Setting the Scene

Where we are now

Modern developments in medicine, information technology and telecommunications are transforming what medical care we can provide, where, and for whom. Improvements in roading and transportation are also changing where and how we can provide medical care.

These developments mean that the public expect more specialised knowledge and comprehensive services than ever before from their health care providers.

Further pressures on the public health system come from adapting to the changes in where we live, how long we live, and what health problems we have.

The Government’s health strategy over the last few years enables us to respond well to these opportunities and pressures.

We have made the necessary shifts in health policy and its implementation. Now we want to work within the current structure. It has all the key elements needed to reach our goals for health and disability support.

Change is inevitable in the current environment, but from now on it will be evolutionary.

Future changes will fit into a nationally consistent framework, but local decisions will be made at a local level. In fact, it is expected that changes will most likely originate from the local perception of local needs.

The Government’s commitment is to guarantee access to quality services. It is open to the idea of using alternative providers and facilities if that improves access, efficiency and the quality of services.

Our modern health structures now provide that freedom to innovate.

Where the Hospital Services Plan fits in

The Plan is part of the Government’s general health strategy which is motivated by the ideal of timely access to quality, cost-effective health care throughout New Zealand.

The Plan can be regarded as a ‘living document’ because this is not a one-way process. To get the best services possible, we need the contribution of everyone involved in health care.

It belongs to the Government’s vision of a health care system that puts the patient’s and the community’s needs at the centre. That includes our need to remain as healthy as possible. To better meet these needs requires health care providers to work together in new ways. This central focus on patients and communities is most effective when communities are also involved in the shaping of their local health services.
Our public hospitals are an integral part of this vision. This Government is committed to their maintenance and development.

That is why, in the last five years alone, the Government has invested $920 million replacing and upgrading equipment and modernising buildings. Current plans are to invest up to $1 billion more in hospitals over the next three years. Over these eight years the value of our state-owned hospitals will have been more than replaced.

The Government commits to maintaining the current distribution of hospital services for the next three years. This responds to the need for greater certainty about hospital services, especially for rural and provincial communities.

In this Hospital Services Plan, people can see clearly where their hospital services are for the next three years, and how they fit together.

We are ensuring a modern and dependable hospital sector remains at the heart of our public health care system.
Objectives and Ways We Are Achieving Them

The Hospital Services Plan is underpinned by five main objectives. These are the essential criteria the Government considers and balances when looking at how best to provide hospital services.

These objectives are:
- timely access to hospitals
- safe, quality hospital services
- fairness across the country
- value for money
- acknowledging the special needs of rural and provincial communities.

In considering these objectives we must always keep in mind the principle that services need to be built around the needs of people, not institutions. Access to high quality services across the country is more important than access to particular buildings.

**Timely access to hospitals**

Getting to hospital in time matters most for accident and emergency care. But knowing when and where non-urgent or elective surgery is available is also extremely important for patients.

There is a lot of work currently under way on how best to ensure the quickest and most appropriate access to hospital services. New Zealand has a difficult terrain and a small and scattered population, so this area of work does require high quality analysis.

**Access to acute and emergency services**

Every New Zealander needs to have access to 24-hour acute and emergency services. The Government is committed to ensuring a safe backbone of these services. The following two projects are examples of this commitment. The underlying theme in both is building better networks between providers.

A 24-hour clinically integrated acute management system is being developed by the Government in consultation with health care providers. Its aim is ‘the right care at the right time and in the right place’. This ties in with the concept of ‘the golden hour’, which is the critical period of time after injury and shock.
Key elements of this system are:

- patients transferred directly to a hospital that can provide definitive care or managed locally if that is appropriate
- integration of all services for acute health needs
- regional networks of all agencies involved (ie, pre-hospital care, emergency transport and hospitals)
- safe practice guided by agreed guidelines, protocols and standards (with guidelines being updated)
- an appropriate emergency transport system
- streamlined processes.

The PRIME (Primary Response in Medical Emergencies) scheme funds rural doctors and nurses to attend accidents, and also supplies special training, emergency equipment and supply kits. Efficient transport and quality standards are part of the programme. It is a good example of different agencies working together, as it has had the support of the ACC, the Health Funding Authority, the Order of St John and the New Zealand Rural GP Network. It is being first implemented in the South Island.

Access to elective (non-urgent) surgery

The Government wants to make sure that elective or non-urgent surgery is available to those who most need it when they most need it. We are therefore introducing booking systems and explicit criteria for measuring need. The aim is to replace waiting lists with booking systems for non-urgent procedures and specialist assessments.

Using such explicit criteria and booking systems will make the public health system more open and so improve fairness of access to services.

Patients want to know exactly why, when and where they are going to receive an operation. They also want to know that they will get an operation when it is needed. Explicit criteria and booking systems are effective tools to help ensure such certainty and security.

The Booking System demonstrates the Government’s commitment to funding a reasonable level of elective surgery. However, not all surgery need always be performed at the local hospital. The new criteria and explicit commitment on elective surgery open up new ways for these services to be provided.

For example, some of the smaller hospital and health services could provide elective surgery for people from outside their region. This could shorten waiting times for people from the larger centres, help maintain the surgeons’ skills and provide better value for money from the hospital.

Another option could be the use of private hospital facilities, which might allow publicly funded surgery to be provided in a lower cost or more convenient way.
Safety and quality

The Government is committed to having hospitals that are safe, and provide quality health services.

This aim can be seen in the ways we examine the safety and quality of each hospital and in nationwide legislative changes.

Safety and quality in individual hospitals

The term ‘clinical sustainability’ is how we define whether individual hospitals are safe, are of an acceptable quality, and are likely to remain so.

The Government looks at a very wide range of factors when assessing whether a hospital is clinically sustainable. The assessment is not just about how surgical services are provided. It examines all the ways hospital services interact with community needs.

Some of the following are crucial for assessing the clinical sustainability of a hospital.

Feedback from individual doctors is one way of assessing whether the volume of work being done and support from peers are adequate to maintain safety and quality.

Reviews of competence are an important way for doctors to maintain high standards and to keep up to date with best practice. It can be difficult for doctors to objectively review their own work. Therefore it is often unsatisfactory for them to work in isolation, particularly for long periods of time.

In general terms, services where doctors have access to ongoing reviews of their competence would be seen as more clinically sustainable.

Consumer feedback and clinical audits are ways the Health Funding Authority assesses the quality of services.

Volumes of procedures and the population base can affect the quality of services. Some specialties require a certain volume of procedures to maintain quality.

Whether these volumes can be achieved usually depends on the size of the population served by the facility. Other factors affecting volumes are the general health of the population and clinical practice.

The ‘critical mass’ within a hospital is another defining feature of its clinical sustainability. The critical mass of a hospital is to do with the number of individual doctors, the skills and experience of other medical and nursing staff, and the links between specialties.

If a hospital falls below this critical mass, so too will the quality of its services.

Co-location with support and other services influences the viability of many hospital services. For example, good diagnostic services are essential for the best surgical outcomes, and some surgical services need to have intensive care available.

Staffing levels obviously affect the quality of services. Safe quality hospitals need the right numbers of staff with the right kinds of skills.
Many services in New Zealand depend upon one or two key individuals. This means the services are of good quality for now, but that they may not be in the long term if replacements cannot be found.

The increasing trend towards specialisation does make it more difficult to recruit medical staff with good generalist skills. Moreover, many specialists prefer to work in the larger cities, which makes their recruitment for smaller centres more difficult.

**How and whether 24-hour cover is provided** are other factors influencing quality and safety.

Where emergency work is being done, more doctors are needed to provide 24-hour cover. A facility that caters for a small population and has only a small number of doctors will find it difficult to provide a sustainable 24-hour service.

**The physical capability of a facility** places limits on what services can be provided there. It also determines whether other specialties can be co-located, which in itself affects clinical sustainability, as discussed above.

**The availability of technology**, such as diagnostic equipment or telemedicine also determine the clinical sustainability of services.

### Changes in the health and safety legislation

The current licensing regime for hospitals, rest homes and people with disabilities is out of date and inflexible.

It will be repealed on 1 July 1999, and replaced with a new licensing regime. The new legislation is aimed at ensuring safety and quality in ways that allow for innovation and the spread of good ideas. It will reduce unnecessary restrictions and give communities more options for meeting their health care needs.

### Fairness across the country

There are many factors to weigh up when assessing how to allocate the hospital dollar fairly across New Zealand. The most important are:

- how far patients have to travel to the nearest hospital
- whether there is equal access for those with equal need
- how long patients have to wait for a service
- how much patients have to pay for a service
- whether a service is culturally appropriate for all patients
- rates of service use across the country
- how much public money is spent in different parts of the country.

It is impossible to meet all these factors equally and simultaneously.

For example, sometimes the need to provide 24-hour cover means that people in
rural areas have more money spent on their services than those in urban areas.

In short, the Government is willing to support extra spending in some areas so that access, safety and quality are maintained, especially for smaller communities.

**Value for money**

We must keep striving to provide the best value for the health dollar. Funding the most efficient services frees up money to provide more health care where it is needed more. For example, having more efficient services enables us to spend more on elective surgery or preventative measures.

The Health Funding Authority is developing a national pricing strategy that means similar hospitals will be paid the same amount for the same services. It does allow for the extra costs faced by rural hospitals, and those who provide advanced (tertiary) care. The extra costs for hospitals involved in training are also recognised with separate funding.

Paying similar hospitals the same price will encourage them all to perform at the level of the most efficient hospitals.

However, in working towards greater efficiency, we must not overlook the importance of having quality services, and access to them.

**Special needs of rural and provincial communities**

The Government acknowledges the special problems of accessing quality care in time in rural areas.

The Government already pays a significant premium to support rural hospital services. We will continue to do so if other services cannot be reached within an acceptable time.

Financial considerations are less important than the need of communities to have access to health services.

Communities need services that are sustainable for the long term. A fresh approach to providing such sustainable services is evident in the many new health centres around New Zealand.

An example of a health centre in action is the new nine-bed community hospital that opened in Dannevirke in 1997. While the hospital itself is owned by local health providers and other private individuals, the services are publicly funded by the Health Funding Authority.

The new hospital works with the town’s GPs to provide medical inpatient care and includes X-ray and ultrasound facilities, physiotherapy and a medical laboratory. MidCentral Health also provides a range of services from the facility.

Other ways of meeting the health needs of rural and provincial communities are discussed further in the section below on ‘serving smaller centres better’.
Other Government Initiatives Affecting Hospital Services

The Government is implementing a wide range of initiatives to improve access to health care and its quality. Many of these affect hospital services. Ones that have already been mentioned include the booking system and explicit criteria for elective surgery, the 24-hour acute management system, and changes to hospital licensing.

Two other initiatives that will impact on the future development of hospital services are outlined below.

**Integrated care**

Integrated care describes a process in which health providers work together more closely for the benefit of patients. Integrated care breaks down many old boundaries between health providers to reorganise the services around the needs of the patients.

The aim is to streamline continuity of care as patients move between GPs, specialists, hospitals and other providers.

Integrated care initiatives are also set up to allow funding to flow to the parts of the system that give the best results for health. A good example is placing more emphasis on the education or prevention measures that could be provided by GPs or practice nurses. Prevention has the best health outcome of all.

There are more than 30 initiatives that come under the integrated care umbrella, currently under way throughout the country. Some are disease management projects, for example, improving the care of cardiovascular disease in one region. Others can go as far as aiming to manage all the publicly funded health care for a region.

The Government expects to see relationships between hospital services and other parts of the health sector getting stronger over time. These developments will influence the location and organisation of hospital services.

**Legislation affecting the health workforce**

The Government is having a fresh look at the laws governing health professionals. We appreciate that to ensure the best care and the best service for patients, those working in the sector need to be able to work in a flexible way.

Occupational regulations covering 15 groups of health professionals are being reviewed. The need for new forms of practice, such as new professions needed to fill gaps and to create a more effective workforce, are being considered. A range of measures relating to qualifications and competence will be presented.

The planned introduction of prescribing rights for specially trained nurses is a good example of the kind of change that will make better use of the health workforce. The
Government is also looking at a recommendation from the Nursing Taskforce that would allow nurses to order diagnostic tests and refer patients to specialists.

Developments of this kind will pave the way for more flexible service delivery. They are likely to create more options for providing hospital services to communities.
The Framework for Hospital Services

A network of expertise

At present, New Zealand has five large tertiary hospitals providing the most specialised and complex medical care. Smaller hospitals also offer an expert service in the types of care they provide, but pass on the most complex cases to the bigger hospitals where there is a greater range of specialties.

The smaller hospitals cater for most of the health needs of local populations so few New Zealanders ever have to use the most complex services.

The Government proposes to recognise this existing arrangement with a framework that ranks hospitals into five categories according to the complexity of the procedures they carry out and the type of emergency care they provide.

Hospitals that see large numbers of similar cases from a wide catchment area can offer more specialised staff and equipment more efficiently and of a higher quality than the small hospitals can.

Timely access to appropriate services requires an efficient network of retrieval, stabilisation and transfer. The sickest patients need to know they will be moved safely and quickly to where they can get the best help.

Health centres

In many rural places and provincial towns, the old public hospitals have been replaced by new health centres. The majority are still run by larger public hospitals, but increasingly these centres are being developed and run by local community groups or local groups of health providers.

Health centres vary considerably in size and scope. Most offer primary and community health services, as well as a skilled nursing facility with medical support. A centre may have its own inpatient beds for such things as continuing hospital care or low-risk births. It would arrange for transfers of emergency medical patients to a secondary or tertiary hospital.

The variety among the health centres is one of their strengths. This is because each has evolved in response to the needs and capabilities of their communities and health professionals.

Another very important strength of these health centres is the way they bring hospitals, GPs, nurses, pharmacists, physiotherapists and many other health professionals closer together. Closer working relationships mean greater co-operation, communication and co-ordination of care for the benefit of patients.
Sub-acute units

The next level up are the sub-acute units which provide inpatient medical beds and day surgery. Lower level diagnostics, day stay care, some inpatient surgery, and clinical support services may also be available.

Additional services might include patient transfer and travel support, enhanced community health services including Community Mental Health Teams, antenatal care, and outpatients (excluding ophthalmology, ENT and urology).

Sub-acute units can initiate resuscitation of an injured patient, but would almost always need to transfer emergency medical patients to a secondary or tertiary hospital service.

Secondary hospitals

These are equipped to cater for most of the local population’s health needs, and so offer 24-hour acute secondary services.

The secondary hospitals are staffed by specialist physicians and surgeons. Most provide general medicine and general surgery, paediatrics, maternity, orthopaedics, gynaecology, ENT, ophthalmology, urology and community health services. Diagnostic and clinical support at a higher level is also available.

Additional services might include special care baby units, Assessment, Treatment and Rehabilitation, and mental health secondary services.

Secondary hospitals contain intensive care units, but where patients need prolonged ventilation or tertiary surgical management, they would be transferred to a tertiary hospital service.

Lower level tertiary hospitals

These hospitals are likely to provide all that secondary hospitals can, as well as a greater number of sub-specialities such as oncology and regional public health units.

Emergency care is based around a comprehensive intensive care unit committed to treating the ill and injured. It is staffed with ‘on site’ as opposed to ‘on call’ specialists.

At this advanced level, these hospitals have many 24-hour/7-day resources, and have all major modern diagnostic services. They provide a rapid retrieval and primary response service within their geographic areas.

Some patients might be referred on from these hospitals to higher level tertiary facilities or specialised units, for example for spinal injuries. They may also have patients referred to them from other trauma hospitals for the management of specific injuries in which they specialise.

Lower and higher level tertiary hospitals are the five advanced trauma centres in New Zealand. These are in Auckland, Hamilton, Wellington, Christchurch and Dunedin.
Higher level tertiary hospitals

The higher level tertiary hospitals provide all that the lower level tertiary hospitals provide, but usually also have neurosurgery, burns/plastics, spinal, bone marrow, cardiothoracic, adult liver transplants, renal transplants, and the most specialised neonatal units and forensic mental health services. Patients are not usually referred on from these hospitals, unless to specialised units.

Maps

The following maps show the different hospital services provided throughout New Zealand. There will be no significant changes to the distribution of these hospital services over the next three years.

It has not been easy to draw precise boundaries between the different hospitals on these maps. The various health centres have been especially difficult to capture. This is because of the wide variety of facilities and new providers at the lower end of the range.
South Island – Health Centres

Facilities with hospital beds

Smaller facilities without hospital beds
North Island – Secondary and Tertiary Service Facilities

* also provides some lower level tertiary services
^ provides some tertiary services, these will be transferred to Wellington in 1999
South Island – Secondary and Tertiary Service Facilities

- South Island
- Secondary and Tertiary Service Facilities
- Sub-acute
- Secondary
- Lower level tertiary
- Higher level tertiary

Facilities:
- Grey Base (Greymouth)
- Ashburton
- Wairau (Blenheim)
- Christchurch
- Burwood
- Chch Women’s
- Buller (Westport)
- Timaru
- Dunedin
- Southland (Invercargill)
Particular Issues

The opportunities and pressures on health care, such as medical specialisation, meeting patients’ expectations and demographic changes, mean that hospital facilities will have to continue to evolve. The areas that are feeling the most pressure on their health care needs at present are the small rural and provincial communities, and the fastest growing urban areas.

Serving smaller centres better

As has been discussed, it can be particularly difficult to provide a quality health service in small centres. This is because of problems like the difficulties of recruiting staff, and lack of professional peer contact and review.

Some of our rural and provincial hospitals provide costly services because of the low number of patients seen.

We need to consider ways of organising the services to provide better quality and better value for money while still maintaining access for local people.

One option for improving value is to bring in overflow patients from larger population centres. That would also help to cut down waiting times for people from the larger centres if they chose to go to a smaller centre.

Service quality could be improved by arranging for doctors to spend time in larger hospitals, and for them to have regular reviews of their competence.

We are continually looking at new ways to make rural and small town medical work more attractive to practitioners, to cut down on the sense of professional isolation, and to upgrade skills as necessary.

Other agencies, such as the Dunedin School of Medicine, are working with the Government towards these goals. The School of Medicine is looking at how best to provide administrative support and visiting specialists for teaching purposes in rural areas. This is another way of bringing hospital expertise out to smaller communities.

The Government wants to reassure our smaller communities their hospital services are not under threat. We will consult with affected communities to work out the best solutions to these problems of quality and value.

Meeting the needs of growing communities

Some large urban populations are straining to meet the needs of their growing populations. For example, Auckland’s population grew by more than 126,000 between the 1991 and 1996 Censuses.
The Government has identified five key locations where services need to be increased to ensure access to services matches access throughout the rest of New Zealand. They are:

- West Auckland
- Central Auckland
- South Auckland
- Tauranga
- Christchurch.
Centrally imposed plans are no substitute for the creativity and motivation of those who know local circumstances.

The Government will work with communities, health care providers and other key groups over the next three years to address how best we can ensure quality, safety and access to our hospital services.

In this time there will be no major changes to the distribution of hospital services. There will however continue to be significant Government expenditure on our hospitals.

This Hospital Services Plan is seen as an important part of the communication between Government and interested parties on how best to continue to provide health care.

The best communication comes when there is mutual understanding. It is hoped this Hospital Services Plan will help with that understanding, and give New Zealanders confidence that their suggestions can only improve what we already have.

**Comment on framework**

We are interested in general comments on the suggested framework. Please send these by 30 November to:

Hospital Services Plan  
Ministry of Health  
PO Box 5013  
WELLINGTON

**Comment on local issues**

Anyone wishing to comment, makes suggestions or become involved in discussions about their local hospital services should telephone or write to their local Health Funding Authority from 1 October as follows:

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