increase (see Table 2 above), these factors create a gap between what the public expect and consider acceptable, and what the publicly funded health system can provide.

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What the health system can provide is constrained by what is affordable and cost effective, given New Zealand's geography, the size and spread of its population, and the level of wealth. Because of the relatively low population density in much of New Zealand, services may be more costly per head of population compared to other countries.

In some cases it is not feasible to offer local access to highly specialised and expensive services, both on quality of service and fiscal grounds. This means other solutions must be found. For example, to secure access to modern acute emergency services across the country, health services are being organised in networks that link primary rural care, through secondary services to the five tertiary public hospitals. Telemedicine, and the Healthline being piloted, offer other effective solutions.

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### **But increased funding will not satisfy all expectations**

Increased public funding may translate into more publicly funded services, but it would not avoid the difficult prioritisation decisions. It would only shift the boundaries.

The merit of additional public funding for health and disability services in New Zealand depends on where the additional money would be spent (how it would add to our health status), how well we use the money currently available, how much we value our own and others' health, and how the effects of spending additional money on health would compare to impacts of spending that money on something else (such as education).

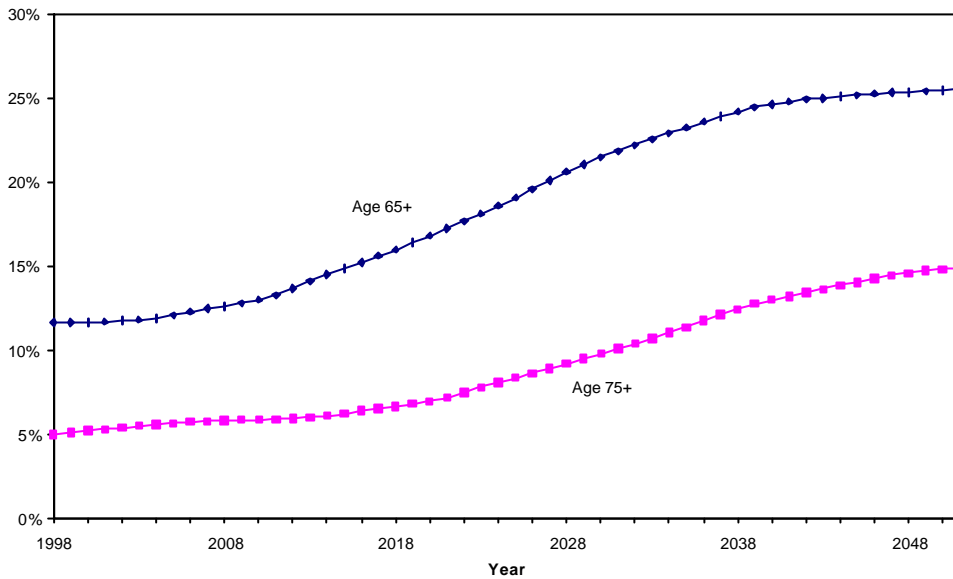
Because expectations will always outstrip what the country can afford, it is more important to ensure that the level of funding is sustainable, and that the best use is made of those resources, in a way that is acceptable to the public and achieves the Government's objectives for health and independence.

### **Ageing will put pressure on health funding**

An emerging issue is how to manage the potential fiscal impact of the ageing population. The proportion of the population who are aged 65 or over is projected to more than double (from 12 percent to 26 percent) over the next 50 years (see Figure 7). The highest spending per capita is incurred in the older age groups (see Figure 8).

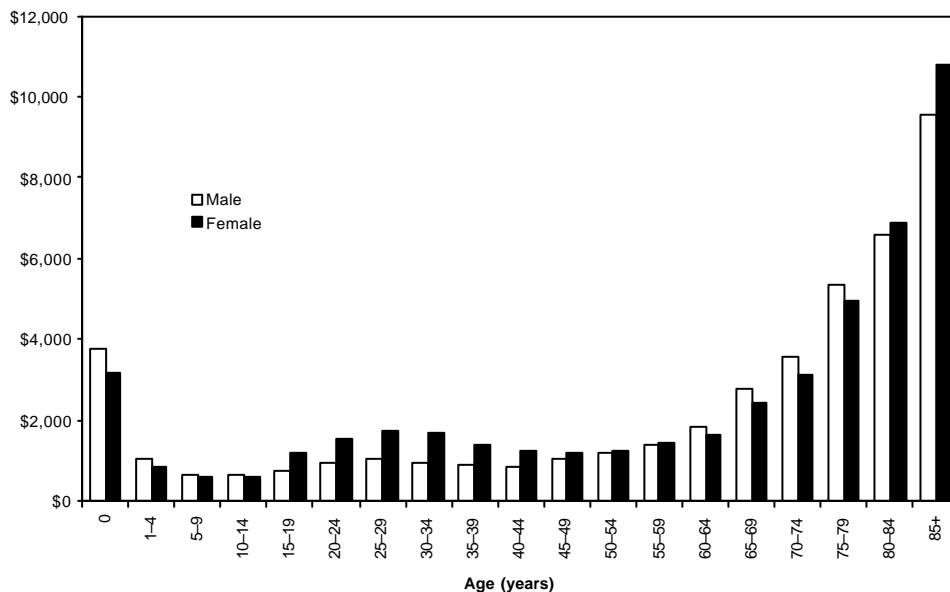
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**Figure 7: Elderly people as a proportion of the total population, 1998–2051**



As a result of ageing alone, it is projected that real per capita health funding will need to rise by an average of 0.8 percent each year over the next 50 years. Given the ageing population and a continuation of current policies and funding trends, Vote Health would grow from 6.0 percent of GDP in 1997/98 to 8.4 percent of GDP in 2051. Growth is particularly fast between the years 2020 and 2040. Changes in the relative per capita health costs of elderly people, or in future fertility and mortality trends, do not make a large difference to this projection.

**Figure 8: Per capita cost weights by age and sex, 1997/98**



The ability of governments to afford health and disability support services depends primarily on sustained economic growth and pressures in other sectors (such as superannuation). Long-term options for financing health services must be considered in this wider social services context.

## 2.3 Solutions

### Manage pressures

The gap between public expectations and what countries can afford to fund publicly is one of the key reasons behind the poor public perception of health and disability systems around the world. This creates pressures at all levels in the system. Mechanisms to assist managing such pressures include the need to:

- issue and demonstrate the Government's priorities to the public and people working in the health and disability services, and keep these priorities stable over a sustained period of time
- continue to clarify what publicly funded health and disability support services will be available, and build acceptance that the publicly funded health system can provide 'coverage for all, but not coverage of everything' (World Health Organization)
- enhance an understanding of what works, what does not, and where the greatest benefit is derived (for example, antibiotics do not work on viral illnesses and may increase bacterial resistance; the benefits of introducing leading-edge unproven technology for some should be balanced with the known benefits of providing basic services to people with the poorest health)
- extend the use of assessment and scheduling systems that give people certainty that they will get appropriate services according to need and ability to benefit. Systems and strategies that fail to give such certainty will fall into disrepute with clinicians and needs assessors, and then with the public at large
- enhance an understanding of what services can do, and their limits (for example, with all screening programmes there are known likelihoods of false negatives and false positives)
- reduce resistance to change by demonstrating the benefits of services and approaches that replace the traditional services (for example, better health outcomes by people with diabetes managing their own blood glucose testing and adjusting their own medication with support from health professionals).

*See, for example, Health Authority 19'*

While some expectations need to be managed downwards, groups with low health status need to be encouraged to access services sooner.

## Refine the prioritisation tools

At whatever level of funding the Government decides to resource the system, it will not provide everything for everyone. It will thus continue to be heavily dependent on methods used to ensure that the funds are allocated in the best possible way. New Zealand has made good progress in developing tools to assist in prioritisation, and it is important to develop those at all levels within the system:

- Ministerial decision-making about funding levels and targeted initiatives, distribution using funding formulae and ringfences, and setting priorities
- the Health Funding Authority's allocation processes and decisions about purchasing services
- providers' responsibility for delivering cost-effective services
- health and disability professional decision-making
- decisions made by individuals themselves, including whether and when to consult a health professional, and lifestyle choices.

At government level, a population-based funding formula for allocating funding to the regions has been in place for some time. It is a useful tool in allocating funds equitably across the country, and the Ministry has been updating the model.

Ringfences are used to ensure that funds are spent on disability support services and public health. This secures funding objectives, for example by ensuring that particular services are brought and protected against demand-driven items. But ringfences are also inflexible. For example, they hinder spending money in other areas when that would reduce future demands, such as when an earlier hip replacement would reduce the need for ongoing community-based disability support. Ringfences and separate funding streams have helped protect funding of some vulnerable services but they are blunt instruments that focus on money (inputs), rather than what services can achieve (outcomes). They prevent cost-effective resource shifts and work against service integration.

The assessment of what would be the appropriate mix of services at the population level, and the purchasing of those services, is the next layer of prioritisation. Prioritisation at the funder-level is an area that all health and disability systems struggle with. The approach in New Zealand has been mainly an iterative process at the margin within operating areas (such as personal health or disability support services). It is inevitable that not everyone will be happy with the difficult trade-offs that need to be made. The current health sector structures have been designed to facilitate sensible and acceptable shifts in resources.

PHARMAC, the Health Funding Authority's subsidiary that manages its pharmaceutical expenditure, has been very successful in using a variety of mechanisms to keep pharmaceutical spending within budget and targeted to the most cost-effective areas. By using criteria for funding new drugs and 'reference pricing' for groups of closely related pharmaceuticals, PHARMAC has been able to manage this demand-driven expenditure, and the significant savings have been redirected to other areas of health expenditure. The Ministry considers that it is very important to build on PHARMAC's achievements.

The greater the cost-effectiveness of providers, the more resources are available for enhanced services and priority areas. Tools for health professionals, such as evidence-based guidelines and clinical priority criteria, are currently a more practical way to get fairer access. Health professionals have a key role to play in ensuring that those most in need and most able to benefit get appropriate access and treatment. Developments in the area of elective surgery are a good example of how the evidence base can be used. People seeking publicly funded treatment are given clear advice about their priority for surgery and those with the greatest ability to benefit are given a firm date for surgery. All patients receive a care plan for management of their disease or disability. This gives people certainty of access if their need for surgery is above the funding threshold.

It is important that these types of approaches are developed further and that the processes and results are acceptable to patients and to consumers of health and disability support services, to service providers, and to the public. While progress is being made, some clinicians have not always found these approaches acceptable. For example, some consider 'financially sustainable' thresholds for qualification for some services to be too high; some consider the state of knowledge about who benefits most to be inadequate for sound prioritisation. Such debates usefully highlight the difference between average, population-wide outcomes and the uncertainty that clinicians face when making individual assessments.

The clinicians take the individual decisions on who accesses what services, and must be involved in the design of effective prioritisation tools. Effective tools take the criteria that clinicians use and make these explicit so that they can be debated by other clinicians and the public. Therefore, clinician involvement in the design of such tools is imperative.

The Ministry believes that it will be important to:

- engage the health and disability workforce more effectively in developing and expanding practical, evidence-based and acceptable prioritisation tools (such as clinical guidelines, assessment criteria, protocols, and prioritisation criteria for disability support)
- encourage understanding of the benefits of explicit criteria: accountability to the public, better information, and openness in decision-making
- widely debate the difficult trade-offs that such tools will show up, and feed this into the larger public debate about what would be an appropriate and sustainable level of funding, while managing the fiscal risks that this will create

- use opportunities to educate the public about the cost-effectiveness of different interventions
- find mechanisms for incorporating community preferences in prioritisation decisions in a fair and just way.

### **Retain the Sustainable Funding Path**

As Minister of Health you play a pivotal role in securing the public funding for the health system. What is important is that the level of funding can sustain the level of services over time, and that there is planning certainty for the funders and providers of the health and disability support services.

Since 1997 funding has been calculated by a Sustainable Funding Path formula, which takes into account predicted expenditure pressures from population changes, price increases, and changes in technology and efficiency in order to maintain the existing level of services. New government initiatives are separately funded.

The Ministry believes it is desirable to stick with the principles of growth in the Sustainable Funding Path because:

- consistent, transparent and planned adjustments over a three-year period help planning for the medium term
- it is one of your tools to manage the financing pressures inherent in publicly funded systems by making it clear that agencies must live within a set, but growing, budget.

You can build on the benefits of the Sustainable Funding Path by promoting different forms of contracts between the funder and providers that support longer-term planning, and relationships that focus on outcomes and systemic improvements.

### **Lower barriers to access**

Goal 1 described the range of current strategies to improve health status for Māori, Pacific people and people in low socioeconomic groups. These will improve access to services. There is also scope to review the user-charges regime to see where charges are useful and where they are not, in order to manage access for targeted groups.

Further gains in access can be made by removing any regulatory barriers that limit flexibility and do not contribute to consumer safety. For example, by amending legislation to remove restrictions on who owns pharmacies or optician businesses, you can improve access to them by allowing these services to reduce their overheads and making it easier to integrate with other health services. Nurse prescribing offers similar advantages. Taking opportunities to increase desirable flexibility in regulation and the workforce (see section 3.2) will increase access and reduce the costs to consumers, particularly to people in provincial and remote areas.

Access to primary care and to non-specialised secondary care can also be improved by enabling the use of a wider range of health professional providers (such as nurse practitioners, nurse prescribing, and general practitioners trained in advanced techniques), extending the availability and use of telemedicine, and by introducing other means of bringing services to communities (including the Healthline being piloted). Outpatient specialised secondary care can be made more accessible by specialists travelling to provide consultative services in smaller localities.

*The Rural Health  
Ministry of Health  
describes strategies  
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access issues in  
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Sometimes access is constrained by recruitment difficulties, for example in the case of mental health professionals skilled in areas such as child and youth, forensic and Māori mental health. The facilitation of the development of national training standards for community support workers has been a significant step forward in workforce development.

### Goal 3. A high-performing system in which people have confidence

The better the health and disability system runs, the more New Zealanders will benefit from improved health and independence. For the population as a whole, success is measured by improvements in health and independence outcomes. For an individual, success is measured by their being satisfied with the availability and quality of services received.

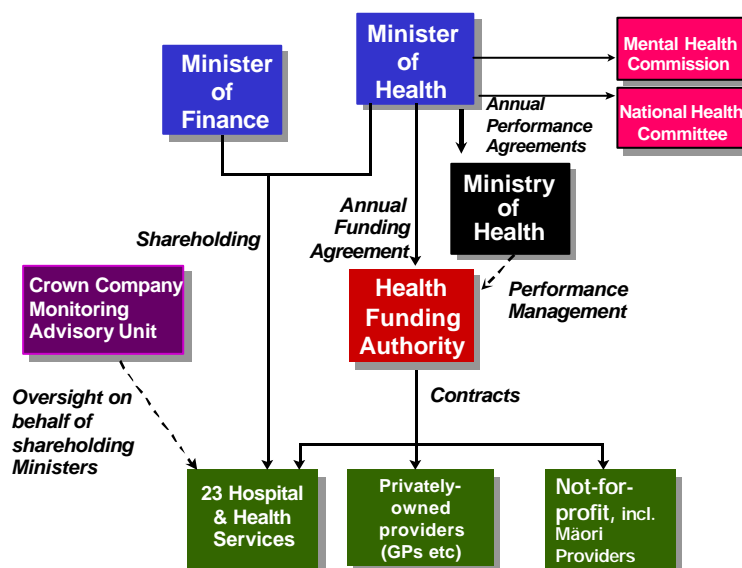
A high-performing health system channels its scarce resources to the right services for the right people at the right time. The strength of a system is also assessed by its ability to successfully evolve in response to new pressures and new demands, and its ability to balance the difficult tensions.

Over the last decade, different structural arrangements have been put in place to balance these tensions (see Figure 9). This has involved:

- integration of funding for disability support, primary and secondary care to reduce cost-shifting and to encourage service co-ordination
- emphasis on local responsiveness of providers to local circumstances
- a funder-provider split to encourage a range of health services providers and provision of more effective services
- a funder-owner split for public hospitals to highlight the trade-off between health services sought and the services and facilities provided
- changes to user-charges (co-payments) to target access better and to control costs.

In this section we describe how the performance of the system can be increased by promoting positive relationships, using funding approaches that encourage co-ordination, improving the flexibility of the health and disability workforce, championing a quality culture and unlocking the potential of the system’s information base.

Figure 9: The publicly funded health and disability support system



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### 3.1 Brief assessment

#### Assessment of system performance over the last decade

The gains include:

- improved information on the cost and use of services
- better mechanisms to manage fiscal pressures
- integration of funding streams, raising the potential for desirable shifts of resources and service integration
- emergence of new community-based providers, particularly Māori, mental health, and disability support services in the non-government organisations sector
- comprehensive needs assessment and coordination services for disability support
- improved national equity of funding
- general practice groupings to enable quality initiatives, budget holding and population approaches
- investment in public hospitals.

Areas for improvement include:

- relationships among agencies and between health professionals
- slow uptake of opportunities created by funding integration, for example in encouraging service integration and new service patterns
- regulations that no longer have consumer safety benefits, and inhibit flexible responses and beneficial change
- variable quality, including variations in practice and some weak systems
- high transaction costs and transition costs of structural changes
- slower than expected improvements in efficiency
- poor investment in future capability (workforce, integrated information)
- public confidence.

### 3.2 Policy issues

#### Relationships must become more positive

Good relationships are key to moving the sector forward. But relationships between agencies and between professional groups have often been unproductive.

While hospital managers are accountable for ensuring that contracts for quality services are complied with in the most efficient manner, they have limited influence over what clinicians do. At the same time, clinical staff perceive that managers without 'health' knowledge may not understand what is involved in running quality health services. In some cases, clinicians have refused to co-operate with management. More recently, doctors and nurses have been encouraged to become

*See the Health Commission on Canterbury.*

more involved in hospital management at all levels, and many have responded enthusiastically.

Health professionals must continue to make the best clinical decisions for their patients, but such decisions must take into account the bigger picture. Methods are continually being developed and introduced to assist health professionals to take account of the wider implications of their choices for care, applying clinically-developed guidelines and protocols to practice evidenced-based health care to secure quality and thus reduce variations in care. However, the extension of knowledge blurs the boundaries between professions, and this has contributed to some professional rivalries.

The development of contracting approaches into legalistic, sometimes secretive and resource intensive annual contracting rounds have been criticised for contributing to adversarial relationships, and poor planning and service decisions on both hospital service and funder sides.

These poor inter-agency relationships have distracted attention from the task of building relationships and investing in the infrastructure to deliver health gain. For example, there has been a lack of information sharing and working together in areas where other, even highly competitive, industries have seen the benefits of doing so voluntarily – for example, the banking industry has joint approaches to information strategies, and in other industries training organisations provide the basis of co-operation in the training and development of a high-quality workforce.

### **Funding approaches can be improved**

Over the last six years, one of the key gains has been better information on volumes and costs of services. This in turn has increased the Government's ability to specify the quality and quantity of services sought. This enables the funder to hold service providers accountable for the volume and quality of services delivered, and to monitor cost-effectiveness. Compared to other countries, New Zealand has been successful in introducing this approach with some degree of fiscal control.

But the use of contracts that specify what price will be paid for delivery of services also has constraints, because it:

- does not give good incentives to choose the best intervention (for example, prevention rather than treatment), particularly when there is scope for retrospective top-ups (such as deficit financing)
- raises the potential for cost-shifting (for example, services that are reimbursed on a per-case basis do not have strong incentives to question referrals, which is problematic if other providers have incentives to refer patients on)
- has in itself not been sufficient to influence what providers actually do: while some changes have been driven through contracts, service delivery continues to be dominated by historical patterns

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- is designed for episodic care, but is less appropriate for more relational, longer-term services
- has high transaction costs, and annual budget rounds give smaller community-based organisations insufficient certainty to plan or invest
- has resulted in mixed efficiency gains (for example, there have been reductions in length of stay and increased discharges, but poor control of costs).

### **Current health workforce arrangements constrain desirable change**

A competent, adaptable health and disability support workforce is a crucial ingredient for quality health and disability support services. By international standards, the New Zealand health and disability support workforce is highly skilled and knowledgeable, and well equipped to provide the wide range of technical and complex health care services available today.

With technological innovation and the re-orientation of the sector, traditional roles will blur, new occupations will emerge, and multidisciplinary teamwork will become the norm. The health workforce must be able to adapt its roles, activities and orientation so that labour with the right skills, knowledge and attitudes is available at the right time, at the right price. This means that the education, training and competency assurance agencies must also be flexible and responsive to support service delivery innovation.

Prescriptive planning cannot anticipate or control the many influences that affect the size and distribution of the health and disability workforce. To promote resilience and responsiveness to the many influences, the Ministry believes it is necessary to improve the flexibility of the workforce and to get better co-ordination among agencies with the responsibility for the education, training, competency assurance and employment of the health and disability workforce. Flexibility will lead to improvements in access, while ensuring quality and appropriateness of services. However, the current occupational regulation regime is out-of-date (some of the current Acts date back to 1947 and do not reflect the changes in knowledge, skills and working environments). This and the understandable misgivings of professions about evolving roles are constraints on desirable change.

### **System-wide quality needs more work**

Quality is about performance and patient/consumer satisfaction. High-quality care is delivered if the right thing is done for the patient in the right way, the right result is obtained (both technically and from the patient's point of view), care is delivered efficiently, and nothing unexpected goes wrong.

Health care and disability support services in New Zealand are generally safe and of high quality. At all levels in the system there are mechanisms designed to assure the safety and quality, including:

- regulation to ensure safety of services, often by enforcing minimum standards of facilities, consumer rights, and entry into the workforce

The Final Report of the Taskforce on Australian Health and Safety can be 'freedom from harm to an individual's physical and wellbeing' The Ministry of Health

- purchasing to set and then monitor service quality standards in contracts
- ownership of hospitals to ensure that services meet quality and safety standards
- professional standards
- information provision and consumer advocacy to empower consumers to make their expectations known and to follow up on performance failure.

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While most services work well most of the time, things do still occasionally go wrong in New Zealand as they do everywhere else. Examples of recent quality failures in New Zealand include undetected partial cleaning equipment failure resulting in incomplete disinfection of endoscopes over a period of months, replacement of the wrong hip, misreading of cervical smears, failure of a refrigerator leading to ineffective tetanus vaccine, and re-use of syringes.

Not all risk to users of health and disability services can be eliminated. Services are deemed safe when components and systems are in place that reduce risk to levels which are considered acceptable according to recognised, possibly international, standards. However, the events in New Zealand and elsewhere (notably in Bristol, UK) show that some consumers are exposed to greater risk of a poor outcome than is acceptable. Quality problems point to avoidable errors and under- or overuse of service, which are both unfair and wasteful.

While we are doing reasonably well, we can do better. A key issue is that there is no system-wide culture of continuous quality improvement. The current safety regime is focused on the quality of inputs (professional qualifications, equipment, medicines and facilities). This is necessary but not sufficient for assurance as to how those inputs will contribute to safe and effective outputs and outcomes. In particular, system accountabilities are unclear and there is little recognition that delivery occurs within teams and systems of care. Individual accountability needs to be translated into collective accountability to ensure a system of care works for the patient. Some Hospital and Health Services have initiatives that focus on system-wide quality and those may form a core of best practice that others can learn from.

### **Informational advantages are not used to their full potential**

In an international context, New Zealand has been one of the leaders in developing and using health information. The National Health Index (a unique personal identifier), the extent of electronic health messaging (for example, results from laboratories to GPs and general claiming for services), the Health Intranet and the general level of information technology penetration in health services, particularly in primary care, are some of the facets that put New Zealand ahead of many health and disability support systems. However, New Zealand has not yet taken full advantage of the opportunities.

The ability to securely exchange reliable and accurate information between partners in health care and disability support processes (case management, care delivery,

planning, management, research and education) will be vital for a health and disability support system which wants to:

- improve the co-ordination and integration of service delivery to the individual (for example, emergency and chronic care and disability support)
- empower individuals and their families to manage their own health and disability support better (for example, prevention and early intervention) and to manage the services they need (for example, disability support services)
- permit multiple models of care to co-exist (enabling best practice to evolve, yet remain locally relevant)
- allow organisational flexibility (for example, reducing the costs of change).

A nationally coherent and consistent approach to investment in a health information infrastructure is required. This should be based on improving access to and sharing of information, the development of an information culture (which complies with privacy principles) among both people working in the health and disability support system and consumers, as well as the consolidation of appropriate standards.

### **3.3 Solutions**

#### **Promote trusting and collaborative relationships**

It is particularly important to improve relationships between agencies and between professional groups. Over the last two to three years there have been some improvements: there are stronger information disclosure requirements, the Health Funding Authority has been introducing longer-term contracts, and agencies are engaging in joint projects.

Agencies and professional groups often agree on the ends sought, but may disagree on the means to achieve those ends. Any conflicts can undermine public confidence. Therefore a key step is to start engaging clinicians and disability support providers more when considering changing service patterns or policy. Another is to train and encourage clinicians into health management. These approaches can assist in reaching a better understanding of issues from different perspectives (such as clinical and economic perspectives) and finding solutions that are based on shared expertise. The Memorandum of Understanding between the Ministry of Health and the Council of Medical Colleges, and the Clinical Leaders Association of New Zealand are examples of how this could be fostered. Clinicians are important decision-makers within the services, and the opinion leaders for the public.

Collaboration is also important between professionals and patients. Informed consent must underpin this relationship to ensure that patients have sufficient information to assist in making decisions about care.

## Emphasise 'smart funding' approaches

Another way of getting more positive and outcome-focused relationships is by amending the contracting approaches, through stepping up from price-volume to longer-term contracting approaches. The key, however, is to get incentives in place that encourage community- and hospital-based services to work together to provide seamless care for affiliated populations, be more accountable for outcomes, take a longer view in their relationships and investment, and reduce the transaction costs. This implies longer-term, simpler contracts.

We believe this involves putting decision-making as close to communities as is feasible. This must go hand in hand with:

- good incentives and information for health and disability support professionals and for consumers
- a clear national policy framework of standards and expectations (clear goals and targets)
- further development of accountability mechanisms.

## Improve the flexibility of the health workforce

Flexibility in the health and disability support workforce would make an important contribution to improving access to, and the quality and appropriateness of, health and disability support services. This can be achieved by:

- introducing new paths to 'who can do what' based on competence rather than occupation; the professions would need to be closely involved in designing the competency framework, with input from providers, funders, and consumers
- a provider-organised health and disability support workforce co-ordination 'agency' co-ordinating the education, training and recruitment demands of providers in line with the emerging needs of the health and disability support sector; health professions and educators would have to provide input
- funding which reflects reasonable provisions for providers' investments in training and upskilling the workforce
- the Ministry of Health identifying workforce issues and encouraging solutions.

## Champion a quality culture

The emphasis on quality in New Zealand's health system is moving from specifying and monitoring inputs to one of setting standards for outputs or outcomes. Our experience has shown that it is not enough to expect that 'quality in' equates with 'quality out'. We need to foster and support the development of a culture of continuous quality improvement in the delivery of health and disability services, which:

- is system-wide
- utilises a risk-management approach to reduce preventable harm

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- fosters consistency of practice through shared learning, benchmarking and clinical governance within a standards framework
- takes account of community and consumer views on quality of care.

To achieve this we need to:

- replace the current outmoded focus on licensing of premises and facilities with a more modern and flexible regime that focuses on standards of service delivered (New Zealand's public health legislation is set to undergo a similar change to focus on identification and management of risks rather than controls on defined hazards and activities)
- encourage collaboration and information sharing to foster co-operation, establish agreed clinical protocols and processes, and share best practice initiatives
- reward and recognise the achievement of good quality services, and encourage the use of comparative information for quality improvement and learning purposes rather than for punitive purposes
- adopt a 'balanced scorecard' approach which looks more widely than just financial performance to encompass aspects such as customer satisfaction, internal processes, and organisational learning
- move to longer-term relational contracts, with a shift to purchasing for outcomes
- enhance the role of patients and consumers through better information and other ways of increasing voice
- ensure providers engage communities on priorities for quality improvement
- lead the culture change by acting as the champion for continuous quality improvement processes.

### **Unlock the potential of the system's information base**

We want a health information infrastructure that allows system-wide but secure access to, and sharing of, information among people working in the sector and consumers. Based on experiences overseas, the Ministry believes that a health information infrastructure is a crucial complement to the themes described in this paper. Our information strategy is being updated to guide strategic investment to meet current and future health care and disability support goals. We need means of testing and implementing health and disability improvement initiatives that are sector-led, locally appropriate, protect people's privacy, and are unconstrained by entrenched models of care or organisational structures.

The following themes represent the key areas for coherent action for the development of information access and use:

- an information culture – to enhance the capacity of individuals and organisations to plan for, implement and use information initiatives to meet their needs

- high-value content – to enhance the capacity of individuals and quality services to continue to grow effectively into the next century
- sharing and access – flexible and low-cost information services rely on a sound and secure infrastructure
- sustained commitment – which is essential for a successful strategy.

# Opportunities for action

A good health care and disability support system achieves:

- very good health and independence for all New Zealanders, and lower disparities in health and disability outcomes
- access for all New Zealanders to an acceptable range of health care and disability support, regardless of ability to pay
- a high-performing system in which people have confidence.

In this briefing we have shown how we can make further progress toward improving health and disability outcomes for all New Zealanders, and reducing inequalities, in a manner that is sustainable and will give the public confidence. This will involve leading the difficult change in how we think about health care and disability support (see Table 3). We suggest that the opportunities for real gains in the next three to five years are to:

- focus on population groups with the greatest inequalities, particularly Māori, Pacific people, and people with low socioeconomic status
- build up intersectoral approaches
- reorient health and disability support services to primary care, prevention and health promotion
- lead the difficult shift in thinking about health, by targeting the top causes and risks that give most gain for money
- manage the pressures resulting from the gap between public expectations and what health and disability support services the country can afford
- refine the prioritisation tools
- retain the Sustainable Funding Path
- lower barriers to access
- promote trusting and collaborative relationships
- emphasise 'smart funding' approaches
- improve the flexibility of the health workforce
- champion a quality culture
- unlock the potential of the system's information base.

**Table 3: The emerging health and disability support system**

<b>Now</b>	<b>Future</b>
<b>Focus</b>	
illness	health and independence
cure	prevention and chronic care
passive, dependent patients	self-helping, empowered consumers
<b>Content</b>	
episodic care	continuous care
traditional knowledge-based	evidence-based
<b>Organisation of production</b>	
standardised production, input focus	information-based, outcome-focused
clustered around specialists/technology	teams centred around the consumer
roles based on occupation	roles based on competence
fee-for-service and capped budgets	capitation and risk-sharing
output-based purchasing	outcome based purchasing
prescriptive	learning environment

Adapted from: H Vuori. 'The role of schools of public health in the development of primary care'. *Health Policy* 4 (1985): 221–30.

# The Ministry of Health

The Ministry of Health is the Government's principal advisor on health and disability in New Zealand. In performing its role, the Ministry:

- provides policy advice about outcomes and strategies for advancing the health status of New Zealanders, and reducing inequalities in health status
- develops and maintains a framework of regulatory health interventions to protect the health of the public
- establishes and promotes links with other sectors which influence health status and independence
- monitors Health Funding Authority performance against the objectives agreed with the Government
- provides informed, independent advice to Ministers about sector performance
- maintains links with health and disability support agencies in other countries, to keep up with developments of relevance to New Zealand and for benchmarking the performance of New Zealand's health and disability sector
- provides advice on the protection and improvement of New Zealand's biosecurity, and the health impact of measures to control biosecurity risks.

**Policy Branch** provides policy advice on the overall direction and priorities for health. This includes advice on funding levels, the regulatory framework for health and disability services, and intersectoral initiatives for improved health and independence.

**Māori Health Branch** provides policy advice on the overall strategy for achieving the Government's objective for Māori health: to reduce disparities in health status for Māori by increased responsiveness.

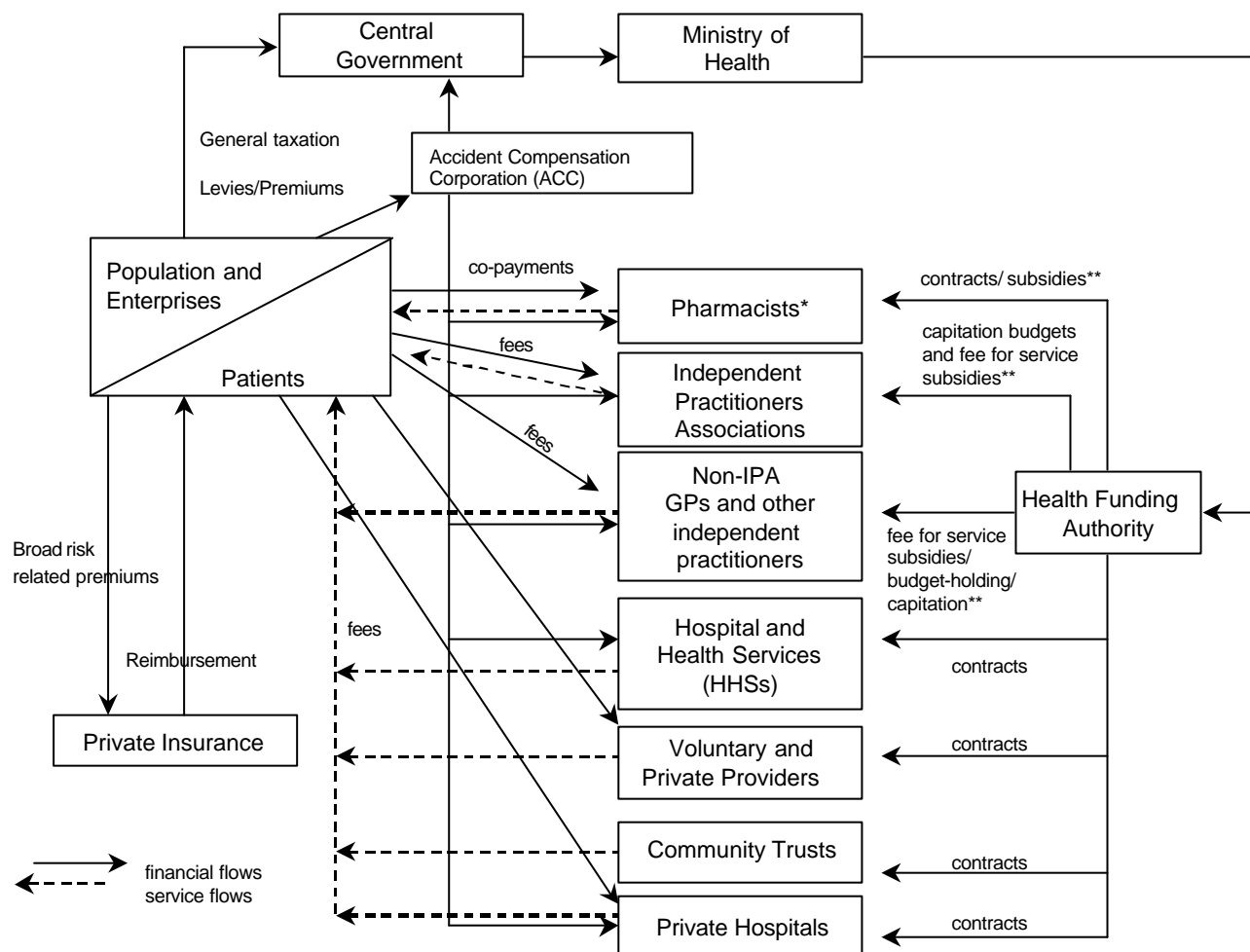
**Safety and Regulation Branch** is responsible for the administration of regulation and the enforcement of health and safety legislation (including mental health) and biosecurity. The Public Health Group with its statutory responsibilities forms a discrete part of the Safety and Regulation Branch. The aim is to move to a modern regulatory framework based on risk analysis: the Safety and Regulation Branch has as its key task the identification and management of these risks.

**Performance Management Branch** manages the Government's purchase and ownership interests in specific Crown entities, including the Health Funding Authority. This involves working in partnership with the health sector to facilitate the achievement of the Government's health and disability goals and objectives. The Branch is responsible for developing and implementing annual accountability documents, monitoring and advising on performance, and identification and management of issues and risks of non-performance in respect of these Crown entities.

**Corporate Branch** provides corporate and support services to the Minister of Health and Associate Ministers, and to the Ministry. The Branch includes the Ministry's business units: the Occupational Registration Boards Secretariat (ORBS), the New Zealand Health Information Service (NZHIS), the National Radiation Laboratory (NRL), and MedSafe, which is responsible for approval/licensing of drugs and medical devices in New Zealand.

*The Ministry's aim is 'Healthy New Zealanders'.*

## Appendix One: Health expenditure sources and flows



\* and other providers such as laboratories and radiology clinics  
 \*\* relating to contracts with the Health Funding Authority

Source: Ministry of Health and OECD 1999

## Appendix Two: The nature of health care and disability support: Why is health different?

There are some fundamental differences that make health care and disability support different from most other goods and services. Primarily, health and the ability to participate in society are fundamental to people's wellbeing. But the nature of health care and disability support means that the way societies regulate, fund and deliver these services is quite different to what applies to other basic services such as food and shelter.

- **Information imbalances:** Health professionals have the technical expertise about health care. This means that consumers start from a position of having insufficient information to feel they can effectively contribute in making decisions about the type, quality and price of health care.
- **Uncertainty:** Because of individual differences, diagnosis is not straightforward and the effectiveness of services may be variable or unknown. This uncertainty makes it hard for consumers or third-party funders to make good decisions when buying services.
- **Subjectivity:** There are few objective measures about what consumers need and how best to meet such need; this is best illustrated by the wide variations in intervention rates. The different views about what health care would be most appropriate or effective for particular diagnoses makes it hard for patients/consumers to judge the effectiveness of services or the performance of health providers.
- **Vulnerability:** People often use health care or disability support at a time when they are at their most vulnerable, or when they feel they have apparently little choice. This means consumers are less able to compare the effectiveness, quality, or price of different services.
- **Natural monopolies:** Because some services are very expensive to set up, or require a very high degree of specialisation, it may not be viable to provide some services in, say, remote areas without some assistance, or the price of services may be high to consumers because providers do not face the possibility that others will take business away.
- **The nature of risks:** Some risks are *uninsurable* (for example, when someone's probability of needing health care or disability support is high as predicted by, say, age or genetic profile). Other risks give rise to adverse selection (for example, when individuals take out insurance when they know they will claim), or moral hazard (for example, when individuals change their behaviour because of insurance – people have been found to drive faster when seatbelts became mandatory and/or cars got more safety features because people feel safer). The inability to insure leads to affordability issues when the costs of care or support are high relative to the means of an individual, or when it is difficult for people to rely on borrowing or saving.

- ***Health and independence for all:*** Individuals want other people to have an acceptable health status (externalities), but individuals have only a limited capacity to realise this on their own.