

STATEMENT OF INTENT

2008–11

Citation: Ministry of Health. 2008. *Statement of Intent:
2008–2011*. Wellington: Ministry of Health.

Published in May 2008
by the Ministry of Health
PO Box 5013, Wellington, New Zealand
ISSN 1175-852X (Print)
ISSN 1178-8585 (Online)
HP 4580

This document is available on the
Ministry of Health website:
<http://www.moh.govt.nz/soi>



MANATŪ HAUORA

Foreword: Minister of Health

I am pleased to present the Ministry of Health's (the Ministry's) Statement of Intent for 2008–11. This document is a key accountability document between myself and the Ministry. It outlines the key areas that I expect the Ministry to lead and also specifies how its own activities contribute to outcomes relevant to the health and disability sector.

Since becoming Minister of Health (the Minister) in November 2007 I have observed that the health and disability sector consistently performs at a very high level. It is internationally recognised as a system that provides high quality, trusted services that are delivered in a cost-effective manner that makes it the envy of other countries. The system has a hard working and dedicated workforce of which we can be justifiably proud.

In spite of these strengths we must continually strive for improvements in services in order to achieve our goals of improving health and independence for all New Zealanders. This Statement of Intent highlights a stronger role for the Ministry in ensuring that the strengths of a semi devolved system are maximised in a way that focuses improvements in care and services. Key to the improvements are:

- Continued emphasis upon realising the potential of ongoing improvements in preventive and primary care, with a strong focus on management of key disease groups and the social determinants of health that impact them, and a parallel focus on key population groups with particular needs such as Māori and Pacific New Zealanders, our children, young people and our senior citizens.
- Strengthening health services we can trust through:
 - a greater focus upon collaboration at local, regional and national levels. A country of four million people spread over a significant geographical area needs a health and disability support system that has collaborative working at its heart. Closer relationships will make innovative solutions possible, resulting in a more cohesive and efficient system, with fewer barriers to success
 - taking forward the quality agenda to ensure services are as safe and effective as they can be. Continuous improvement in quality and safety is vital as it underpins all that we do, has a real impact on the public's trust and confidence in the health and disability system, and on achieving satisfactory health and disability support outcomes. The health and disability system needs to be consistently better at measuring quality, as well as benchmarking against proven standards to reduce inappropriate variation.
- Taking a strategic approach to further developing the key enablers of a strong public health system for the longer term, including workforce development, information technology and communications, and ensuring that our capital development programme is optimally configured towards our long term needs.

The Ministry's work programme reflects these three areas and I expect it to show leadership in each of them. To this end I wish to empower the Ministry to play a stronger leadership role across the sector and I will, as appropriate, hold it accountable for sector-wide results. This will complement existing statutory responsibilities for individual DHBs who are accountable directly to the Minister of Health under the New Zealand Public Health and Disability Act 2000. This is a significant difference in focus to previous Statements of Intent and reflects my belief that we need to effectively combine the strength of locally accountable and run DHBs with strong leadership from the centre.

Making gains in these areas will assist in progress around the six priority areas I have set for the health and disability sector. While these priority areas remain the same as in previous years I have signalled a number of changes in emphasis. The Statement of Intent explains why this work is important, and how it will help to improve health and disability services and outcomes.

Accordingly, the priority areas where I believe concerted action needs to be placed, are as follows.

A. Taking public and primary health care to the next level:

1. getting ahead of the chronic disease burden (including by investing in wellness and its determinants)
2. driving forward the Primary Health Care Strategy
3. investing in the early years and youth potential
4. caring for older New Zealanders.

B. Strengthening health services we can trust:

1. achieving value for money
2. actioning the agenda for quality
3. strengthening regional and national collaboration among DHBs.

C. Enabling a strong, sustainable health sector for the longer term:

1. strategically developing the health sector workforce
2. building seamless health information and communication systems
3. optimising capital infrastructure development.

Overall, I expect to see faster performance improvement by the health and disability sector across all the priority areas. The Ministry has a key role in leading and providing effective support to DHBs to achieve these improvements, and assessing the level of achievement through monitoring of the Health Targets. The Ministry also has an obligation to rigorously apply the monitoring-intervention framework where DHBs do not perform to the agreed level.

The priorities I have set are consistent with the directions set by the sector's overarching strategies. The New Zealand Public Health and Disability Act 2000 requires the New Zealand Health Strategy and the New Zealand Disability Strategy to provide the framework for the health and disability sector's overall direction.



Hon David Cunliffe
Minister of Health

Introduction from the Director-General

The Ministry of Health continues to evolve and change as we deliver on the key findings of the 2006 Review of the Current State of the Ministry of Health. We have reorganised how we are structured and how we work with the health and disability sector. We have strengthened our leadership capability, and we are taking a wider whole-of-system approach with a strengthened focus on improving Māori health and reducing health inequalities and how implementation of key strategies are undertaken.

Important in this has been the creation of the Sector Capability and Innovation Directorate to work with the sector to share learning and support programme delivery. We've also started the Long Term System Framework to foster better planning and co-ordination. We need a health system that anticipates changes, develops the right responses, and makes the best use of resources. Given the known pressures on the system, such as workforce shortages, an ageing population, increasing public expectations, and emerging technologies, this work is key.

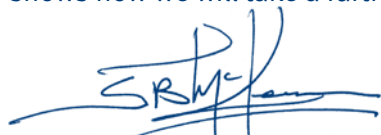
We have a world class health system. On many measures we compare well internationally. A recent Commonwealth Fund study ranked us second only to Germany and ahead of Australia, Canada, the United Kingdom and the United States overall in patient safety, effectiveness, patient centeredness, timeliness, efficiency and effectiveness (Cylus and Anderson 2007). We still face challenges, particularly in achieving a higher performing health system. On many national health indicators we have too great a variation in the performance and delivery by DHBs, hospitals and providers. Building our understanding of why these exist and what to do about them is an important part of our work.

Our Health Targets, agreed last year, are a mechanism for focusing performance improvements in the system, including reducing inequalities across population groups, and giving clear signals about the Minister's and sector's priorities.

These priorities give a focus for the system on areas where we know we can improve health outputs and outcomes. We know that long term conditions are the leading cause of illness. Diseases such as diabetes, heart disease and cancer account for more than 80 percent of preventable deaths, and 70 percent of health funding (Ministry of Health 2007). They are also a leading driver of inequalities amongst different population groups. It is fitting that initiatives reducing the incidental harm from chronic conditions are given priority over other initiatives.

The Ministry of Health provides a range of important functions that maintain the core of a government's essential functions in a modern health system. We are policy advisor, legislator, regulator and funder. We invest in a broad range of national services, such as the National Cervical Screening Programme, BreastScreen Aotearoa and newborn screening. The Ministry funds \$371 million in public health services (including screening programmes) and \$840 million of disability services. We also provide shared support services, such as the processing of HealthPAC payments (some 93 million transactions on behalf of the sector each year).

I want to acknowledge the Ministry's staff for their continuing hard work and dedication to making a difference in health. The path we have embarked on allows us to better support the system as a whole and to provide the necessary leadership to achieve better health, fairer treatment and greater independence for all New Zealanders. This is a laudable aim. This Statement of Intent shows how we will take a further step towards making it real.



Stephen McKernan
Director-General of Health

Contents

Foreword: Minister of Health	iii
Introduction from the Director-General	v
Strategic Direction	1
Taking primary and preventive care to the next level	2
Strengthening health services we can trust	3
Enabling a strong, sustainable health sector for the longer term	4
Summary of key priorities	4
Nature and Scope of Functions	6
Operating Intentions	9
A. Taking public and primary health care to the next level	9
A1 Getting ahead of the chronic disease burden	9
A2 Driving forward the Primary Health Care Strategy	13
A3 Investing in the early years and youth potential	16
A4 Caring for older New Zealanders	20
B. Strengthening health services we can trust	22
B1 Achieving value for money	22
B2 Actioning the agenda for quality	25
B3 Strengthening regional and national collaboration among DHBs	28
C. Enabling a strong, sustainable health sector for the longer term	29
C1 Strategically developing the health sector workforce	29
C2 Building seamless health information and communication systems	31
C3 Optimising capital infrastructure development	35
D. Ongoing Ministry operational priorities	37
D1 Improving Māori health	37
D2 Reducing inequalities	39
D3 Supporting health and wellbeing through nationally funded services	42
Managing in a Changeable Operating Environment	45
Emergency preparedness	46
Organisational Health and Capability	47
Attraction and commitment	47
Healthy workplaces	47
Learning and development	48

Departmental Capital Intentions	49
Additional Information	50
Additional Statutory Reporting Requirement	50
References.....	51
Appendix One	53

Figures

Figure 1: Ministry of Health outcomes framework	2
Figure 2: The structure of the New Zealand health and disability sector	8
Figure 3: New Zealand population, by age group, 1940–2100 (projected)	21
Figure 4: Value for money – the relationship between expenditure, inputs, outputs and outcomes	23
Figure 5: Service and capital planning linkages	37
Figure 6: Life expectancy (LE) at birth versus health inequality index (HII), 1999–2003, by DHB	41

Tables

Table 1: Measuring the success of the health and disability sector in, and the Ministry’s contribution to, reducing chronic disease.....	12
Table 2: Measuring success of health and disability sector in, and the Ministry’s contribution to, improving primary health care	15
Table 3: Measuring the success of the health and disability sector in, and the Ministry’s contribution to, improving child and youth services	19
Table 4: Success of health and disability sector in, and the Ministry’s contribution to, caring for older New Zealanders	21
Table 5: Measuring the success of the health and disability sector in, and the Ministry’s contribution to, achieving value for money.....	24
Table 6: Measuring success of the health and disability sector in, and contribution of the Ministry to, actioning the agenda for quality.....	27
Table 7: Measuring success of health and disability sector in, and the contribution of the Ministry to, strengthening regional and national collaboration among DHBs.....	29
Table 8: Measuring the Ministry’s contribution to improving infrastructure (workforce)	31
Table 9: Measuring the Ministry’s contribution to improving infrastructure (workforce and information systems)	34

Table 10: Measuring our progress in achieving cost-effective and safe capital investment	36
Table 11: Measuring the success of the health and disability strategy in, and the Ministry’s contribution to, improving Māori health	39
Table 12: Measuring the progress of the health and disability sector in, and contribution of the Ministry to, reducing inequalities	42
Table 13: Measuring success of health and disability sector in, and Ministry’s contribution to, supporting health and wellbeing through nationally funded services	44
Table 14: Fixed asset purchases.....	49
Table A1: Health targets and indicators	53
Table A2: System and societal-level outcomes and associated headline indicators	55

Strategic Direction

The health and disability sector is a large and complex one. It directly employs 130,000 people and consumes 20 cents of every tax dollar raised. It touches every New Zealander every day, whether it is in the quality of the water we drink, the health information messages we see, as one of the 17.3 million annual visits to a GP or one of the 681,102 annual hospital discharges.

There have been a number of significant differences in organisational design over the years. The current structure was established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). This Act replaced the previous market based system, which tried to apply notions of competition, with a system of 21 semi-autonomous DHBs. These organisations are responsible both for assessing the health and disability support service needs of their populations and also providing services to meet that need.

Within the legislative framework set by the NZPHD Act, the strategic direction of the sector has been set within two overarching strategic documents, the New Zealand Health Strategy and the New Zealand Disability Strategy. These two strategies have been supported by other more targeted strategies that provide guidance and advice in areas such as Māori health, Pacific health and primary health care.

The system is operating well and is demonstrating significant improvements in health and wellbeing. Some achievements include:

- around 4 million New Zealanders enrolled in PHOs
- lower doctors' fees
- growth in elective services while maintaining relatively short waits
- improved public attitudes towards those with mental illness
- improvement in some significant indicators of health status
- a significant fall in smoking rates
- high patient satisfaction levels.

The Ministry has a well established framework that links key attributes of a fair and functional system with key outcomes for all New Zealanders. This framework is shown in Figure 1.

Figure 1: Ministry of Health outcomes framework



Taking primary and preventive care to the next level

Primary care and prevention services are key to addressing the burden of long term conditions. We have created an environment of low fees, greater investment in health promotion and services that increase access in the primary health care and community setting. This is a strong platform for us to be able to get momentum on visible improvements in the health outcomes that can be influenced by community and primary care based services.

We need to build on the platform established by the Government's primary and preventive health care strategies. Long-term conditions continue to be the most significant contributor to early death and premature disability among our populations, and our most vulnerable communities bear a greater burden of early onset and faster disease progression than other New Zealanders. A determined focus on disease management for key disease groups is at the heart of the public health strategy. Better access to screening and development checks, diagnosis and supporting the continuum of care for long term conditions is a priority. So too is a broad view of

the underlying social determinants of health; like housing, sanitation, nutrition and lifestyle issues that impact inexorably on the need for primary and secondary layer interventions.

The disparities in health outcomes between European, Māori, Pacific peoples and other migrant New Zealanders have diminished but remain unacceptably high. Our children and young people, and older people are among the most vulnerable members of our society. We will also increase our focus on the health of children and young people, because many of these conditions can be influenced earlier in life. Better addressing the health needs of those with the most capacity to benefit, lifts overall health outcomes and reflects New Zealanders' aspirations to live in a fair and decent society.

Strengthening health services we can trust

New Zealanders expect that the very significant investment they make in health care will be well stewarded. They expect safe, high-quality services will be there for them when they and their families and whānau need them. To deliver on these expectations the Minister will hold the Ministry as his agent accountable, as appropriate, for the performance, effectiveness and efficiency of the health system. The statutory accountabilities of DHBs and other health sector entities under relevant legislation will remain. Value for money must continue to be ensured through the annual planning and performance management cycle of DHBs, through which some 75 percent of public health investment is currently channelled. Ministry-led performance monitoring can be supplemented where necessary and appropriate through Ministerial and Board level support.

Quality and safety are crucial to ensuring the public has trust and confidence in the system. Patient safety in New Zealand compares well with wealthier countries from the OECD. It is the job of the Ministry and DHBs to further build on these gains. The sector is getting better at measuring quality and benchmarking against proven standards to reduce inappropriate variation, but there is room for further improvement.

The role of the Quality Improvement Committee will be enhanced over the coming year. The Ministry has an important role in supporting implementation of its national improvement programme. This includes safe medication management, management of health care incidents, infection prevention and control, optimising the patient's journey, and the introduction of a national mortality review system. Each project will be led by a DHB and will report regularly to the Quality Improvement Committee.

Closer relationships across the sector are needed to ensure organisations share information and develop innovative solutions at district, regional and national levels. Partnership arrangements such as joint purchasing and regional clinical networks will enable our system to be more cohesive and efficient. The Minister expects to see better operational effectiveness through increased clinician input and closer relationships between clinicians and management, primary and secondary services, and between DHBs and the Ministry. This will reduce barriers and ensure the system is working effectively.

While the fundamental design of the DHB system therefore remains sound, there is potential to achieve more and to improve some key processes. We still see significant variation in the performance of the sector and there is potential to further strengthen collaboration through regional shared services and stronger central leadership on strategic nationwide priorities.

A key challenge is therefore to make consistent national gains within our semi-devolved health and disability system. We also need to ensure that any changes are not unduly disruptive, and add to rather than detract from the effectiveness of the system while maintaining an appropriate focus on value for money and the delivery of measurable outputs according to target, including elective services.

Enabling a strong, sustainable health sector for the longer term

Closer relationships also enable the spread of innovative ideas and practices, which is vital to performance improvement being achieved. Access to information, resources, tools and systems helps provide the sector with the capability needed to capitalise on the innovations. The Ministry has strengthened its focus on sharing innovations and information across the sector. A directorate was established during last year's organisational restructure that is dedicated to working proactively with the sector to share innovations and support implementation. A feature of the work programme this year will be to establish a Health Initiatives Clearing House to promote innovations within the sector.

To achieve this over the longer term, a clear focus on the key long-term enablers will be further developed. Considerable investment has already been made into building a strong and sustainable health sector workforce, but despite these gains there are still areas of need as the balance between workforce supply and demand shifts over time. The clinical workforce must be empowered to contribute their best to system improvement.

Long-term productivity and quality gains also depend crucially on improved flows of clinical and operational information between providers. Relevant clinical information should follow the patient wherever possible to facilitate seamless interaction along the patient care journey. DHBs must be networked with high speed connectivity and interoperability to enable the sharing of data and the benefits of telemedicine. Achieving these gains will require a long-term and centrally co-ordinated approach to investment in information and communications systems.

Summary of key priorities

Accordingly during the coming year the Minister's priorities are grouped in three key focus areas.

A: Taking public and primary health care to the next level:

1. getting ahead of the chronic disease burden (by investing in wellness and its determinants)
2. driving forward the Primary Health Care Strategy
3. investing in the early years and youth potential
4. caring for older New Zealanders.

B: Strengthening health services we can trust:

1. achieving value for money
2. actioning the agenda for quality
3. strengthening regional and national collaboration among DHBs.

C: Enabling a strong, sustainable health sector for the longer term:

1. strategically developing the health sector workforce
2. building seamless health information and communication systems
3. optimising capital infrastructure development.

Using these three areas to drive further health and independence gains has implications for the roles of Ministry, DHBs and the Minister.

For the Ministry:

- the adoption of a stronger leadership role within the sector and clear accountability for system-wide outcomes
- an enhanced strategic and analytical capability
- a model of accountability that enables it to leverage improvements in DHB performance within a devolved model.

For DHBs:

- increased collaborative activity with the Ministry, other DHBs and PHOs, including with shared services and clinical networks at regional level and participation in key initiatives co-ordinated nationally
- a focus upon working for both their local populations and for the population of the country as a whole.

For Health Ministers and the Ministry working together:

- a team-based approach with Associate Ministers of Health actively liaising with groups of DHBs and overseeing the implementation of key health strategies
- the Minister overseeing the overall integration of the health strategic framework laid out in this SOI, and leading some cross-cutting projects in areas such as workforce, IT, productivity and funding.

Nature and Scope of Functions

New Zealand's health and disability sector is largely a devolved system in which 21 DHBs plan, fund and provide health and disability services to their geographically defined populations. The Ministry funds services that have not been devolved to DHBs.

The health and disability system is broad and diverse, touching the lives of many New Zealanders in a variety of ways. For example, in 2006/07:

- 17.3 million visits were made to general practitioners and nurses in Primary Health Organisations (PHOs)
- 46.4 million prescription items were dispensed
- 23.2 million laboratory tests were performed
- 681,102 hospital discharges for medical and surgical services occurred
- 91,092 people accessed mental health services
- 418,332 cervical smears were taken
- 440,392 free influenza vaccinations were given
- 74,902 free annual checks for people with diabetes were undertaken
- 1.69 million personal care and home management hours were provided for older people
- 20,211 'green prescriptions' (advice on exercise or nutrition) were dispensed
- 5907 items of ministerial correspondence and 2696 written replies to parliamentary questions were drafted by Ministry staff.

Around 80 percent of a total \$12 billion, administered by the Ministry on behalf of the Government, is distributed to DHBs. Public hospitals and the majority of public health services come under the umbrella of DHBs. DHBs fund 82 PHOs to provide essential primary health care services to local communities. More than 200 national and local non-governmental organisations (NGOs) and voluntary organisations provide not-for-profit services funded by the Ministry and DHBs. The DHBs also fund some private providers, such as aged-care hospitals, rest homes, pharmacists, laboratories and radiology clinics.

Almost 20 percent of the total funding is used to fund services purchased nationally. The Ministry purchases services directly with this funding, including disability support services, public health services, specific screening services, mental health services, electives and national personal health services, Māori health services, and post-graduate clinical education and training.

Less than two percent of the total funding is spent on the Ministry to deliver its functions in support of the sector and government. The Ministry's core functions are:

- strategy, policy and system performance: providing policy advice to government on improving health outcomes for all, reducing inequalities and increasing participation, nationwide planning, facilitating collaboration and co-ordination within and across sectors
- monitoring and improving the performance of health Crown entities, including DHBs
- funding and purchasing of health and disability services on behalf of the Crown including maintenance of service agreements, particularly for public health, disability support services and other services that the Government has determined shall be purchased nationally

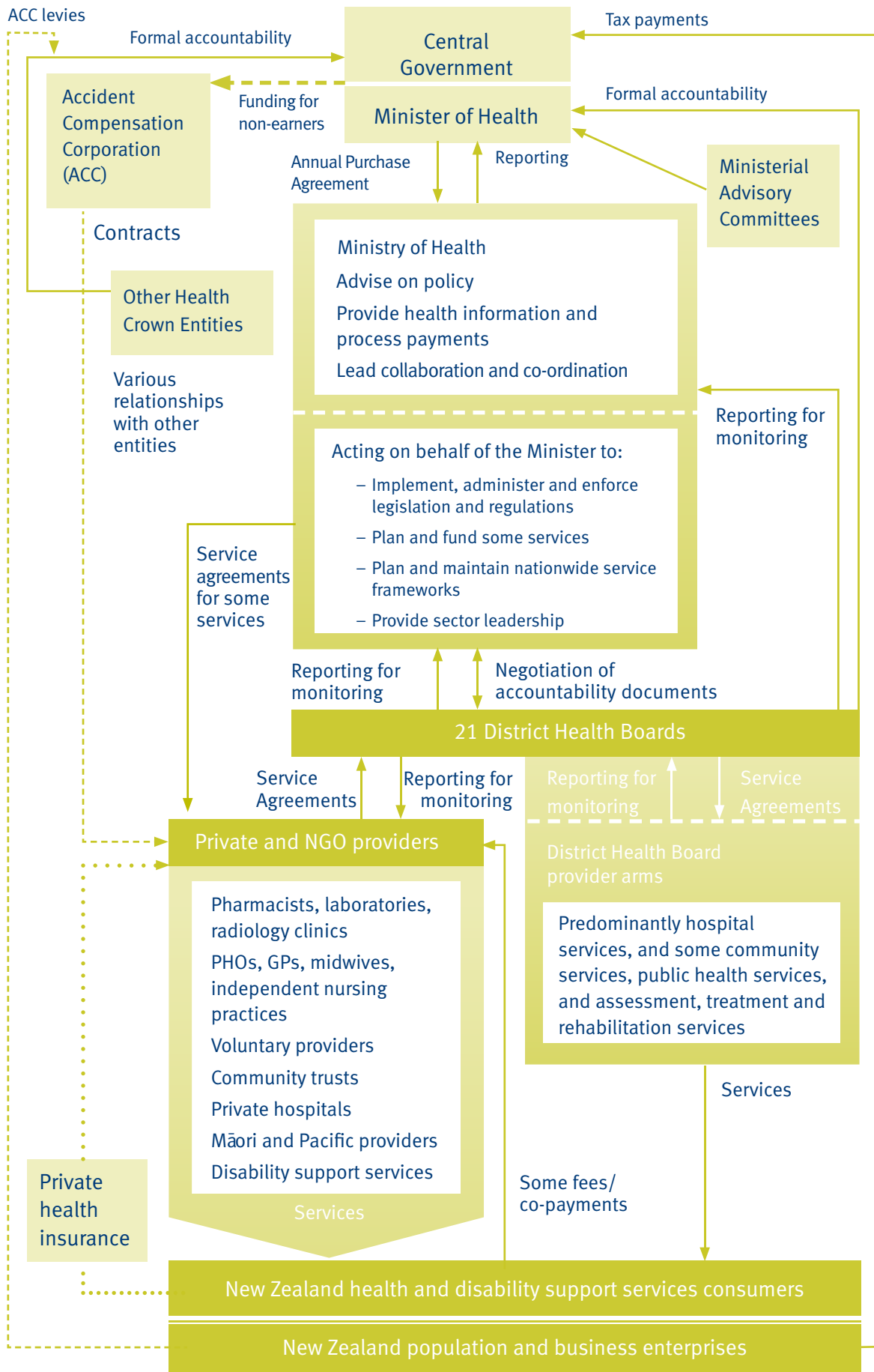
- servicing Ministers' offices and ministerial advisory committees
- payment services: administering and monitoring service agreements and payments for health benefits and service agreements
- information services: collecting and analysing health information
- administration of legislation and regulations, and meeting legislative requirements.

The Minister of Health has overall responsibility for the health and disability system. The Ministry is the principal advisor to the Government on health and disability policy. It also acts as the Minister's agent in managing the formal relationship with DHBs and as an intermediary between the Minister and representatives of the sector.

The health and disability sector primarily contributes to the Government theme 'families, young and old'. The Ministry is the lead agency for the sub-theme 'better health for all'. The overriding outcome the Ministry is working towards is 'Healthy New Zealanders'. This is the Ministry's vision. The Ministry works towards this vision by providing a wide range of functions and delivering a number of initiatives. The Minister's priorities, and three other Ministry-identified priorities, are the primary areas of focus over the medium term. This is explained further in the 'Operating Intentions' section.

The Ministry is able to influence improvement in health and disability outcomes by working closely with the wider health and disability sector, and the public sector. The diagram below shows the Ministry's relationship within the health and disability sector.

Figure 2: The structure of the New Zealand health and disability sector



Operating Intentions

The Minister gives a sharper focus to achieving outcomes over the short to medium term by identifying priority areas for the sector to apply concerted effort. The priority areas for 2008/09 are as follows.

A. Taking public and primary health care to the next level:

1. getting ahead of the chronic disease burden
2. driving forward the Primary Health Care Strategy
3. investing in the early years and youth potential
4. caring for older New Zealanders.

B. Strengthening health services we can trust:

1. achieving value for money
2. actioning the agenda for quality
3. strengthening regional and national collaboration among DHBs.

C. Enabling a strong, sustainable health sector for the longer term:

1. strategically developing the health sector workforce
2. building seamless health information and communication systems
3. optimising capital infrastructure development.

The Ministry will reflect these areas of emphasis through its work programme. The Ministry focuses its work around the Minister's priorities and in doing so also ensures that it meets three other ongoing priorities:

- improving Māori health
- reducing inequalities
- supporting health and wellbeing through nationally funded services.

The Ministry's contribution to each area of focus is described in the remainder of this section.

A. Taking public and primary health care to the next level

A1 Getting ahead of the chronic disease burden

What are we seeking to achieve?

Chronic conditions and their social determinants are a major cause of poor health and mortality in New Zealand. They are also a significant driver of inequalities in health outcomes. In particular, a higher proportion of illness and mortality among Māori, Pacific peoples, and people with low incomes is attributable to chronic conditions. The Ministry aims to contribute to a reduction in the incidence and impact of chronic conditions by:

- providing leadership and direction in policy development on the issue of chronic conditions
- supporting initiatives and programmes that address the determinants of chronic conditions, particularly for people at greater risk

- supporting the development of services that meet the needs of people with chronic conditions, particularly among those populations that experience inequalities in outcome
- fostering an environment of collaboration, innovation, and evaluation in the health sector in the area of chronic conditions.

What will we do to achieve this outcome?

Better prevention and management of chronic diseases and their social determinants at a population level, and in primary health care and community settings among groups at greatest risk, will contribute directly to reducing inequalities in outcomes. To achieve this, the Ministry needs to do a range of activities that are on a continuum from reducing risk to managing disease.

Over the medium term, the Ministry will focus on supporting and leading the development and implementation of action plans; encouraging the development of networks; and funding the development and evaluation of new initiatives. A particular focus will continue to be applied to the public health needs of Māori and Pacific peoples. New migrant populations also have specific health needs that require specific focus.

Supporting and leading action plans

National and international research shows that action plans collaboratively developed, prioritised and agreed have increased buy-in and a greater chance of achieving successful outcomes. The Ministry's work programme includes a number of initiatives focused around action plans.

- Support and monitor the delivery of newly developed DHB tobacco control plans from 2008/09. The DHB plans focus on decreasing the rate of smoking, in particular in the primary care setting. Increasing quitting will reduce smoking-related illness and deaths.
- Review and widen the scope of the existing Healthy Eating – Healthy Action (HEHA) implementation plan (Ministry of Health 2004), in response to the recent Health Select Committee Inquiry into Obesity and Type 2 Diabetes. The HEHA Strategy and its associated implementation plan aim to decrease the risk factors for a range of diseases including cancer, cardiovascular disease and diabetes (Health Committee 2007).
- Fund DHBs to develop breastfeeding action plans. The plans will reflect the population needs and identify activities to increase the breastfeeding rates in their districts. Evidence indicates that breastfeeding has short- and long-term health benefits for the infant and mother. Longer-term benefits include a reduction in some chronic diseases.
- Lead the Long-Term Conditions Programme (LTCP) to establish a 10-year pathway for a 'whole-of-system' response to long-term conditions. The LTCP, which began in 2007, aims to galvanise action for effective long-term conditions management in the health sector and intersectorally, and create suitable structures within the Ministry for working on long-term conditions.
- Continue implementation of Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015 (Minister of Health 2006).
- Continue to implement projects which support the implementation of the Cancer Control Strategy Action Plan 2005–2010 (Cancer Control Taskforce 2005).

Encouraging the development of networks

A report on innovation in the health sector, commissioned by the Ministry last year, identified the establishment of networks as an important way of assisting to create innovation and build relationships (Lomas 2008).

The Ministry's work programme includes two initiatives focused on encouraging the development of networks:

- further development of regional cancer networks
- the national HEHA network will improve leadership, communication, learning and development within the HEHA sector to support implementation of the HEHA Strategy.

Funding the development and evaluation of new initiatives

The Ministry's work programme includes two initiatives focused on funding the development and evaluation of new initiatives.

- Fund and support implementation of a mass vaccination programme for Human Papillomavirus (HPV). Cervical cancer is caused by persistent infection with HPV, which is a common sexually transmitted infection – 70 percent of women are infected in their lifetime. HPV vaccination alongside the cervical screening programme is expected to reduce the incidence of cervical cancer in the vaccinated population.
- Work with the Law Commission to review the Misuse of Drugs Act 1975 by December 2008. This review will consider the principle of harm minimisation and the most suitable model for controlling drugs, and New Zealand's international obligations under United Nations conventions. The report is expected to be considered by the Government in 2009.

Why is this outcome a priority?

Chronic diseases are a priority because they impose a significant burden on disadvantaged populations.

- Nutrition, physical activity and healthy weight play a critical role in maintaining health, reducing premature deaths and preventing chronic diseases, such as cardiovascular disease, diabetes and cancer.
- Tobacco smoking will result in the deaths of about 5000 people this year, about 1500 of whom will be in middle age.
- Diabetes affects about 200,000 people in New Zealand, but only half of these have been diagnosed. The prevalence of diabetes in the Māori and Pacific populations is more than twice as high as among other New Zealanders.
- Cardiovascular disease is the leading cause of death for New Zealanders, accounting for around 40 percent of all deaths each year. The burden of cardiovascular disease is greatest among Māori and Pacific peoples.
- Cancer is the second leading cause of death in New Zealand, accounting for 29 percent of all deaths each year. There are about 17,000 new registrations of cancer each year, with the highest rates in the middle and older age groups. There are significant inequalities in cancer outcomes for Māori and Pacific peoples, and cancer incidence is increasing.
- Nearly 47 percent of the population are predicted to meet criteria for a mental disorder at some time in their lives, 39.5 percent have already done so, and 20.7 percent have had a disorder in the past 12 months. Māori and Pacific peoples have a greater burden due to mental health problems, when adjusted for age and socioeconomic disadvantage.
- In any year, 8 percent of the New Zealand population will experience a depressive disorder. Twenty percent of the population will experience a depressive disorder at some stage in their lifetime. About 500 people die by suicide each year, and there are 5000 hospitalisations for suicide attempts. Māori, male young people and people living in deprived areas are over-represented in suicide mortality statistics.

Achieving changes in risk factor profiles such as decreasing smoking, obesity and physical inactivity requires approaches that modify the social and health environments so they support individuals to make and sustain healthy life choices. The ways in which the health and disability sector makes its services accessible, the quality of the services it provides, and how easy it is for people to traverse the care pathway, also influence health inequalities. All of these factors can be improved. There are also opportunities to minimise the impact of disability and illness.

How will we demonstrate success?

Table 1 shows how we will measure the success of the health and disability sector in, and the Ministry’s contribution to, reducing chronic disease.

Table 1: Measuring the success of the health and disability sector in, and the Ministry’s contribution to, reducing chronic disease

Level	Indicators/measures
Health and disability sector	<p>The following health sector targets:</p> <ul style="list-style-type: none"> • reduced cancer waiting times • reduced ambulatory-sensitive admissions • improved diabetes services • improved mental health services • improved nutrition • increased physical activity • reduced obesity • reduced harm caused by tobacco.
Ministry of Health’s contribution	<p>The following initiatives, delivered in accordance with agreed measures and standards:</p> <ul style="list-style-type: none"> • tobacco control • Health Eating – Health Action • implementation of Cancer Control Strategy Action Plan • Long-Term Conditions Programme • implementation of the Diabetes and Cardiovascular Disease Quality Improvement Plan • implementation of Te Kōkiri: The Mental Health and Addiction Action Plan.

How will we demonstrate cost-effectiveness?

It is estimated that smoking kills around 5000 people in New Zealand every year (including deaths due to exposure to second-hand smoke). A key area of tobacco control is supporting New Zealanders to quit smoking and therefore prevent adverse health outcomes. Quitline is a smoking cessation service the Ministry funds for this purpose. An analysis of the Quitline service gives very favourable cost-effectiveness ratios.

The value of investing in HEHA interventions is supported by a number of economic analyses. Modelling work has indicated that HEHA-type interventions could save up to 1000 lives a year by 2011 (Ministry of Health and University of Auckland 2003). Preliminary estimates suggest cost-effectiveness ratios in the order of \$3000 to \$10,000 per year of life saved, and a net health benefit of 1500–3000 deaths avoided in the first six years of intervention.

Estimates of the direct health care costs of obesity alone are in the order of \$460 million for the year 2004. Given that the Māori and Pacific populations have higher rates of obesity than the rest of the population, a small reduction in obesity rates is likely to reduce the health care costs. Value for money is a key component of the overall evaluation of HEHA, so further information regarding the cost-effectiveness of the implementation of HEHA will become available as the evaluation gets under way.

Long-term conditions are a major driver of health sector costs, within both primary and secondary care. More than 70 percent of health care funding is spent on managing long-term conditions. When combined with the burden of disease, this also has social and economic costs through loss of work, support payments, and the physical and emotional toll on families, caregivers and the community.

The Ministry's focus on supporting the sector, through initiatives such as the Long-Term Conditions Programme and Cancer Control Strategy Action Plan, will be significant in helping the system to provide care that results in a sustainable reduction in this economic burden.

Data from a New Zealand health economic analysis of HPV vaccine estimates that administration of HPV vaccine to girls at age 11, with a catch-up programme for 11–17-year-olds would result in 3584 cases of cervical cancer being avoided over 90 years, and a cost offset of \$200 million (with no changes to the National Cervical Screening Programme).

A2 Driving forward the Primary Health Care Strategy

What are we seeking to achieve?

The fiscal year 2008/09 year will be the seventh year in a 10-year implementation pathway for the Primary Health Care Strategy (Minister of Health 2001). The infrastructure to support implementation of the strategy is now in place, including the final capitation funding formulae rollout for Very Low Cost Access and under 6s. DHBs are working with their local primary health care sectors, including 82 PHOs and 94 percent of the population are covered by a PHO.

The 2008/09 year will be marked by the consolidation of the current policy and implementation settings, and a sharper focus on health gains and outcomes that are influenced by the primary care sector, using tools such as Health Targets and the PHO Performance Management Programme. This will be achieved through the review of current clinical programmes (eg, Careplus) and improving the way we work with health professional and clinical leaders to realise the full potential of the Strategy.

The Ministry's aim is to work with DHBs to strengthen the effectiveness of the primary health care sector, which will strengthen the ability of primary health care services to improve health outcomes for New Zealand's population.

What will we do to achieve this outcome?

Almost full enrolment of New Zealand's population in the PHOs provides an important platform for a focus on health gains and outcomes. As at 1 April 2008, the 82 PHOs have a combined enrolment population of 3.9 million New Zealanders.

The Ministry, consistent with the intentions of the Strategy and the current policy and implementation settings, and working with DHBs, will do the following.

- Review the key policy parameters and funding formulae underpinning the Strategy (informed by implementation experience) to ensure that the policy intentions of the Strategy are fully realised.
- Integrate existing funding streams and clinical and service programmes that are delivered in primary care settings through PHOs.

Integration will support greater flexibility for DHBs, PHOs and their providers to better co-ordinate care for their enrolled populations within agreed national service and health gain priorities and performance management programme. Integration includes:

- transforming Careplus into a long-term conditions fund
 - supporting after hours services in line with DHB acute demand management approaches in the primary health care setting
 - implementing the findings of a review of Services to Improve Access funding to better link with local and regional care programmes
 - expanding coverage of primary care-based mental health services, including services for suicide and depression management, and targeting youth health services
 - implementing a framework for the integration of complementary and alternative medicine into primary care.
- Improve access and coverage for populations who are most vulnerable but can benefit from primary care services including Māori, Pacific peoples, young people and people in low socioeconomic groups, to ensure they receive the full benefit of the Primary Health Care Strategy.
 - Invest in infrastructure and processes that support shared learning, promote the quick diffusion and spread of improvements and innovations across primary health care sector.

This includes the dissemination of the findings from the evaluations of the Strategy, support for research capacity and capability in the primary care sector and nationally agreed information standards (Key Directions).

- Improve national processes for PHO, health professional and clinical leadership groups to engage and participate in the development and implementation of the Primary Health Care Strategy.

This comprises refining the joint DHB/Ministry work programme to ensure joined up decision making at a national level, establish a new national primary health care council with mandated membership to inform and provide sector leadership on implementation. This includes membership in key groups, such as general practice, primary health care nursing, pharmacists, allied health groups and linkages with the NGO sector both locally and nationally, community and consumers. Through these forums, the primary health care sector will participate in how further implementation planning is progressed.

Why is this outcome a priority?

Primary health care, for most of the population, is the first point of contact for the prevention, diagnosis, treatment and ongoing management of many conditions that are a burden on the national health system and New Zealand society. Primary health care plays an influential role in managing acute demand, supporting access to specialist and other referred services (pharmaceuticals, laboratory and other diagnostics) that are accessed in other parts of the health system, such as hospitals.

The New Zealand health system values the role that the primary health care sector can play, in particular, in preventing chronic disease, identifying people at risk of developing long-term conditions and providing ongoing treatment, management and co-ordination of services for those groups.

The primary health care sector is an important component of improving access to services for the Government’s strategies in other health areas (eg, Cancer Control, Tobacco Control Action Plan, Health Eating – Health Action, Mental Health Strategy).

Many vulnerable groups, such as Māori, young people, Pacific peoples, and people from low-income groups, are more likely to access services in primary health care settings. These groups are over-represented as having high health needs. Despite high population enrolment overall, only 83 percent of Māori were enrolled as at 1 January 2008. Young people are over-represented in mortality and morbidity statistics and have high rates of preventable disease, suicide, unintended pregnancies, sexually transmitted diseases, injuries and mental illnesses.

How will we demonstrate success?

Table 2 shows how we will measure the success of the health and disability sector in, and the Ministry’s contribution to, improving primary health care.

Table 2: Measuring success of health and disability sector in, and the Ministry’s contribution to, improving primary health care

Level	Indicators/measures
Health and disability sector	<p>The following health sector targets:</p> <ul style="list-style-type: none"> • improved immunisation coverage • reduced ambulatory-sensitive hospital admissions • improved diabetes services • reduced harm caused by tobacco.
Ministry of Health’s contribution	<p>The Ministry will work with DHBs and PHOs, in accordance with agreed measures and standards, to:</p> <ul style="list-style-type: none"> • achieve targets in Clinical Performance Indicators in the PHO Performance Management Programme (led by DHBNZ on behalf of DHBs) • deliver the joint DHB/Ministry primary health care work programme that implements the Primary Health Care Strategy, including: <ul style="list-style-type: none"> – implementation, planning and delivery – realising the potential of the Primary Health Care Strategy – a Framework for Integrative Primary Care.

How will we demonstrate cost-effectiveness?

The final evaluation of Primary Health Care Strategy implementation will be completed in 2009, providing further evidence of outcomes, including cost-effectiveness and access.

Interim evaluation reports will inform the impact of the Strategy on the Māori and Pacific populations, and on workforce participation.

The 'Realising the potential of the Primary Health Care Strategy' initiative will include a review of funding formulae and the blend of funding and how to maximise health outcomes from PHC funding.

Integrative care has the potential to enhance the earlier detection and treatment of certain conditions, reducing the need for specialist or hospital referrals at a later stage.

The PHO Performance Management Programme (that includes clinical performance indicators) is one lever of a wider performance assessment and management system that will be developed over the 2008/09 year. It will help to align PHO performance with the health gains and outcomes sought from the primary health care sector.

A3 Investing in the early years and youth potential

What are we seeking to achieve?

Children and young people make up about a quarter of New Zealand's current population, but 100 percent of our future. Child and youth services aim to ensure that:

- children and young people receive the best possible care and support from the health and disability sector, within existing budgets
- the approach used in child and youth services recognises the developmental needs of children and young people, related to critical events and developmental processes.

What will we do to achieve this outcome?

The Ministry's focus for child and youth services over the medium term is on prevention, early intervention and improved access to health services. This will contribute to a decrease in the demand for secondary and tertiary services in the long term.

Prevention

The Ministry will help to improve prevention by providing leadership on the following initiatives.

- The development of an action plan to reduce the incidence of fetal alcohol spectrum disorder (FASD) and maternal drug use, and improve the lives of those affected by that disorder and drug use.
- The development of an immunisation strategy to provide direction for the National Immunisation Programme over the next 3 to 5 years.

The strategy will form the basis of the National Immunisation Programme's annual plans and work programme with the health sector. A key component of the strategy will be the implementation of improvements to the current arrangements for decision-making about the funding and procurement of, new vaccines. The scientific consensus is that immunisation is one of the most cost-effective means of preventing disease and improving health.

Early intervention

Early intervention is a key strategy in the provision of health care. It ensures that potential problems are identified and treated early, to lessen the likelihood and impact of long-term illness and disability where possible.

- The implementation of the recommendations from the review of the Well Child Framework will take place from 2008/09.

This will involve several initiatives, including the development of a needs assessment tool, the introduction of a screening programme, support for mothers with postnatal depression, a review of resources, and the development of a quality framework and child health indicators.

- The implementation of a comprehensive and universal health check for all four-year-olds, for which new funding has been allocated.

DHBs will roll out the B4 School Check service nationally during 2008. This service is an opportunity for health-promoting, wellness-enhancing contact between parents and a child health nurse. It provides an opportunity for parents and the nurse to identify any issues with health, development or behaviour that may affect the child's ability to learn at school. Appropriate and timely referrals can be made to support the child and their family, improve the child's health and maximise their chance of doing well at school.

Improved access

The Ministry will provide leadership in two improved access initiatives.

- A continued focus on the reorientation of child and adolescent oral health services, and funding to support a second round of oral health research projects.

The Ministry will work with DHBs to substantially upgrade community-based oral health facilities, support enhanced delivery of child and adolescent oral health services, and complete a review of the hospital dental services service specification. This initiative's impact on oral health status and outcomes will be better access to dental services, supported by better facilities and modern equipment, enhanced information and better models of care.

- The consideration of expanding comprehensive school-based health and social services that are similar to the services provided under the Achievements in Multicultural High Schools Programme in nine decile 1 schools, to other low decile schools. This will meet the needs of a larger group of high-needs youth.

Why is this outcome a priority?

Good progress has been made towards improving the health status of children in New Zealand. However, there are still disparities and New Zealand has a long way to go before it can be ranked in the top half of OECD countries. Within New Zealand there are large disparities in health status between population groups. Tamariki Māori, Pacific children and children from low-income families and whānau are experiencing comparatively poorer health outcomes than the overall child population.

Good health in childhood and adolescence is important for children and families, and is vital for good health in adulthood. A number of the risk factors for many adult diseases – such as diabetes, heart disease, and certain mental health conditions such as depression – arise in childhood. Poor child health and development also have an adverse impact on broader social outcomes, including family violence, crime and unemployment. Many of these conditions are intergenerational, in that

unrecognised and untreated, many child victims will go on to repeat the cycles of disadvantage and illness in their own lives and those of their children. The statistics below give an indication of the child and youth health landscape.

- The proportion of children fully immunised at age two years has improved from less than 60 percent in 1992 to 77.4 percent in 2005 (Ministry of Health 2007b), but there is still a long way to go. Māori are significantly less likely to be fully immunised at age two years (69 percent) than are European/other children (80.1 percent).
- Internationally, the prevalence of mental health problems with clinical impairment in children and young people has been found to be around 15 percent (Ramage et al 2005).
- The World Health Organization has identified alcohol-related harm as one of the leading causes of preventable morbidity, mortality and disability in the Western Pacific Region and the third largest risk factor in developed countries such as New Zealand. Alcohol-related harm also increases health inequalities by affecting Māori and Pacific peoples, youth and people from low socioeconomic groups more significantly than it affects other population groups.
- Unintentional injury is the cause of 36 percent of deaths in children aged under four years.
- Dental decay is slowly increasing in prevalence and severity in five-year-olds, and there are significant disparities exist between ethnic groups. In 2006, 52 percent of all five-year-olds in New Zealand were caries free, but the rates for Māori five-year-olds the rates were significantly lower at approximately 30 percent (Ministry of Health 2008).
- The 2002 New Zealand Children's Nutrition Survey (of children aged 5 to 14) found that 16 percent of five- and six-year-old boys and 22 percent of five- and six-year-old girls were overweight, and 9 percent of five- and six-year-old boys and 7 percent of five- and six-year-old girls were obese (Ministry of Health 2003).
- The declining trend in ambulatory-sensitive admissions (primary health care avoidable hospitalisations) for children aged under five is statistically significant. However, admission rates are higher for Māori and Pacific children than for other children.

How will we demonstrate success?

Table 3 shows how we will measure the success of the health and disability sector in, and the Ministry's contribution to, improving child and youth services.

Table 3: Measuring the success of the health and disability sector in, and the Ministry's contribution to, improving child and youth services

Level	Indicators/measures
Health and disability sector	<p>The following health sector targets:</p> <ul style="list-style-type: none"> • improved immunisation coverage • improved oral health • reduced ambulatory-sensitive hospital admissions • improved nutrition • increased physical activity • reduced obesity • reduced harm caused by tobacco • improved mental health.
Ministry of Health	<p>The Ministry, in accordance with agreed measures and standards, will deliver:</p> <ul style="list-style-type: none"> • the National Alcohol Action Plan and FASD Action Plan • Good Oral Health For All, For Life • the Well Child Review recommendations • the Maternity Services Strategic Plan • the National Immunisation Programme.

How will we demonstrate cost-effectiveness?

Investment in child and youth health, with a focus on prevention, early intervention and improved access to health services, aims to decrease the demand for secondary and tertiary services in the long run.

Immunisations can be cost-effective and successful preventive health interventions. It is an important component of Well Child and adult preventive health services, and a key aspect of the Ministry's contribution to child and youth services.

- International evidence suggests significant financial costs are associated with foetal alcohol spectrum disorder. Preventing the incidence, and reducing the burden of, foetal alcohol spectrum disorder will reduce the costs of health, education, justice and social services.
- Implementation of the Well Child Review recommendations will improve the funding formulae, to maximise cost-effectiveness and health outcomes from Well Child Services.
- An economic analysis of postnatal depression screening, commissioned by the Ministry, has shown this screening to be highly cost effective.
- The oral health reorientation process has included financial and productivity benchmarking to help achieve cost-effectiveness. Investing in the service's infrastructure and into new models of care is critical to ensuring appropriate facilities, ongoing service delivery and improved oral health outcomes.

A4 Caring for older New Zealanders

What are we seeking to achieve?

The Ministry is seeking to improve the quality of life and increase the participation and independence of older people, today and in the future, by providing services that are affordable, targeted, integrated and responsive to the needs and preferences of older people.

What will we do to achieve this outcome?

In line with the Minister's priorities, and the Government's commitment to both the Positive Ageing Strategy (Minister for Senior Citizens 2001) and the Health of Older People Strategy, (Associate Minister of Health and Minister for Disability Issues 2002) the Ministry has a multi-year work programme focused on improving services targeted at older people by:

- supporting the stability of services (eg, ongoing access to safe and reliable services)
- facilitating improvements in the quality of services (eg, improvements to existing services that allow purchasers to require higher service standards, such as training)
- encouraging the service development (incentives to restructure services and change policy settings to better meet future needs, such as improving integration for users and rebalancing services towards home and community services)
- achieving sustainability (mechanisms capable of responding to growth in demand from population growth and to meet the Health of Older People Strategy objectives, such as increased use of technology).

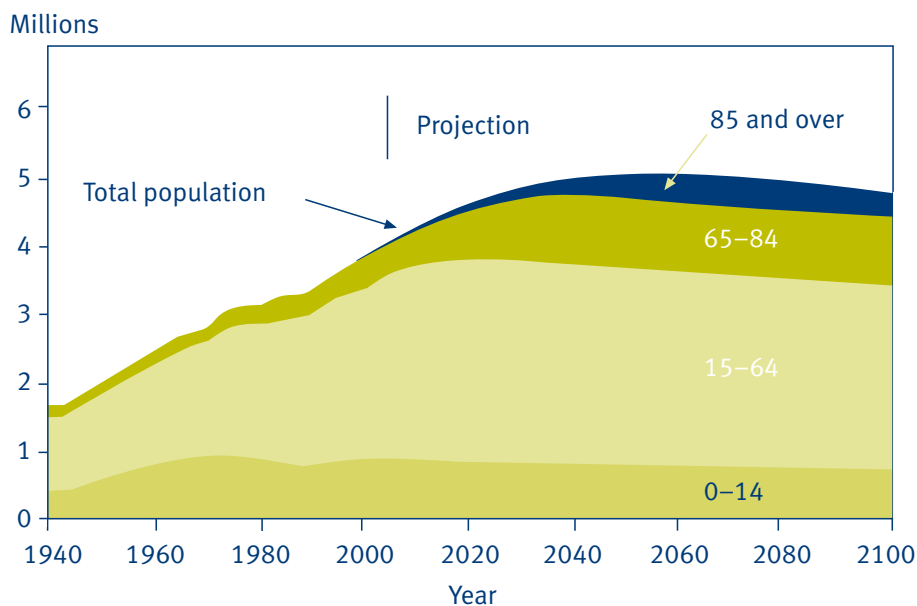
In recent years the focus has been on supporting stability in the sector, particularly the workforce in the home based sector. In 2008/09 the Ministry will be working with DHBs on new service development including assessment services and improving the clarity of service coverage requirements for DHBs.

Why is this outcome a priority?

New Zealand's population is ageing. By 2020 the population's age distribution will have a significantly larger proportion of older people including a significant number over the age of 85. This part of the population is projected to continue to relatively increase until 2040. New Zealand's life expectancy compares well internationally, but independent life expectancy is about 13 years less than life expectancy.

According to the 2006 Census of Population and Dwellings, the proportion of the Māori population aged 65 years and over has increased from 3.4 percent in 2001 to 4.1 percent in 2006. The priority placed on this work programme acknowledges the importance of the health needs of this part of the population today and in the future.

Figure 3: New Zealand population, by age group, 1940–2100 (projected)



Source: The Treasury 2006

How will we demonstrate success?

Table 4 shows how we will measure the success of the health and disability sector in, and the Ministry’s contribution to, caring for older New Zealanders.

Table 4: Success of health and disability sector in, and the Ministry’s contribution to, caring for older New Zealanders

Level	Indicators/measures
Health and disability sector	<p>The following health sector target:</p> <ul style="list-style-type: none"> • proportion of people in subsidised aged residential care* • percentage of people aged 85 years and over living in private dwellings.†
Ministry of Health	<p>The Ministry, in accordance with agreed measures and standards, will:</p> <ul style="list-style-type: none"> • finalise proposed health of older people service cover requirements • advise on Health of Older People Strategy developments in the areas of new services in the community, assessment, information collection and workforce.

* Recorded in five year age groups, starting from age 65.

† This is measured five-yearly as part of the census.

How will we demonstrate cost-effectiveness?

An objective of the overall programme of work is to contain future cost pressures arising from an increasing ageing population. The Ministry aims to do this through early intervention and introducing programmes that not only improve older people's quality of life, by allowing them to remain at home longer, but are less costly than residential and hospital care alternatives.

B. Strengthening health services we can trust

B1 Achieving value for money

What are we seeking to achieve?

Well-performing, cost-effective health systems like New Zealand's constantly seek out and exploit opportunities to improve further. Demonstrating value for money and ongoing improvement in overall system performance will remain important to governments in future decades as a means to manage demand for, and justify levels of expenditure on, health care services.

What will we do to achieve this outcome?

The Ministry is undertaking a range of work to achieve better value for money in health and disability expenditure. The Ministry wants to improve its capacity and capability to undertake and interpret economic analysis.

Phase two of an initiative to rationalise accountability arrangements for DHBs will be implemented. These arrangements for DHBs will provide a more streamlined and simplified accountability process. This is an extension of the Ministry's core work of providing DHB and Crown entity ownership advice, which includes the following work with DHBs and other entities to ensure value for money and performance is demonstrated.

- A range of mechanisms for monitoring, including assessment of indicators of DHB performance, health targets, and regular progress reports.
- Two service reviews will be undertaken with DHBs in 2008/09. These reviews will involve the Ministry working closely with individual DHBs to identify opportunity for service and systems improvements. Savings and/or service enhancements in DHBs will improve the quality and quantity of service provided by DHBs.
- Advice provided to assist DHBs to carry out their functions. In 2008/09 funding advice will include review of the Population Based Funding Formula to ensure it can best enable DHBs to fund services to improve outcomes.
- The Diabetes and Cardiovascular Disease Quality Improvement Plan: a three-year initiative aimed at reducing the impact and incidence of diabetes and cardiovascular disease by establishing a nationally consistent framework and recommended priorities, for continuous quality improvement of clinical services.

The Ministry will continue its focus on improving systems, in the coming year.

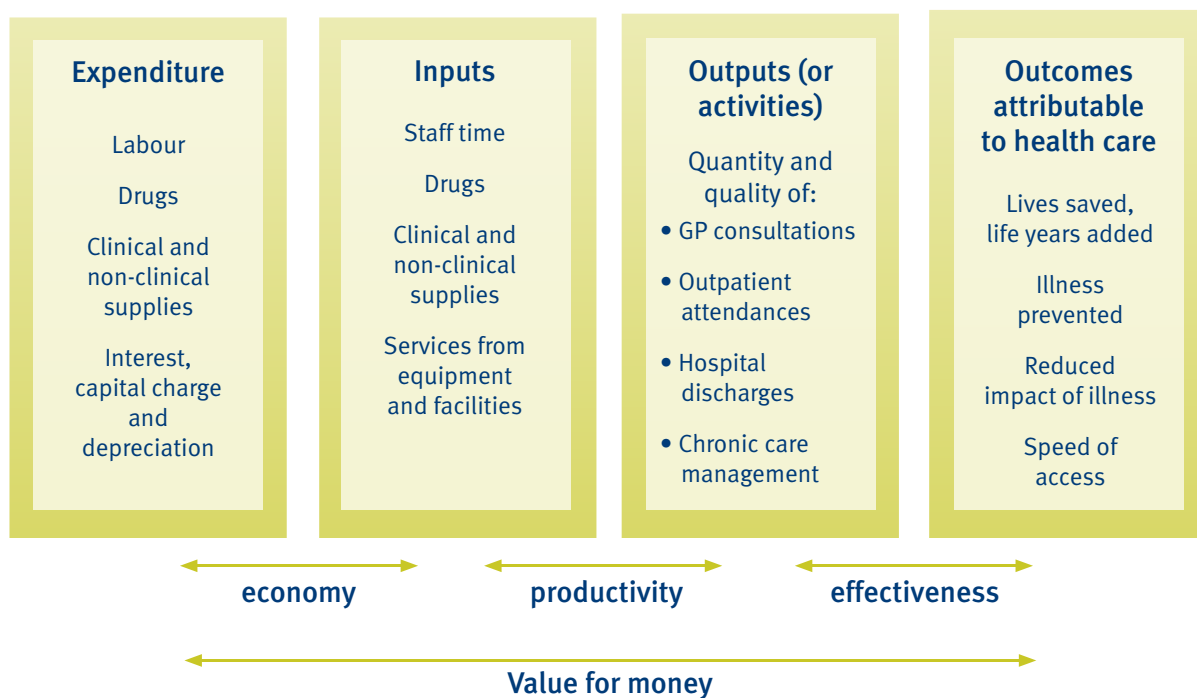
- Service Planning and New Health Interventions Assessment (SPNIA) will be strengthened, with dedicated expertise deployed to support the service change decision-making and implementation of decisions. SPNIA is a framework intended to help DHBs and the Ministry with health service changes that require a collective decision.

- Updating the 2003 Health Capital Investment Guidelines, including extending the principles of this policy to the Ministry.
- Joint work with The Treasury will look at the appropriateness of Vote Health funding.

Why is this outcome a priority?

Government expenditure on health continues to increase as a proportion of total government expenditure. The risks of poorly informed health and disability investment decisions are poor health outcomes and higher costs. It is therefore in the interests of all New Zealanders that the potential of these investments is realised through well-informed decisions and resource allocations. Figure 4 illustrates the many opportunities in the health system to improve value for money and reduce wastage.

Figure 4: Value for money – the relationship between expenditure, inputs, outputs and outcomes



Source: The Treasury

How will we demonstrate success?

Table 5 shows how we will measure the success of the health and disability sector in, and the Ministry's contribution to, achieving value for money.

Table 5: Measuring the success of the health and disability sector in, and the Ministry's contribution to, achieving value for money

Level	Indicators/measures
Health and disability sector	<p>The following headline indicators:</p> <ul style="list-style-type: none"> • day-case procedures • older people living independently • productivity of public health services • efficiency of primary health care.
Ministry of Health	<p>The Ministry will:</p> <ul style="list-style-type: none"> • ensure plans are in place to meet previously agreed targets for Ministry expenditure • deliver, in accordance with agreed measures and standards: <ul style="list-style-type: none"> – DHB and Crown Entity ownership advice – DHB and Crown Entity performance – improving prioritisation of additional funding made available to Vote Health – Service Planning and New Health Interventions Assessment (SPINIA) strengthened – improved asset management planning locally, regionally and nationally – planning, service development, purchase management, performance management and evaluation of services directly purchased by Ministry – National Quality Improvement Programme.

How will we demonstrate cost-effectiveness?

By working closely with DHBs to establish and lead a single agreed process, instead of separate processes for each entity, the Ministry is able to increase efficiency and effectiveness, and reduce costs. For instance, without a nationally co-ordinated process, each DHB would have to negotiate with every other DHB on interdistrict flow pricing and volumes, definitions for purchase units, service specifications, and so on.

Effective and efficient accountability and reporting arrangements for DHBs reduce the costs to the health system by minimising the risks arising from poor quality and ineffective mechanisms. Improved quality and quantity, and service improvements, leads to the same services being delivered for less cost, or increased service provision for the same cost.

Strengthening the Service Planning and New Health Interventions Framework will improve the quality and equity of investment and divestment decisions in Health, and reduce the current wasteful duplication of decision processes. The better value for money will take the form of improved population health and reduced inequalities.

The framework covers regional and national collaborative decision-making in two related areas.

- New health interventions (including a method of delivering an existing treatment).
- Service reconfiguration (including the introduction of a new service, cessation of a service, service expansion, quality change or change of providers).

Therefore, it has a powerful influence on improving value for money in health investment/divestment decisions.

Cost effective capital investment decisions require good information on current and future health service need and information on the gaps between that health service need and the current asset base. Improved asset management planning and a national asset management plan informed by a sector-wide view of service priorities will improve cost effectiveness.

B2 Actioning the agenda for quality

What are we seeking to achieve?

A modern health and disability system puts people at its heart and uses all the levers available to ensure higher-quality care is provided. Our health and disability system must support continuous quality improvement by each individual who works in our system, those responsible for the organisational environments within which our health professionals work and for the systems as a whole.

Quality is the cumulative result of the interactions of people, individuals, teams, organisations and systems. Its improvement includes continuous quality improvement and quality assurance activities. While both are important, there is growing international evidence indicating that focusing on quality improvement leads to better outcomes than a focus on quality assurance activities alone.

The health and disability sector has already undertaken many activities that have improved quality and patient safety at multiple levels. This includes but is not limited to:

- accreditation of many health and disability support service providers by a range of accreditation agencies
- credentialling, continuous education and training to maintain professional standards for all health and clinical professional groups
- celebrating those innovative improvements that have contributed to quality and safety improvement.

For many health and disability services, meeting these standards of quality assurance and improvement is a requirement of contract and/or ongoing funding.

Despite quality improvement progressing at some levels of the health and disability system, more needs to be done to support an environment for learning and continuous improvement across the whole health and disability system.

The Quality Improvement Committee, in recognition of this, has developed a new model that will be used in the implementation of four national quality improvement programmes. This new model has the support of the Ministry and will require DHBs to lead the projects within the four national quality improvement programmes. A measure of success of this new way of implementing improvements across the system will be the ability of DHBs to strongly co-ordinate the actions and

changes and learn from each other. Another measure of success will be gaining the co-operation of related agencies (eg, ACC, Health and Disability Commissioner, Coroners) to progress the following initiatives:

- establish national collaboratives that implement effective processes that optimises the flow of patients and improves their journey through the health system
- progress the establishment of a national incident management system that continues the annual reporting of serious and sentinel events and ensures that all providers learn what changes are needed to prevent future errors
- implement programmes that reduce the rate of infections that are acquired in hospital starting with the adoption of the WHO Guidelines on hand hygiene
- implement strategies that reduce the rate of errors in medication management
- establish a national perioperative mortality review committee, increase local mortality review and systematic analysis of deaths in New Zealand to support system learning.

The Quality Improvement Committee is preparing advice to resource co-ordinated consumer endeavours within the New Zealand health and disability sector to strengthen consumer voice by building capacity and improving consumer participation. There is an increasing body of evidence that indicates health outcome benefits through consumer participation. This requires consumers being actively involved in decision making about health and disability services at every level including governance, planning, policy development, setting priorities, and highlighting quality issues in the delivery of health services. It is anticipated that this project will commence early in 2009.

The Ministry will lead implementation with the health and disability sector on the Quality Improvement Plan for Cardiovascular Disease and Diabetes, support quality framework implementation in the primary health care sector (including the PHO Performance Management Programme); updating information for the maintenance of management of clinical competency for all practitioners and other programmes with a view to:

- system-wide learning on innovations and improvements that contribute to quality improvement
- increasing the safety of patients through the defining of individual practitioners scope of practice in a given setting
- plan for the actions required by the sector to maximise patient safety and care delivery in health and disability service and to meet the Minister's obligations in Part 2, Section 9, of the New Zealand Public Health and Disability Act 2000
- improve the regulatory regime to enforce the use of standards as a mechanism to require a reasonable standard of service delivery that supports continuous quality improvement
- working collaboratively with other agencies, celebration and promotion of proven innovations in the New Zealand health and disability system through the Health Innovation Awards and Summit.

Why is this outcome a priority?

The context for the current policy settings on quality in the New Zealand health system is set by government policy as articulated in the New Zealand Health Strategy, the New Zealand Disability Strategy and 'Improving Quality: A Systems Approach for the New Zealand Health and Disability Sector 2003'. Within a devolved health and disability system, the need for national consistency and shared system wide learning requires leadership from the centre as well as within locally provided services.

Consistent with other themes discussed earlier in this document, 2008/09 is an important year for creating an increased and visible emphasis on quality projects and programmes that contribute to improvements, quality assurance of safety for patients across the whole health and disability system. Internationally, health systems have already made significant progress in the development of their own quality agendas – New Zealand can learn from these experiences to fast track our own development.

How will we demonstrate success?

Table 6 shows how we will measure the success of the health and disability sector in, and the Ministry’s contribution to, actioning the agenda for quality.

Table 6: Measuring success of the health and disability sector in, and contribution of the Ministry to, actioning the agenda for quality

Level	Indicators/measures
Health and disability sector	The national Quality Improvement Committee is working with the sector to develop indicators that will provide measures against which quality of the health and disability system may be assessed.
Ministry of Health	The Ministry, in accordance with agreed measures and standards, will deliver: <ul style="list-style-type: none"> • Cardiovascular Disease and Diabetes Quality Improvement Plan • PHO Performance Management Programme Indicators • implementation of activities to support QIC projects against agreed indicators.

How will we demonstrate cost-effectiveness?

A particular emphasis needs to be placed on improving quality and safety because of the impact this has on ensuring the public has trust and confidence in the system, and on the achievement of satisfactory outcomes. Patient safety in New Zealand compares well with wealthier countries from the OECD. It is the job of the sector, the Ministry and DHBs to further build on these gains. The sector is getting better at measuring quality and benchmarking against proven standards to reduce inappropriate variation, but there is room for further improvement.

The QIC is one of the vehicles for promoting an increased emphasis on quality over coming years, and the Ministry has an important role in supporting implementation of its national improvement programme. This includes safe medication management, management of health care incidents, infection prevention and control, optimising the patient’s journey, and the introduction of a national mortality review system. Each project will be led by a DHB and will report regularly to the QIC.

B3 Strengthening regional and national collaboration among DHBs

What are we seeking to achieve?

The New Zealand Health and Disability Act 2000 set up a semi-devolved system of delivering health services in New Zealand. While local representation is a core feature of this model, DHBs are accountable to the Minister of Health and must respond to national priorities. National co-ordination of services between DHBs is essential in areas of national priority. For example national priorities in quality improvement, workforce development, and information services – because they are pervasive and sector-wide – will be most effectively implemented if they have strong national co-ordination.

We are seeking an increased focus on collaboration and co-operation between DHBs. Collaborative and co-operative activities are important tools for realising the strengths of the DHB model. While progress has been made in this area there is more that can and should be done and the Ministry intends to take a stronger role in leading inter-DHB collaboration. For example, regional clinical networks are supported by evidence as a good way to improve safety and ensure that best practice is adopted yet their development in New Zealand to date has been patchy.

The Ministry's stronger role in coordinating inter-DHB collaboration will be facilitated by the Long-Term System Framework (LTSF) developed in 2007/08. The LTSF seeks to enhance sector sustainability and improve health system performance. The LTSF action plan sets out a range of measures to improve co-ordination of service planning and delivery.

Why is this outcome a priority?

While part of a vision of the New Zealand Public Health and Disability Act 2000 and the New Zealand Health Strategy, collaboration and co-operation between DHBs are not always progressing as rapidly and consistently as the Government would desire. The system is at the point where it is not only possible, but essential to enhance collaborative and co-operative activity to ensure the delivery of sustainable and safe services. The need to make collaborative and co-operative activities a priority has been illustrated through recent events in the health system where patient safety has been called into question.

How will we demonstrate success?

Table 7 shows how we will measure the success of the health and disability sector in, and the Ministry's contribution to, strengthening regional and national collaboration among DHBs.

Table 7: Measuring success of health and disability sector in, and the contribution of the Ministry to, strengthening regional and national collaboration among DHBs

Level	Indicators/measures
Health and disability sector	<p>DHBs will build on the Long-Term System Framework, existing collaborative activities and evidence by:</p> <ul style="list-style-type: none"> • moving to the co-ordinated delivery of stroke services • identifying how a co-ordinated approach can be adopted for specialist services that risk becoming unsustainable • co-ordinated asset management planning via the National Asset Management Planning improvement programme and Regional Capital Committees.
Ministry of Health	<p>The Ministry will, in accordance with agreed measures and standards:</p> <ul style="list-style-type: none"> • report on the steps required to develop clinical networks in New Zealand • work with DHBs to ensure collaboration over services for people with disabling chronic health conditions • develop pragmatic steps to improve the implementation of proposed new services and to streamline the SPNIA process • in collaboration with DHBs, support development of regional asset management plans and a national asset management plan • encourage health sector agencies to contribute to the funding of the shared Identity Verification Service (IVS).

How will we demonstrate cost-effectiveness?

Cost-effectiveness is one of the reasons for enhancing collaborative and co-operative activity across the system. This will be demonstrated by the provision of safe and sustainable services, in a way that maximises the expertise and organisational resources available.

C. Enabling a strong, sustainable health sector for the longer term

C1 Strategically developing the health sector workforce

What are we seeking to achieve?

Workforce issues impact on all of the Minister’s priority areas. The Ministry is leading the sector in the creation of an environment where innovation is able to prosper, resulting in increased recruitment and improved retention of an appropriate health workforce.

What will we do to achieve these outcomes?

The role of the Ministry in workforce development is to ensure that the policy and regulatory environments support the Government's strategic objectives, and to provide leadership and support to the sector.

The Ministry will in 2008/09 be undertaking a number of linked initiatives that move towards a system-wide infrastructure to support workforce activity at the national, regional and local levels. Increasing the number of workers in the health and disability sector will ensure we can provide future services.

- **Development of the Career Framework (Ministry of Health and DHBNZ Workforce Group 2007).**
The Career Framework is a medium to long term project to help with the recruitment and retention of the health and disability workforce in New Zealand. The framework for the health sector was launched in October 2007. Work will continue into 2008/09 to develop the framework to include the disability sector. It is intended that the framework will help the disability support workforce and the provision of support services for disabled people by better understanding the current workforce, acknowledging what people currently do, giving workers more status, analysing gaps in the disability workforce, and predicting and planning for the future.
- **Initiate phase two of the Barriers to Workforce Innovation project.**
The Ministry will this year initiate phase two of the Barriers to Workforce Innovation project. This will involve consulting stakeholders to identify those barriers that are most material and most amenable to central government solutions. The project will have an impact on many health outcomes by enabling service providers to better use workforces to deliver services that meet people's needs. As 70 percent of health expenditure is on workforce, better, more flexible and more efficient service delivery will mean higher returns.
- **Development of the Maternity Services Strategic Plan.**
Leadership and support on workforce planning and development will include development of a Maternity Services Strategic Plan to provide better co-ordinated and integrated maternity services. This will support improved health outcomes for women and their children and more streamlined linkages in the continuum of care.

The Ministry's core operating functions also support workforce development. Administration of funding and purchasing of health and disability services is focusing on service development for targeted groups, such as home-based support service workers and needs assessment and service co-ordination, mental health workforce development and clinical training services.

Why is this outcome a priority?

The health workforce is the sector's largest resource. It accounts for approximately 70 percent of public health expenditure. The ageing of the population will have a significant impact on the health labour force – not only on demand but also critically on supply. Although New Zealand has always had a significant migrant-derived workforce, the international shortage in skilled health workers is a concern, both currently and over the long term. With fewer workers available, health delivery will need to become less labour intensive through changing work practices, supporting individual care, and the use of technology. We need a different health workforce capable of working in new ways to meet increased demands.

How will we demonstrate success?

Health is a labour-intensive industry. Achieving the health targets is critically dependent on the quality and distribution of the health workforce, which will be influenced by the Ministry's key interventions.

Table 8 shows how we will measure the Ministry's contribution to improving the workforce infrastructure.

Table 8: Measuring the Ministry's contribution to improving infrastructure (workforce)

Level	Indicators/measures
Ministry of Health	The Ministry, in accordance with agreed measures and standards, will: <ul style="list-style-type: none">• lead and support workforce planning and development• review the Health Practitioners Competence Assurance Act 2003.

How will we demonstrate cost-effectiveness?

The investment in leadership and support on workforce planning and development is designed to support a better strategic alignment of services and increased co-ordination and communication among maternity care services. Taking a joint approach reduces duplication and improves the likelihood of improved efficiencies being achieved.

Good workforce planning and an approach that allows for more innovative and flexible deployment of the workforce will result in the more cost-effective delivery of services.

C2 Building seamless health information and communication systems

What are we seeking to achieve?

Health information is a key input into the provision and administration of effective health services and the development of policies and strategies to improve health outcomes. Improved information systems are integral to supporting this to happen, by:

- supporting better decision-making and service delivery
- a more patient-centric approach to health information management
- providing faster dissemination of best practice through well-developed information systems
- reducing costs associated with poor decision-making.

The vision for the future for ICT in the health system is one of networks, connectivity and sharing of information for community health care. This requires an environment where every health provider is connected through a cohesive sector networking capability. High speed, high capacity broadband is a foundation for this improved connectivity and is fundamental to enabling dependable electronic co-ordination of care between all health care providers and improved efficiency and effectiveness of health care delivery throughout the health system.

What will we do to achieve these outcomes?

To achieve these improvements in connectivity, the Ministry will work with other government agencies on joint initiatives to drive increased utilisation of existing networks and will support

demand aggregation across the state sector to accelerate the deployment of high-speed broadband. The Ministry will support the Digital Strategy's Common Framework for broadband and build on these principles to establish standards around linking networks and health data transfer. The objective is to establish a national 'virtual network backbone' of interlinked networks and link these to local broadband fibre access capability. These local access networks then provide an aggregation point for multiple local health providers to access high speed broadband services. This provides the opportunity to support increased collaboration and the potential for wider access to health applications.

The Ministry will develop and promote policies to leverage this improved connectivity and move the focus to patient centric, collaborative clinical systems. The objectives of these changes will be to enable:

- improved linkages between primary and secondary care
- consistent clinical and non-clinical processes supported by availability of consistent data content
- effective information sharing, cross-referencing and interaction in a standardised and consistent way across different parts of the health system
- easier implementation of new health initiatives and programmes because they will be built on a foundation of nationally accessible consistent data
- better value for money through better utilisation of telecommunications investments, shared use of applications and databases and easier integration of diverse applications.

The Ministry maintains a large and varied programme of work towards achieving these outcomes. This includes a mixture of ongoing support to the health and disability sector infrastructure, implementation of programmes over a limited time, and advice to the Minister and sector.

National Services Development Programme (NSDP)

2008/09 will be the third year of the NSDP's four-year initiative to deliver improved and sustainable national payment, information and connectivity systems that interact more efficiently in the health and disability sector. The Programme seeks to consolidate, rationalise and optimise a range of core payment, information and connectivity systems. Areas of focus for this year include the following.

- The Connected Health Programme will continue to address issues within the health and disability sector by delivering a set of national reference standards, linking infrastructure (including a health directory search engine), procurement framework and governance and management structure.
- The Access and Integration Workstream will deploy the strategic secure portal infrastructure which will support the improved financial reporting project.
- The Health Statistics and Reporting Workstream will complete the pilot implementation of a new online health information framework that will provide consumers with improved access to health information.
- The Recipient and Provider Identity Services Workstream will provide a single unique identifier for each recipient, provider, facility, organisation and address, which will be used throughout the health and disability sector. This will contribute to improved electronic information sharing and collaboration.
- The Health Payments Systems Workstream will deliver improved health-related information and supporting infrastructure, and reduce constraints on information availability and quality. Better quality and more accessible data will help planners and funders to allocate funds to the most valuable areas.

Health payments and agreements

Payments are made to the sector for a wide variety of claim types and agreements are produced under a national framework, which are used by funders across the sector to contract services. In 2008/09, a National Contact Centre will be provided for the health sector for national health information and payments services. A comprehensive programme of audits and investigations will also be undertaken, to safeguard specified areas of funding to health service providers.

Health information policy

In 2008/09 the Ministry will provide the Minister with an analysis of the value of a Health Information Act, to provide clarity in the law of the roles, rights and responsibilities of the various parties and stakeholders in health information.

Information services to the Ministry and sector

New areas of focus for information services to be provided in 2008/09 include:

- review of the Ministry's formal statistical publications programme for usefulness and value for money
- review of the Memorandum of Understanding with DHBs and any necessary improvements to the model used in the sector to govern health information systems will be implemented
- implementation of a governance framework for the sector-facing Ministry IT to define, capture and measure the value of the electronic services provided to the sector by the Ministry
- establishment of a Terminology and Classification Centre to co-ordinate the activities necessary to promote emerging electronic health information, terminologies and standards (eg, input into New Zealand's adoption of SNOMED CT as the clinical terminology which will enable semantic interoperability in New Zealand)
- implementation of the plan for NGOs to report to national mental health information system (PRIMHD).

All DHB provider arms will be reporting to the national system from end of July 2008, after which the NGO reporting implementation plan will be implemented. Planning for Phase 3 NGO reporting will also be completed, to enable implementation in 2009/10.

Why is this outcome a priority?

Knowledge underpins improvements in the health system. It is essential that decision-makers (increasingly individuals and community bodies) have access to relevant and timely information to ensure their choices are well informed. Stable, accessible and well developed information systems are a pre requisite for the faster dissemination of best practice information.

Improvements in the collection use and management of health information for servicing of Ministers and Ministerial committees is one of the keys to ensuring that the health system is well placed to keep delivering quality services to support the achievement of health outcomes for New Zealanders. In particular the role of information is well recognised as critical to support the management of chronic conditions at affordable levels.

How will we demonstrate success?

Table 9 shows how we will measure the Ministry's contribution to improving information systems infrastructure.

Table 9: Measuring the Ministry’s contribution to improving infrastructure (information systems)

Level	Indicators/measures
Ministry of Health	<p>The Ministry, in accordance with agreed measures and standards, will deliver:</p> <ul style="list-style-type: none"> • National Systems Development Programme • information services to the Ministry and sector • health information policy • health payments and agreements.

How will we demonstrate cost-effectiveness?

The National Systems Development Programme will demonstrate cost-effectiveness in the following ways:

- The Connected Health Programme will improve the cost-effectiveness of health care delivery by enabling easier and more efficient information sharing and clinical collaboration.
- The Access and Integration Workstream will contribute to the Ministry’s cost-effectiveness by improving the effectiveness of infrastructure, applications and processes. It will improve the health sector’s ability to access key national systems, which will result in efficiency and accuracy gains.
- The sector’s access to information is inefficient and costly. The Health Statistics and Reporting Programme will enhance internal and sector productivity, freeing up resources and enhancing the cost efficiency of information accessed.
- The Recipient and Provider Identity Services Workstream will return long-term benefits to the sector that arise from staff needing less time to access and use identity data. This workstream will also reduce the risk of an unplanned and lengthy National Health Index systems outage.
- The Health Payments Systems Workstream investment will deliver substantial cost improvements for the sector and the Ministry by reducing current administration and compliance costs. Revitalised systems will enhance the prevention of fraud and over/under payments. Investment decisions will be presented with a supporting return on investment analysis to ensure public funds are best utilised.

Improvements in the national health information collections will enable the Ministry, DHBs and other organisations to undertake more accurate and timely, administration processes. A feasibility study conducted in 2005 found that it was more cost effective for service providers to report one integrated data set than continue to collect and report two.

Audit and investigation risk management of payment services will ensure money is used for its intended purpose. Using internationally accepted calculations, the effects of audit and investigation programmes have stopped, deterred and recovered funds at a level greater than the cost of operating the programmes, in every year of operation so far.

The ongoing provision of health information for developing policy will identify opportunities to improve the value of health information to support improvements in the provision and administration of health services and the management of the health system.

C3 Optimising capital infrastructure development

What are we seeking to achieve?

Modern health care systems require capital investment which enables the system to operate safely and effectively and support new models of care. Following a period of under-investment in capital, there has been \$2 billion of major capital investment since 1998 to maintain and enhance the capital infrastructure of DHBs. However, the sector faces ongoing capital pressures in the Auckland region in particular. The Ministry needs to ensure cost-effective and safe provision of health and disability services through the alignment of capital investment with national, regional, and local service priorities and new models of care.

What will we do to achieve this outcome?

To achieve greater cost-effectiveness and safe service provision through capital investment and service planning alignment, the Ministry will further strengthen current prioritisation processes and the link between service planning and capital investment. This will include updating the 2003 Capital Investment Guidelines, including extending the principles of this policy to the Ministry, strengthening the Service Planning and New Health Interventions Assessment framework, supporting improved DHB asset management practices via the National Asset Management Improvement Program, updating the National Capital Plan, supporting development of regional asset management plans, continuing work on the Long Term Systems Framework, and implementing wider government capital management processes.

The potential for capital investment policy to improve primary health care services will also be investigated. The Ministry will also continue to collaborate with the Australian states on areas where joint activity is the most cost effective way to fund large and complex on-going activities, for example keeping current the Australasian Health Facility Guidelines. This is undertaken by the Centre for Health Assets Australasia at the University of New South Wales. The Ministry will continue to support the sanitary works subsidy scheme and progress implementation of re-oriented child and adolescent oral health services.

Why is this outcome a priority?

Demographic growth is increasing beyond the current physical capacity of some health facilities, particularly in the Auckland region. Additionally, changing demographic profiles, for example, ageing populations, and new models of care require the constant reassessment of capital needs and the ability of assets to support modern models of care. For example, development of community oral health services and team-based care mean that larger facilities, new locations and greater mobility are required for our oral health assets. Improved asset management planning and a national asset management plan, informed by a sector-wide view of service priorities, will further improve the ability of the health asset base to support quality and safe services.

As well as major building programmes, investing in improving IT infrastructure, data collection capability, and information on current and future asset bases are all necessary to support improved service planning, development of new models of care and sound decision-making.

Changes to the Building Act in 2004 have also placed pressure on health's capital investment. These changes have caused several existing facilities to be classified as non-compliant earthquake-prone buildings resulting in the need to hasten replacement of some buildings if they do not meet current service needs rather than simply upgrading them.

How will we demonstrate success?

Table 10: Measuring our progress in achieving cost-effective and safe capital investment

Level	Indicators/measures
Health and disability sector	<ul style="list-style-type: none"> • Collaborative input via the National Capital Committee (NCC) and national asset management improvement program into strengthening capital investment decision-making that supports with national, regional, and local service needs. • Successful development and implementation of approved business cases. • Well informed DHB and regional asset management plans.
Ministry of Health	<p>The following initiatives delivered in accordance with agreed measures and standards:</p> <ul style="list-style-type: none"> • update of the 2003 Assets and capital strategic framework (Capital Investment Guidelines) including extending the principles of this policy to the Ministry of Health • joint leadership (with DHBs) of the National Asset Management Improvement Programme • Service Planning and New Health Interventions Assessment strengthened • development of National Capital Plan • capital investment informed by service planning models as developed in the Long-Term Systems Framework and DHB and regional health service plans that are required for major capital approvals • development of a Long-Term Capital Profile • effective implementation of Treasury’s Capital and Asset Management initiative • collaboration with Australian states to keep current the Australasian Health Facility Guidelines facilitated by the University of New South Wales • support sanitary works subsidy scheme • progress implementation of re-oriented child and adolescent oral health services.

How will we demonstrate cost-effectiveness?

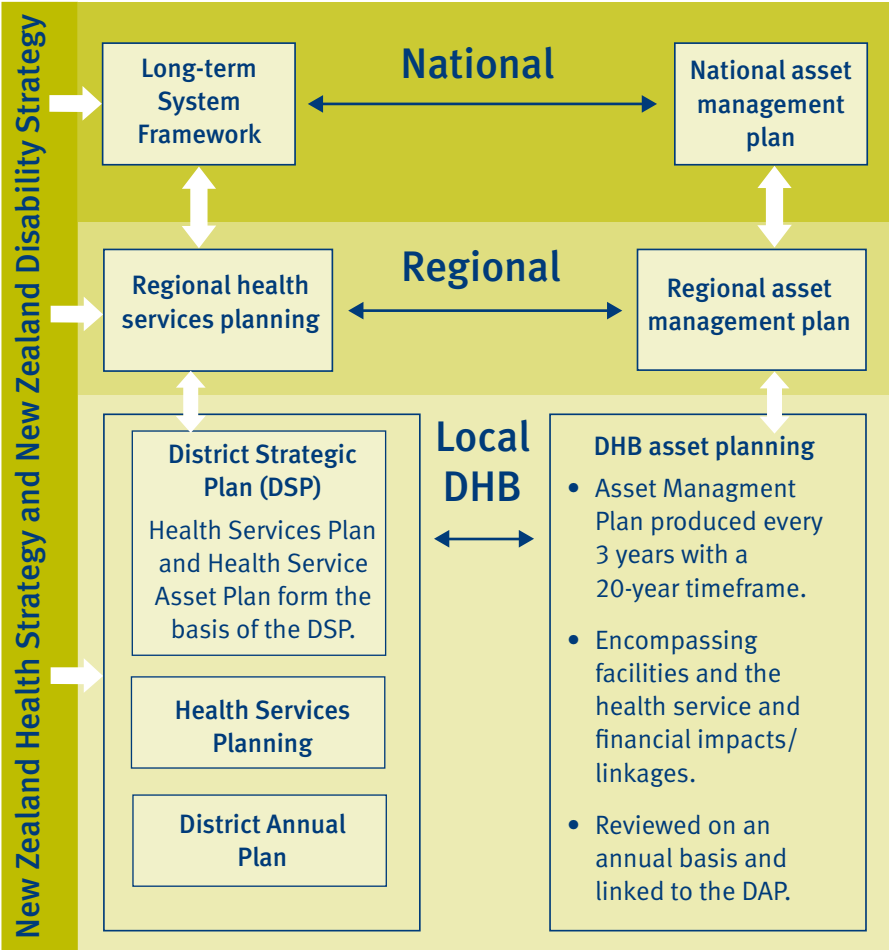
Demand for capital investment commonly exceeds the resources available and the Ministry has developed a robust prioritisation process to underpin its advice to Ministers. The prioritisation process is led by the National Capital Committee (NCC) and emphasises cost-effectiveness, regional collaboration, enablement of modern models of care and health gain. The NCC comprises DHB and Ministry representatives, with attendance by Crown Health Financing Authority officials. It assesses and prioritises DHB capital investment proposals.

The NCC considers DHB capital investment proposals through a three stage business case process consisting of a strategic stage, options analysis stage, and final business case stage. During the

process expert advice is provided to DHBs and the Ministry and prior to receipt of a final business case two independent review are undertaken. Through this process affordability (at both the DHB and national capital budget level), regional and national resource implications, and clinical sustainability of proposed capital investments are considered.

Health capital investment is also informed by the Crown Financing Health Authority and soon by new wider government capital management processes such as Treasury’s Capital Asset Management framework and the State Services Commission’s Gateway programme.

Figure 5: Service and capital planning linkages



D. Ongoing Ministry operational priorities

D1 Improving Māori health

What are we seeking to achieve?

The Minister has made it clear that an overarching aim of the health and disability sector is the improvement of Māori health. Given the impact of socioeconomic determinants of health and the existing disparities between health outcomes for Māori and non-Māori, improving Māori health remains an urgent priority for the Ministry. The concept of improving Māori health also includes work across sectors to address the broad determinants of health. This is underpinned by maintaining a proper Treaty relationship focused on improving Māori health and reducing Māori health inequalities.

As part of Whakatātaka Tuarua: Māori Health Action Plan 2006–2011 (Minister of Health and Associate Minister of Health 2006), the Ministry has identified the following areas for priority attention:

- building quality data and monitoring Māori health
- developing whānau-ora based models
- ensuring Māori participation: workforce development and governance
- improving primary health care for Māori.

What will we do to achieve this outcome?

The Ministry recognises the critical role that Māori providers and mainstream providers play in improving Māori health. Therefore, the Ministry will continue its dual focus on strengthening and sustaining the quality of services provided by Māori providers and enhancing the effectiveness of mainstream services in order to achieve positive gains in Māori health outcomes.

In addition to this, a new internally focused monitoring work programme will be established. The aim of the programme is to monitor Ministry activities aimed at improving Māori health outcomes and reducing Māori health inequalities to ensure that these activities are gaining traction toward their respective aims and their intended benefits are being realised.

Why is this outcome a priority?

Despite significant gains in recent years, Māori as a population group still experience poorer health outcomes than non-Māori. For example, Māori prevalence of diabetes is 2.5 times higher than non-Māori (Robson et al 2007), while cardiovascular disease death rates are 2.3 times higher for Māori than non-Māori (Ministry of Health 2006) and the gap in life expectancy between Māori and non-Māori is over 7.5 years (Robson et al 2007). These stark disparities are unacceptable and the Ministry of Health continues to make the improvement of Māori health a priority.

How will we demonstrate success?

Table 11 shows how we will measure the success of the health and disability sector in, and the Ministry's contribution to, improving Māori health.

Table 11: Measuring the success of the health and disability strategy in, and the Ministry’s contribution to, improving Māori health

Measuring progress	Indicators/measures
Health and disability sector	<p>The following health sector targets:</p> <ul style="list-style-type: none"> • improved immunisation coverage • improved oral health • reduced ambulatory sensitive hospital admissions • improved diabetes services • improved nutrition • increased physical activity • reduced obesity • reduced harm caused by tobacco • improved mental health services.
Ministry of Health	<p>The Ministry, in accordance with agreed measures and standards, will deliver:</p> <ul style="list-style-type: none"> • innovative approaches by Māori health providers case studies • Māori health and disabilities focus in nationally purchased services • Māori Provider Development Scheme • monitoring of the Ministry work programme from an improving Māori health perspective.

D2 Reducing inequalities

What are we seeking to achieve?

To address inequalities we need action that focuses on the causes of inequalities, which are complex. Much of what influences health status, for example, lies outside of the control of the health and disability sector. Nevertheless, we know that health sector policy, planning and delivery can either decrease or increase inequalities in health outcomes. For this reason, an active emphasis on Māori and Pacific peoples’ health should run through all health programmes and be a particular focus for DHBs with high Māori and Pacific populations. Achievement of progress in Māori and Pacific peoples’ health will be an essential part of reducing disparities in health outcomes between DHBs.

Research tells us that specific one-off projects to reduce inequalities are less successful than a co-ordinated approach that makes reducing inequalities ‘business as usual’ across all the priorities. The first step in this co-ordinated approach is raising awareness, which is the primary aim of the workshops and includes providing tools such as the Health Equity Assessment Tool. The second step is to implement co-ordinated actions to reduce inequalities, on an ongoing basis.

What will we do to achieve this outcome?

The Ministry has engaged in a variety of reducing inequalities activities in recent years. This includes raising awareness and understanding of health inequalities, introducing an intervention framework and introducing health equity tools to complement the framework. Other activities include, but are not limited to, Services to Improve Access funding and the reorientation of child and adolescent oral health services.

This year the Ministry will consolidate these ongoing activities. In addition it will produce an updated edition of Reducing Inequalities in Health (Ministry of Health 2002d). This edition reflects an increasingly sophisticated understanding of health inequalities and will feature new tools for health decision makers to support an equity focus.

Te Puawaitanga: Māori Mental Health National Strategic Framework will guide the sector to act on the evidence of Māori mental health and addiction needs and disparities (Ministry of Health 2002b). The Ministry will prioritise Māori as the sector works to broaden the approach to mental health and addictions in the areas of prevention and promotion and primary health care, while continuing to improve outcome for Māori severely affected by mental illness and addictions.

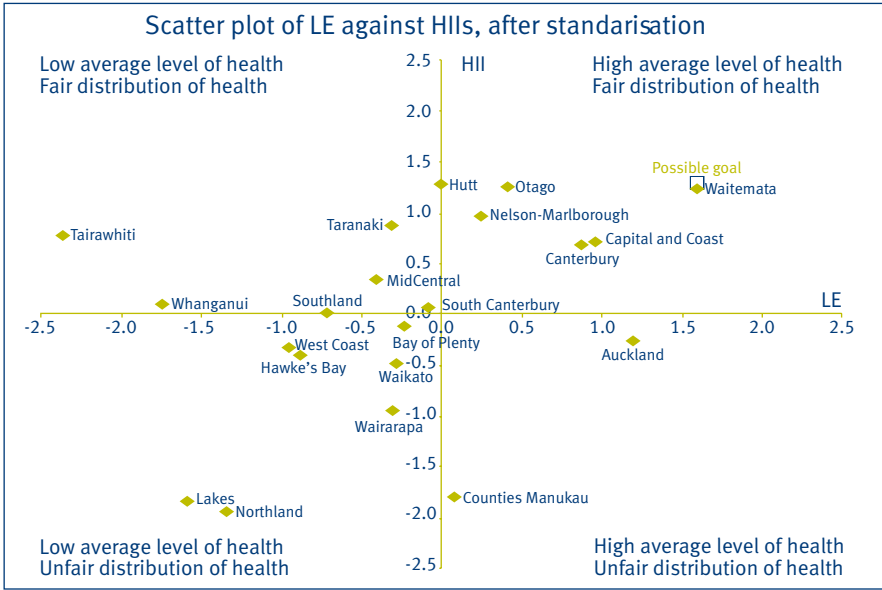
Why is this outcome a priority?

Considerable evidence, internationally and in New Zealand, exists of significant inequalities in health between socioeconomic groups, ethnic groups, people living in different geographical regions and males and females (Acheson 1998). Research indicates that the poorer you are the worse your health. In countries with a colonial history, indigenous people have poorer health than others. Reducing inequalities is a priority for government. The New Zealand Health Strategy acknowledges the need to address health inequalities as ‘a major priority requiring ongoing commitment across the sector’ (Minister of Health 2000).

The recent publication in a series on disparity, *Decades of Disparity III: Ethnic and socioeconomic inequalities in mortality* (Ministry of Health and University of Otago 2006), analysed the roles that ethnicity and socioeconomic position play in shaping health inequalities. It found that health inequalities are not fully explained by socioeconomic position, and that ethnicity has an impact on health even after socioeconomic position is taken into account. The authors also suggested that discrimination can contribute to structural inequalities in society.

Health inequality is distributed unevenly throughout New Zealand. Using the 2001 Census of Populations and Dwellings and mortality data for 2001, analysis conducted by the Ministry has found that the range of life expectancy at birth was approximately 5 years across DHBs’ usually resident populations, but approximately 28.5 years across neighbourhoods (from 64.4 to 93.0 years). DHBs varied widely in a ‘health inequality index’ (HII) from 50 percent more to 60 percent less than New Zealand as a whole, a 2.5-fold range. While over 1 in 2 Māori have experienced mental illness, sometime in their life, Māori are less likely than other population groups to make contact with mental health services and are more likely to present to services at a later stage in an acute state of unwellness.

Figure 6: Life expectancy (LE) at birth versus health inequality index (HII), 1999–2003, by DHB



Note: 'Standardisation' in this context refers to normalisation of HII (health inequality index) and life expectancy estimates so that both variables are measured on comparable scales – multiples of their respective standard deviations (Z scores).

How will we demonstrate success?

Table 12 shows how we will measure the success of the health and disability sector in, and the Ministry's contribution to, reducing inequalities.

Table 12: Measuring the progress of the health and disability sector in, and contribution of the Ministry to, reducing inequalities

Level	Indicators/measures
Health and disability sector	<p>The following health sector targets:</p> <ul style="list-style-type: none"> • improved immunisation coverage • improved oral health • reduced ambulatory-sensitive hospital admissions • improved diabetes services • improved nutrition • increased physical activity • reduced obesity • reduced harm caused by tobacco • improved mental health services.
Ministry of Health	<p>The Ministry, in accordance with agreed measures and standards, will:</p> <ul style="list-style-type: none"> • develop the second edition of Reducing Inequalities in Health publication • monitor the Ministry work programme from an inequalities perspective • implement a strategic framework for Pacific health • deliver the Pacific Provider Development Fund.

D3 Supporting health and wellbeing through nationally funded services

What are we seeking to achieve?

The Ministry aims to improve the wellbeing and health of New Zealanders by planning for and buying those health and disability support services that the government has determined shall be purchased nationally.

Disability support services

Disability support services help to ensure that disabled people are valued, included, and respected, have some influence and control, are connected to their communities and have disability support services that are useful. The services purchased are disability support services for people with a long-term physical, intellectual and/or sensory impairment that will require ongoing support. These are generally for disabled people under the age of 65.

Personal and public health services

Personal and public health services purchased nationally promote health, prevent illness, and reduce the inequality of health outcomes for our populations and communities, help ensure cohesion between national and regional services, and contribute to DHB outcomes. Services purchased include immunisation, injury prevention, nutrition, physical activity, tobacco control, elective services, emergency ambulance services, well child services, and HealthLine.

Population screening

Population screening is about saving lives, reducing inequalities, and building the nation's health by leading the delivery of quality screening programmes that are trusted by the community.

Workforce development

Workforce development contributes to health and disability support services achieving their outcomes by training and developing the workforce and strengthening provider capability. The aim is an appropriately skilled and sized workforce to deliver services and well functioning, robust, providers.

Developing and disseminating information

Developing and disseminating information supports the health and disability support services in improving health and independence by enabling better planning, policy, and performance management.

What will we do to achieve these outcomes?

Each Non Departmental Expenditure class or sub-class will have an annual service plan that describes the generic outcomes to be achieved, key drivers, services to be purchased, specific outcomes and outputs, and the implications for resources.

This will be supplemented with an annual service development programme to improve the outcomes of the services. Services to be purchased will have a purchase plan developed.

The Ministry purchases (or repurchases) services according to the relevant purchase plan. Performance management will include support and development of providers where needed, management of the relationship, and management of issues as they arise.

An evaluation programme will contribute to performance management, service development, and planning.

The Ministry will use guidelines and standards for these processes to enhance the consistency and quality of the management of Ministry managed non-departmental Expenditure.

Why is this outcome a priority?

The outcome of Supporting Health and Wellbeing Through Nationally Funded Services is a priority because of the value, size, and scope of the national services purchased. The efficient expenditure of \$2.3 billion each year on a range of services purchased nationally adds enormously to bettering the health and independence of New Zealanders, reducing inequalities, and enhancing trust and security.

This range of services:

- contributes to the Minister's priority areas of taking public and primary health care to the next level, strengthening health services we can trust, and enabling a strong, sustainable, health sector for the longer term and to the supporting priorities of the New Zealand Health Targets (improving elective services; reducing the harm caused by tobacco; improving nutrition; increasing physical activity; reducing avoidable admissions; and reducing obesity)
- continues a comprehensive range of services provided for the health and independence of New Zealanders, and develops those services

- advances the government’s strategic aim for disability support services, namely a move towards an outcomes-based approach to planning and funding of disability support services. An outcomes-based approach means that services are funded in a way that allows more flexibility in what is provided, encourages cross-agency collaboration in providing these services and shifts the ownership of the services more towards the consumer.

How will we demonstrate success?

Table 13 shows how we will measure the success of the health and disability sector in, and the Ministry’s contribution to, supporting health and wellbeing through nationally funded services.

Table 13: Measuring success of health and disability sector in, and Ministry’s contribution to, supporting health and wellbeing through nationally funded services

Level	Indicators/measures
Health and disability sector	<p>The following health sector targets:</p> <ul style="list-style-type: none"> • improved elective services • reduced the harm caused by tobacco • improved nutrition • increased physical activity • reduced obesity • reduced ambulatory-sensitive hospital admissions.
Ministry of Health	<p>The Ministry, in accordance with agreed measures and standards, will deliver:</p> <ul style="list-style-type: none"> • annual service planning • annual programme of service development activity • purchase management • performance management • programme of evaluation.

Managing in a Changeable Operating Environment

The risk management approach underlying the Ministry's Risk Management Programme is based on the Australia-New Zealand Risk Management Standards (AS/NZS 4360) (Standards Australia and Standards New Zealand 2004). Parts of these Standards are cross referenced in the Ministry's Risk Management Guidelines for staff.

The key objectives of risk management at the Ministry are to ensure:

- an environment where all employees will assume responsibility for managing risk
- risk management practices are embedded in decision-making processes
- risks faced by the Ministry are identified and assessed using a consistent approach
- risks are documented, monitored and managed using a consistent approach
- risks are prioritised and resources for management allocated appropriately.

Each of the Ministry's directorates has a nominated risk administrator who facilitates the co-ordination and administration process of risk reporting within their directorate. Risk administrators are also responsible for ensuring that information about their directorate's risks in the Ministry's Risk Management Register is up to date, and for providing the Ministry's Risk and Assurance Group with their directorate's monthly risk report. Each Directorate's monthly risk report is approved by the directorate's Deputy Director-General. Directorates' risks are incorporated into their monthly report to the Executive Leadership Team, with any key risks being highlighted.

Monthly reporting of risks to the Director-General and Executive Leadership Team is overseen by the Ministry's Risk and Assurance Group. The Ministry's Audit, Finance and Risk Committee reviews the Ministry's risks on a bi-monthly basis.

As the Ministry is a large organisation with a diverse range of responsibilities and objectives, it faces a range of day-to-day and strategic risks. Each risk has mitigation strategies in place. Mitigation strategies are varied depending on each individual risk and can include both existing practices (controls) and future actions (treatments).

While the Ministry has a robust risk management process in place, the recent changes to the organisational form have provided the opportunity to reassess the strategic risks and mitigation strategies which will fall into five groups.

- External environment risks relate to political and sector issues, public and central government expectations, and legislation.
- Internal environment risks relate to organisational structure and culture, achievement of internal Ministry goals, and fiscal and litigation risk.
- Reputation and integrity risks are risks that may result in changed perceptions of the Ministry.
- Information risks relate to the reporting and management of information.
- Processes risks relate to the Ministry's business processes and systems.

Over the coming year we will further build on the risk management process with enhanced reporting and analysis.

Emergency preparedness

The Ministry has key statutory and non-statutory emergency preparedness obligations, which require the Ministry to:

- be capable of continuing to function to the fullest extent possible in an emergency
- have the capability and capacity to respond in an emergency as required
- provide leadership and co-ordination for the health sector in planning for, preparing, and responding to a health emergency
- lead the all-of-government response to a national health emergency, such as a pandemic.

The emergency preparedness work programme is strongly focused on increasing the capability and capacity of the health sector to deal with health emergencies. The Ministry maintains strong links with a number of other government agencies in delivering our emergency management responsibilities.

Organisational Health and Capability

The Ministry's initiatives for 2008/09 to maintain and improve our capability and capacity build on its 2006/08 work programme. The initiatives are informed by the Government's strategic priority areas, the Ministry's health targets (which are aligned to strategic priorities) and the 2006 review of the Ministry. The ability of the Ministry to undertake the key functions outlined in these documents depends on identifying and addressing our future capacity and capability requirements.

The initiatives have been mapped to two of the six State Services Commission's (SSC) development goals, on which the Ministry will focus over the medium term. Goals one and six specifically relate to strategies to develop people capability across the state sector.

- SSC Development Goal 1 – Employer of Choice: ensure the state services is an employer of choice attractive to high achievers, who are committed to service and the achievement of results.
- SSC Development Goal 6 – Trusted State Services: Strengthen trust in the State Services and reinforce the spirit of service.

The Ministry's four levers for capability development (attraction and commitment, learning and development, healthy workplaces and human resources information capability) are aligned to the streams of SSC work that sits beneath the goals (attracting and hiring the best, positive workplaces and developing for excellence and trust).

Attraction and commitment

The Ministry needs to be able to improve its ability to recruit and retain competent and capable staff to deliver the Ministry's work programme. The monitoring of our five-year retention rate and staff surveys indicate that further encouragement of staff commitment and trust will be a focus over the next year.

The key milestone in 2008/09 is to:

- implement a recruitment strategy that ensures consistent recruitment practice in the Ministry and provides the context for future initiatives with clear linkages to the results of the Pay and Employment Equity Review (January 2007).

Healthy workplaces

Modelling the way forward in supporting healthy lifestyles and providing healthy workplaces are key strategies to ensure we maintain our people capability.

The key milestones in 2008/09 are to:

- implement a wellness strategy including Team Challenge initiatives in line with the Government 'Walk the Talk' programme to promote awareness of physical and nutritional impacts on lifestyle
- have an ongoing commitment to improving our workplace in line with the ACC Partnership Programme.

Learning and development

The Ministry review in 2006 highlighted the need to ensure that leadership capability is strengthened to adequately fulfil the Ministry's potentially revised roles in the sector. There is a need to develop a shared, organisation-wide vision and achieve an outcomes-based culture which will require capable leadership. Initiatives build on last year's work plan as well as ensuring the Ministry works towards addressing future needs.

The key milestones in 2008/09 are to:

- implement supporting tools for the Ministry's Management and Leadership framework including mentoring and career development programmes
- centralise the availability of secondments internally and across the health sector ensuring opportunities are identified and provided to staff.

Departmental Capital Intentions

The Ministry has an annual capital planning process that prioritises expenditure and agrees allocations for capital expenditure. Significant approved items are additionally required to submit business cases, and follow the Ministry's Performance Management regime for the life of the project. IT projects over \$7 million are carried out according to the Government protocols on approvals and engagement with other agencies.

Table 14: Fixed asset purchases

Fixed Assets	Fixed Asset Purchases					
	2007/08 Supps	2007/08 Estimated Actuals	2008/09 Budget	2009/10 Budget	2010/11 Budget	2011/12 Budget
	\$000	\$000	\$000	\$000	\$000	\$000
Non-residential buildings	0	50	50	0	0	0
Plant and equipment	1,000	178	1,595	1,000	1,000	1,000
Computer hardware	12,803	2,362	5,500	10,000	11,000	11,000
Vehicles and vessels	500	180	500	500	500	500
Furniture and fittings	500	1,635	500	500	500	500
Total fixed assets	14,803	4,405	8,145	12,000	13,000	13,000
Intangibles	3,738	3,734	19,877	2,566	10,500	4,000
Total fixed asset purchases	18,537	8,139	28,022	14,566	23,500	17,000

Additional Information

The Minister of Finance has not specified any additional reporting requirements.

Additional Statutory Reporting Requirement

The Director-General of Health's Annual Report on the State of Public Health.

References

- Acheson D. 1998. *Independent Inquiry into Inequalities in Health Report*. London: Stationery Office.
- Associate Minister of Health, Minister for Disability Issues. 2002. *Health of Older People Strategy: Health sector action to 2010 to support positive ageing*. Wellington: Ministry of Health. URL:<http://www.moh.govt.nz>
- Cancer Control Taskforce. 2005. *The New Zealand Cancer Control Strategy: Action Plan 2005–2010*. Wellington: Ministry of Health.
- Cylus J, Anderson GF. 2007. *Multinational Comparisons of Health Systems Data*. New York: Commonwealth Fund.
- Health Committee. 2007. *Inquiry into Obesity and Type 2 Diabetes in New Zealand: Report of the Health Committee*. Wellington: House of Representatives.
- Howden-Chapman P, Tobias M (eds). 2000. *Social Inequalities in Health: New Zealand 1999*. Wellington: Ministry of Health.
- Lomas J. 2007. *Formalised Informality: An action plan to spread proven health innovations*. Wellington: Ministry of Health.
- Minister for Disability Issues. 2001. *The New Zealand Disability Strategy: Making a world of difference: Whakanui Oranga*. Wellington: Ministry of Health.
- Minister for Senior Citizens. 2001. *New Zealand Positive Ageing Strategy*. Wellington: Ministry of Social Policy.
- Minister of Health. 2000. *New Zealand Health Strategy*. Wellington: Ministry of Health.
- Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington: Ministry of Health.
- Minister of Health. 2003. *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau: A strategic framework*. Wellington: Ministry of Health.
- Minister of Health. 2006. *Te Kokiri: The Mental Health and Addiction Plan 2006–2015*. Wellington: Ministry of Health.
- Minister of Health, Associate Minister of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.
- Minister of Health, Associate Minister of Health. 2006. *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011*. Wellington: Ministry of Health.
- Ministry of Health. 2002. *Reducing Inequalities in Health*. Wellington: Ministry of Health.
- Ministry of Health. 2002. *Te Puāwaitanga: Māori Mental Health National Strategic Framework*. Wellington: Ministry of Health.
- Ministry of Health. 2003. *NZ Food NZ Children: Key results of the 2002 National Children’s Nutrition Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2004. *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau: Implementation plan: 2004–2010*. Wellington: Ministry of Health.
- Ministry of Health. 2006. *Tatau Kahukura: Māori Health Chart Book*. Wellington: Ministry of Health.
- Ministry of Health. 2007. *Diabetes and Cardiovascular Disease Quality Improvement Plan*. Wellington: Ministry of Health.
- Ministry of Health. 2007a. *The Across Sector Long Term Conditions Programme*. Wellington.
- Ministry of Health. 2007b. *National Childhood Immunisation Coverage Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2008. Oral Health. Wellington: Ministry of Health. URL: <http://www.moh.govt.nz> Accessed 29 April 2008.
- Ministry of Health and DHBNZ Workforce Group. 2007. *A Career Framework for the Health Workforce in New Zealand*. Wellington: Ministry of Health and District Health Boards New Zealand.

Ministry of Health and University of Auckland. 2003. *Nutrition and the Burden of Disease: New Zealand 1997–2011*. Wellington: Ministry of Health.

Ministry of Health and University of Otago. 2006. *Decades of Disparity III: Ethnic and socioeconomic inequalities in mortality, New Zealand 1981–1999*. Wellington: Ministry of Health.

Ramage C, Bir J, Towns A, et al. 2005. *Stocktake of Child and Adolescent Mental Health Services Auckland*. Auckland: Werry Centre for Child and Adolescent Mental Health Workforce Development, University of Auckland.

Robson B, Harris R (eds). 2007. *Hauora: Māori Standards of Health IV. A study of the years 2000–2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

Standards Australia, Standards New Zealand. 2004. Risk Management (AS/NZS 4360). Standards Australia and Standards New Zealand.

The Treasury. 2006. *New Zealand's Long-term Fiscal Position*. Wellington: The Treasury.

Appendix One

Table A1: Health targets and indicators

Health target	Relevant Minister's priorities	Indicator
Improving immunisation coverage	Child and youth Primary health care	95% of two-year-olds are fully immunised* With at least 4 to 6 percent point increase on 2005 national immunisation coverage survey baselines
Improving oral health	Child and youth	Progress is made towards 85% adolescent oral health utilisation*
Improving elective services		Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPis) Each DHB will set an agreed increase in the number of elective service discharges, and will provide the level of service agreed
Reducing cancer waiting times	Chronic disease	All patients wait less than 8 weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D)
Reducing ambulatory sensitive (avoidable) admissions	Chronic disease Child and youth Primary health care Health of older people	There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0–74 across all population groups*
Improving diabetes services	Chronic disease Primary health care	There will be an increase in the percentage of people in all population groups: <ul style="list-style-type: none"> • estimated to have diabetes accessing free annual checks* • on the diabetes register who have good diabetes management* • on the diabetes register who have had retinal screening in the past two years* There will be improved equity for all population groups in relation to diabetes management*
Reducing Cardiovascular Disease (CVD)	Chronic disease	Proportion of priority groups have had a absolute CVD risk assessment in the last five years.
Improving mental health services	Chronic disease	At least 90% of long-term clients have up-to-date relapse prevention plans (NMHSS criteria 16.4)
Improve nutrition Increase physical activity Reduce obesity	Chronic disease Child and youth Primary health care	DHB activity supports achievement of these health sector targets: <ul style="list-style-type: none"> • proportion of infants exclusively and fully breastfed: 74% at six weeks; 57% at three months; 27% at six months* • proportion of adults (15+ years) consuming at least three servings vegetables per day, and proportion of adults (15+ years) consuming at least two servings fruit per day: 70% for vegetable consumption; 62% for fruit consumption*

Health target	Relevant Minister's priorities	Indicator
Reduce the harm caused by tobacco	Chronic disease Child and youth Primary health care	DHB activity supports achievement of these health sector targets: <ul style="list-style-type: none"> to increase the proportion of 'never smokers' among Year 10 students by at least 2% (absolute increase) over 2007/2008* to increase the proportion of homes, which contain one or more smokers and one or more children, that have a smokefree policy to over 75% in 2007/2008*
Reduce the percentage of the health budget spent on the Ministry of Health	Value for money	The percentage of the health budget spent on the Ministry of Health is reduced to 1.65% of the total Vote Health budget over the three years to 2009/2010.

* Data available for analysis by ethnicity

* Data quality will be improved during the year to include ethnicity data

Ethnic-specific targets are set for all of the indicators where data allows, as shown in the table.

In some cases data quality is insufficient, so only a subset of the health targets are used to measure performance in improving Māori health and reducing inequalities. Where poor quality ethnicity data is preventing the reporting of a target, the Ministry focuses on improving the quality of ethnicity data and reporting on its progress.

Table A2: System and societal-level outcomes and associated headline indicators

Outcome	Headline indicators
Better health	Life expectancy* Infant mortality* Healthy life expectancy* Mental health status*
Reduced inequalities	Life expectancy by ethnicity and deprivation* Infant mortality by ethnicity and deprivation* Healthy life expectancy by ethnicity and deprivation*
Better participation and independence	Disability requiring assistance* Unmet need for disability support services
Trust and security	Views of the health care system Confidence in obtaining high-quality and safe care when needed Access to health care Cost of medical care
Equity and access	Primary health care utilisation† Elective surgery discharges Radiotherapy waiting times Matching of health workforce to population characteristics* Rate of new admissions to general acute inpatient mental health services Secondary mental health services utilisation*
Quality	Patient satisfaction Emergency department triage times Hospital readmission rate* Hospital mortality rate* Cancer screening coverage* Immunisation coverage (fully vaccinated two-year-olds)* Proportion of health records with an NHI# number* Treatment injury rates
Efficiency and value for money	Day-case procedures* Age-related residential care admissions Efficiency of primary health care
Effectiveness	Ambulatory-sensitive admissions* Cardiovascular disease mortality* Cancer survival* Diabetes management* Smoking prevalence and consumption*
Intersectoral focus	Obesity* Alcohol available for consumption Destigmatisation of people with mental illness

* Data available for analysis by ethnicity

† Incorporates ethnicity in that it measures the ratio of high need (Māori, Pacific, Deprivation quintile 5) visits to non-high need visits.

