New Zealand Health and Disability Sector Overview
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Introduction

This document aims to give a general overview of the New Zealand health and disability sector. It provides brief information about:

- New Zealand and the demographics of the population
- the structure of the health and disability sector
- the financing of health and disability services and expenditure within the sector
- some health and disability workforce statistics and issues facing the workforce
- the infrastructure for gathering and managing information in the health and disability sector
- the health and disability status of New Zealanders
- important health outcome measures.

Key points to note

- New Zealand is a small country in which the majority of the population live in cities and the minority are widely dispersed in rural areas.
- Over the last decade there has been a general increase in the number of health professionals, including the numbers of doctors and nurses, although there are still shortages in some areas.
- Expenditure on health in real terms has risen consistently over the last decade.
- Health expenditure as a proportion of GDP is similar to that in most other OECD countries.
- Life expectancy has risen over the last half century. However, there remain disparities in life expectancy based on ethnic and socioeconomic differences.
New Zealand in context

New Zealand is a small island nation in the south-west Pacific with a population of 4 million people. According to the 2001 census, the main ethnic groups are European (80%), Māori (14.7%), Asian (6.6%) and Pacific peoples (6.5%), with ethnicity understood in terms of cultural affiliation, rather than necessarily by descent. As respondents could identify themselves as being of more than one ethnicity, the data sum to more than 100 percent. Approximately 86 percent of the population inhabit urban areas (towns larger than 1000 inhabitants), and 69 percent inhabit ‘main’ urban areas (places with more than 30,000 residents).

Figure 1: Population distribution of New Zealand cities

As is the case in many Western countries, the proportion of New Zealand’s population in older age groups is increasing. In 2051, 25 percent of all New Zealanders are expected to be aged 65 or over, compared with 12 percent in 2001. Although the Māori, Pacific and Asian populations currently have a greater proportion of young people than the European population, the proportion of older people in these populations is expected to increase in the next 50 years.
New Zealand’s economy is heavily dependent on overseas trade. In the past 20 years New Zealand has developed its agriculture and manufacturing industries to suit the needs of niche markets. Dairy and meat exports continue to make a significant contribution to the New Zealand economy. Tourism, forestry and manufacturing exports have become increasingly important, while wool has declined. New Zealand’s largest export markets are currently Australia, the USA, Japan, the UK and South Korea.

New Zealand’s economic performance improved significantly over the 1990s following a sustained period of low economic growth during the 1980s. New Zealand’s per capita gross domestic product (GDP) in 2001 (by purchasing power parity, or PPP) was US$13,100. Per capita health expenditure in 2000 was US$1623 (PPP). The unemployment rate in March 2003 was 5 percent. Total health spending in 2000 was 8 percent of GDP while total health expenditure in 2001 was approximately $9.9 billion.
The New Zealand Health and Disability Sector

The organisation of health and disability support services in New Zealand has undergone a number of changes in the last decade. These have ranged from a ‘purchaser/provider’ market-oriented model introduced in 1993, to the more community-oriented model that is currently in place.

Health and disability sector changes 1993–2000

In 1993 the Health and Disability Services Act introduced a system which, unlike the Area Health Board model it replaced, separated the purchasing of health care and disability support services from the organisations that provided these services. Responsibility for purchasing services lay with four Regional Health Authorities (RHAs). These RHAs contracted with providers of services in both the primary and secondary care sectors. The RHAs were not responsible for public health services. These were the responsibility of a fifth organisation, known as the Public Health Commission. The structure of the health and disability sector at this time reflected an international trend towards market-based systems.

Under the 1996 Coalition Agreement on Health the purchaser/provider split in health was retained, but the emphasis on competition between providers was removed. The four RHAs (the Public Health Commission having been dissolved in 1996) were replaced by a single Transitional Health Authority that subsequently became the Health Funding Authority (HFA). The Minister of Health appointed all the board members of the RHAs and HFA. The RHAs and HFA were, however, expected to reflect the needs of users of services and to have a commitment to community consultation. They also retained locality offices across the country.

From 1992/93 funding and responsibility for many disability support services was transferred from social welfare to RHAs.

Figure 2: Structure of the New Zealand health and disability sector, 2003

Source: Health and Independence Report 2002, Ministry of Health
In 2000 the Government initiated changes in the sector that amalgamated the purchase and provision of services in the same organisations and decentralised decision-making to community-focused District Health Boards (DHBs). Figure 2 shows the structure of the New Zealand health and disability sector in 2003 under the New Zealand Public Health and Disability Act 2000, and the main features are described below.

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

• The Ministry of Health has as number of key functions. The Ministry:
  – provides policy advice on improving health outcomes, reducing inequalities and increasing participation
  – acts as the Minister’s agent
  – monitors the performance of District Health Boards, and other health sector Crown entities
  – implements, administers and enforces relevant legislation and regulations
  – provides health information, and processes payments
  – facilitates collaboration and co-ordination within and across sectors
  – provides nationwide planning and maintenance of service frameworks
  – plans and funds public health, disability support services and other services that are retained centrally

• DHBs are Crown entities responsible to the Minister of Health (administration is through the Ministry of Health). Each board has up to 11 members, seven of which are elected by the community. A minority of members (up to four) are appointed by the Minister of Health. In recognition of the Crown’s partnership with Māori, each board must have at least two Māori members, and preferably a greater number if Māori make up a higher proportion of a DHB’s population. There are 21 DHBs in New Zealand, as shown in Figures 3 and 4.
Figure 3: District Health Board boundaries – North Island
Figure 4: District Health Board boundaries – South Island
DHBs are responsible for planning, funding and ensuring the provision of health and disability services to a geographically defined population. This reflects a move away from the purchaser/provider split, as DHBs provide hospital (and some community-based) services. DHBs are responsible for improving, promoting and protecting the health and independence of their populations. Boards must assess the health and disability support needs of the people in their regions, and manage their resources appropriately in addressing those needs.

Central government provides broad guidelines on what services the DHBs must provide, and national priorities have been identified in the New Zealand Health Strategy. Services can be delivered by a range of providers including public hospitals, non-profit health agencies, iwi groups or private organisations. Funding is allocated to DHBs using a weighted population-based funding formula.

Since the passage of the Act in late 2000, DHBs have been progressively devolved greater responsibilities, and in 2003 they are expected to take on responsibility for services for older people with disabilities. This means that DHBs will be responsible for all services except public health, disability support services for people with long-term disabilities (largely under 65) and some national contracts; these areas are the responsibility of the Ministry of Health.

- Service providers – including acute hospitals, some services such as assessment, treatment and rehabilitation services, and most public health services – come under the wing of DHBs, while general practitioners, primary health organisations (PHOs), rest homes and midwives are independent and are contracted to supply services by DHBs or the Ministry of Health. Overall there are approximately 80 public hospital facilities in New Zealand and a large number of privately operated aged-care facilities.

DHBs are responsible for establishing, funding and monitoring PHOs, which are responsible for providing a set of essential primary health care services to a defined population. At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people’s health when they are unwell. The first PHOs were established in July 2002. As of 1 April 2003 34 PHOs had been established, covering approximately one million New Zealanders.

Public health units are owned by DHBs (although public health services are centrally funded by the Ministry). There are 12 public health units throughout New Zealand, which focus on ‘core public health services’ such as environmental health, communicable disease control, tobacco control
and health promotion programmes. Many of these services include a regulatory component performed by statutory officers appointed under the Health Act 1956. These officers are employed by DHBs but are personally accountable to, and subject to direction from, the Director-General of Health.

The non-government organisation and voluntary sector is also important. Not-for-profit services are provided by more than 50 national organisations and even more local providers. This group of providers includes some large organisations such as the IHC, the Plunket Society, the Family Planning Association and the Salvation Army.

In recent years community trusts and iwi-based bodies have also become important. Several communities, especially in rural areas, have established community trusts to develop health services for people in their area, and iwi-based organisations are providing an increasing range of health and social services.

- The Accident Compensation Corporation (ACC) is a Crown entity. Its responsibilities are:
  - preventing injury
  - collecting accident insurance premiums
  - determining whether claims for injury are covered by the scheme and providing entitlements to those who are eligible
  - paying compensation
  - buying health and disability support services to treat, care for and rehabilitate injured people
  - advising the government.

It provides universal accident insurance cover, injury prevention services, care management, and medical and other care and rehabilitation services.

- A number of ministerial advisory committees have been established under various statutes to advise the Minister on specialist issues.
  - The Health Workforce Advisory Committee (HWAC) advises the Minister of Health on health workforce issues that the Minister specifies by notice to the Committee.
  - The Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) advises the Minister of Health on issues to do with complementary and alternative health, and specifically provides advice in areas such as regulation, consumer information needs, research and integration.
The National Ethics Advisory Committee (National Advisory Committee on Health and Disability Support Services Ethics) (NEAC) provides advice to the Minister of Health on ethical issues of national significance regarding health and disability research and services, determines nationally consistent ethical standards and provides scrutiny for research and services.

The National Ethics Committee on Assisted Human Reproduction (NECAHR) reviews all research and innovative treatment proposals involving assisted human reproduction, and advises the Minister of Health on ethical issues relating to assisted human reproduction. Under proposed changes to the Human Assisted Reproductive Technologies Bill intended to come into effect in 2004, a new ministerial advisory committee will be established to advise the Minister on ethical issues relating to assisted human reproduction. The National Ethics Committee on Assisted Human Reproduction will no longer fulfil this role, although it may continue to review research and innovative treatment proposals involving assisted human reproduction.

The National Health Committee (National Advisory Committee on Health and Disability) was established to advise the Minister of Health on the type and relative priorities of public health services, personal health services and disability services that it believes should be publicly funded. The committee is also required to advise on personal health and regulatory matters relating to public health. The committee formulates its advice in consultation with the public and health service providers.

The Public Health Advisory Committee is a sub-committee of the National Health Committee. Its role is to provide independent advice to the Minister of Health on public health issues including:
- factors influencing the health of people and communities
- the promotion of public health
- the monitoring of public health.

The National Health Epidemiology and Quality Assurance Advisory Committee (EpiQual) is responsible for providing the Minister with advice on any matter of health epidemiology and quality assurance, but must specifically examine perinatal, child and adolescent morbidity and mortality.

Other technical committees provide advice on child and youth mortality, medicines safety and classification, new prescribers and other matters.
• Several agencies protect and promote the rights of consumers of health and disability support services.
  – The Office of the Health and Disability Commissioner: Te Toihau Hauora, Hauatanga, is responsible for promoting and protecting the rights of consumers of health and disability support services as specified in the Code of Health and Disability Services Consumers’ Rights.
  – Health and disability consumer advocacy services: Ngā Kaitautoko, operates health and disability consumer advocacy services for people who believe there has been a breach of their rights under the Code of Health and Disability Services Consumers’ Rights.
  – The Office of the Ombudsmen can investigate any decision or recommendation by a central or local government organisation that affects any person or body of people in their personal capacity.
  – Individuals who believe there has been a breach of their rights under the Privacy Act 1993 can take their complaint to the Office of the Privacy Commissioner. The Privacy Act 1993 promotes 12 information privacy principles relating to the collection, holding, use and disclosure of personal information.
  – Consumers of health and disability support services can also complain to the Human Rights Commission if they believe they have suffered unlawful discrimination. Such complaints are pursued under the auspices of the Human Rights Act 1993.
Policy Frameworks

The Treaty of Waitangi

The Crown’s partnership with Māori under the Treaty of Waitangi is central in the health sector and has been interpreted according to the principles of partnership, protection and participation. Specific reference to the Treaty and the need to recognise and respect its principles is contained in the New Zealand Public Health and Disability Act. The Act requires that Māori be part of the decision-making processes within DHBs and that DHBs have processes in place to foster the development of Māori capacity for participating in the health and disability support sector.

In addition to such legislative requirements, the Treaty and the consideration of Māori health issues are central to the work of the Ministry.

Legislation

The organisational features of the sector are, for the most part, governed by the provisions of the New Zealand Public Health and Disability Act 2000 and the Health Act 1956. A number of Crown entities in the sector – such as the Alcohol Advisory Council of New Zealand, Health Research Council, Health Sponsorship Council and Mental Health Commission – have their own specialist legislation.

The safe provision of health and disability services to the public is governed by the Health and Disability Services (Safety) Act 2001. It establishes a framework for improved safety standards for health and disability services and applies to providers of rest homes, residential disability care and hospital care.

Acts administered by the Ministry of Health

Alcoholic Liquor Advisory Council Act 1976
Alcoholism and Drug Addiction Act 1966
Burial and Cremation Act 1964
Cancer Registry Act 1993
Chiropractors Act 1982
Dental Act 1988
Dietitians Act 1950
Disabled Persons Community Welfare Act 1975
Health Act 1956
Health and Disabilities Commissioner Act 1994
Health and Disability Services (Safety) Act 2001
Health Benefits (Reciprocity with Australia) Act 1999
Health Benefits (Reciprocity with the United Kingdom) Act 1982
Health Sector (Transfers) Act 1993
Health Research Council Act 1990
Hospitals Act 1957 (transitional until repealed on 1 October 2004)
Human Tissue Act 1964
Medical Auxiliaries Act 1966
Medical Practitioners Act 1995
Medicines Act 1981
Mental Health Commission Act 1998
Mental Health (Compulsory Assessment and Treatment) Act 1992
Misuse of Drugs Act 1975
New Zealand Public Health and Disability Act 2000
New Zealand Register of Osteopaths Incorporated Act 1978
Nurses Act 1977
Occupational Therapy Act 1949
Optometrists and Dispensing Opticians Act 1976
Pharmacy Act 1970
Physiotherapy Act 1949
Plumbers, Gasfitters and Drainlayers Act 1976
Psychologists Act 1981
Radiation Protection Act 1965
Smoke-free Environments Act 1990
Tuberculosis Act 1948

The Ministry of Health also administers approximately 90 regulations.
The New Zealand Health Strategy

Under the New Zealand Public Health and Disability Act 2000, the Minister of Health is required to determine a New Zealand Health Strategy to provide the framework for the Government’s overall direction of the health and disability sector in improving the health of people and communities. The same Act also requires the Minister of Health to report annually to the public and the House of Representatives on progress in implementing the New Zealand Health Strategy.

Following extensive public consultation, the first New Zealand Health Strategy was launched in December 2000. It places particular emphasis on improving population health outcomes and reducing disparities between all New Zealanders, including Māori and Pacific peoples.

The New Zealand Health Strategy identifies seven fundamental principles that should be reflected across the health and disability sector. Any new strategies for development should relate to these principles.

The seven principles of the New Zealand Health Strategy are:

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

The New Zealand Health Strategy also highlights 13 population health objectives which were chosen, among other things, for the contribution they can make to improving the health status of the population, and their potential for reducing health inequalities.
The 13 population health objectives are to:

1. reduce smoking
2. improve nutrition
3. reduce obesity
4. increase the level of physical activity
5. reduce the rate of suicides and suicide attempts
6. minimise harm caused by alcohol and illicit and other drug use to both individuals and the community
7. reduce the incidence and impact of cancer
8. reduce the incidence and impact of cardiovascular disease
9. reduce the incidence and impact of diabetes
10. improve oral health
11. reduce violence in interpersonal relationships, families, schools and communities
12. improve the health status of people with severe mental illness
13. ensure access to appropriate child health care services including well child and family health care and immunisation.

Under the ambit of the New Zealand Health Strategy, toolkits identify appropriate actions to address the priority objectives, while DHB accountability documents contain specific targets to give effect to the strategy.

The New Zealand Disability Strategy

Twenty percent of New Zealanders report having some type of disability. The proportion of people with a disability in the population increases with age: in 2001 one-quarter of people aged 45–64 reported having a disability, while more than half of people aged 65 years and over reported having a disability. About 60 percent of people with disabilities have more than one disability.

Māori disability rates were higher than the national population rates for each age group in 2001. The disability rate reported for Pacific children was lower than the national rate for children, while disability rates for Pacific people within the older age groups were similar to those for the total population. Figure 5 shows the New Zealand disability rates, by age group and gender, for 2001.
Complementing the New Zealand Health Strategy, the New Zealand Public Health and Disability Act 2000 also requires the development of a New Zealand Disability Strategy. After extensive consultation, the first New Zealand Disability Strategy was launched in April 2001 to guide action to promote a more inclusive society. It is an intersectoral document with relevance across the whole of the public sector in New Zealand.

The New Zealand Disability Strategy presents a vision of a society that values disabled people’s lives and continually enhances their full participation in society. The strategy acknowledges that disability is not something that people have; it is the process that occurs when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people may have.

The New Zealand Disability Strategy identifies 15 objectives, underpinned by detailed actions, to advance New Zealand towards being a fully inclusive society.

Source: Health and Independence Report 2002, Ministry of Health
The 15 objectives of the New Zealand Disability Strategy are to:

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

Departments and ministries across the government sector have developed implementation plans for the New Zealand Disability Strategy. The Ministry of Health was responsible for leading the development of the New Zealand Disability Strategy and overseeing its implementation, as well as funding disability support services. On 1 July 2002 the Ministry’s role shifted to the Ministry of Social Development’s Office for Disability Issues.

The Ministry of Health currently funds a range of disability support services for people with disabilities of all ages, to increase their independence and participation. The family and whānau may also receive support. Disability support services constitute a complex and individualised range of services, from home-based support to residential support services.
Other strategies

Within the ambit of the New Zealand Health Strategy and the New Zealand Disability Strategy the sector has many population- or illness-specific strategies. These include the Child Health Strategy, Achieving Health for All People (public health) and the Health of Older People Strategy. Key strategies covered here in more detail are:

- He Korowai Oranga (the Māori Health Strategy)
- the Pacific Health and Disability Action Plan
- the National Mental Health Strategy
- the Primary Health Care Strategy.

He Korowai Oranga: the Māori Health Strategy

Māori health status is consistently poorer across many indicators than that of non-Māori New Zealanders. He Korowai Oranga was released in November 2002. The overall aim is whānau ora – healthy Māori families, supported to achieve their maximum health and wellbeing. Four pathways are proposed to achieve this:

1. development of whānau, hapū, iwi and Māori communities
2. Māori participation in the health and disability sectors
3. effective health and disability services
4. working across sectors.

Whakatātaka, an action plan to guide implementation of the strategy, was prepared with input from District Health Boards and Māori health groups. The plan outlines roles, responsibilities, performance expectations, measures and initiatives for achieving the strategy. The action plan will be updated every two or three years as implementation progresses.
Pacific health

New Zealand has a close relationship with Pacific peoples, and 6.5 percent of the New Zealand population identify themselves as Pacific people. The gap between the health of Pacific and other New Zealanders shows that Pacific people have poorer health and disability outcomes than non-Pacific New Zealanders. The Pacific Health and Disability Action Plan sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders.
The four principles behind the action plan are:

- dignity and the sacredness of life are integral in the delivery of health and disability services
- active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
- successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

The action plan highlights six priority areas where improvements can be made to health and disability support services for Pacific peoples.

**Mental health**

Mental illness accounts for 15 percent of the total burden of disease in the developed world, with depression predicted to become the second leading cause of disability in the world by 2020 according to the World Health Organization. In New Zealand, it is estimated that at any time 20 percent of the population have a mental illness and 3 percent have a serious mental illness. Mental health services see on average upwards of 30,800 clients per month.

**Figure 7: Estimated prevalence of mental health problems among New Zealanders**

Percentage of New Zealanders ... As a percentage of the adult population

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>General adult population</td>
</tr>
<tr>
<td>20%</td>
<td>another 12% of adult New Zealanders have mild/moderate mental health problems or disorders</td>
</tr>
<tr>
<td>8%</td>
<td>another 5% of adult New Zealanders have moderate/severe mental health problems or disorders</td>
</tr>
<tr>
<td>3%</td>
<td>about 3% of adult New Zealanders have severe mental health disorders</td>
</tr>
<tr>
<td>.06%</td>
<td>about 1% of adult New Zealanders have high support needs</td>
</tr>
</tbody>
</table>

**Source:** Implementing the New Zealand Health Strategy 2002, Ministry of Health
Figure 7 shows the estimated prevalence of mental health problems among adult New Zealanders. Since the 1960s there has been a move away from providing mental health services in large separate mental health institutions. The international evidence is that a community-based model provides the best health and human rights outcomes for service users.

The National Mental Health Strategy is embodied in two Ministry of Health publications: *Looking Forward: Strategic directions for the mental health services* and *Moving Forward*. These publications, along with the Mental Health Commission’s *Blueprint for Mental Health Services: How things need to be*, are the key documents which frame New Zealand’s approach to mental health and mental health services.

**Primary health care**

The Primary Health Care Strategy was released in early 2001. The intention of the strategy is to improve health and reduce health inequalities in the population for all New Zealanders. These changes will be achieved by changing the way that primary health care is provided, organised and funded to better meet the needs of the population served. As previously mentioned, PHOs are the key organisations that will implement the Primary Health Care Strategy.

The six key directions for primary health care highlighted in the strategy are:

- working with local communities and enrolled populations
- identifying and removing health inequalities
- offering access to comprehensive services to improve, maintain and restore people’s health
- co-ordinating care across service areas
- developing the primary health care workforce
- continuously improving quality, using good information.

**Quality improvement**

At the time of writing, consultation was under way on *Improving Quality: A systems approach for the New Zealand Health and Disability Sector*. This document is the Minister of Health’s response to Section 9 of the New Zealand Public Health and Disability Act 2000. It aims to provide a shared approach to
improving quality in the New Zealand health and disability sector. It proposes a system-based approach to quality improvement, recognising that quality results from the complex interaction of individuals, teams and organisations.

**Monitoring achievements and accountability**

A key part of the New Zealand health and disability sector is ensuring accountability for using scarce resources. The Ministry of Health invests considerable effort into the collection, analysis and interpretation of information, and the provision of advice on the performance of the health and disability support system. This has been assisted by the development of a set of performance indicators for DHBs.

To reflect the integration of health delivery and purchasing functions in DHBs, the Ministry of Health monitors all aspects of performance across the health and disability sector. This includes both the delivery of services and the Government’s ownership interests in public hospitals and related services. The New Zealand Public Health and Disability Act 2000 provides for a number of sanctions on DHBs if the Minister of Health is seriously and repeatedly concerned about the performance of an individual board.

As part of the accountability and monitoring arrangements in the health and disability sector, the Director-General of Health is required to report annually on the state of public health. This report, the *Health and Independence Report*, monitors and assesses the New Zealand public health and disability system, the services it delivers, and what they achieve for New Zealanders. The Minister of Health is also required to report annually to the public and the House of Representatives on the progress towards the goals of the New Zealand Health Strategy.

The Ministry of Health monitors and reports on aspects of the health and disability system such as health and disability expenditure, and health and disability status. Information on these can be found at www.moh.govt.nz.

Since late 2001 there has been an increasing focus within the public sector on outcomes. In accordance with this emphasis, the Ministry of Health produces a Statement of Intent each financial year. The statement outlines the outcomes the Ministry is aiming towards, the contribution the Ministry can make to the achievement of these outcomes, and the activities and outputs that will form that contribution. The statement also includes key indicators, which provide an indication of progress towards these outcomes.
Better health
The best possible improvement in New Zealanders’ health status and quality of life over time, within the resources available.

Reduced inequalities
An improvement in the health status of those currently disadvantaged, particularly Māori, Pacific peoples and people with low socioeconomic status.

Trust and security
New Zealanders feel secure that the system will protect them from substantial financial costs due to ill health and trust the system because it performs to high standards, reflects their needs and provides opportunities for community participation.

Better participation and independence
The health and disability support sector contributes constructively to having a society that fully values the lives of people with disabilities.

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A fair and functional health system

Equity and access
New Zealanders in similar need of services have an equitable opportunity to access equivalent services and resources are allocated in a manner that reduces inequity of outcomes.

Effectiveness
The system as a whole, and the services provided within the system are effective in contributing to the end outcome of healthy New Zealanders.

Quality
Health and disability support services are clinically sound, culturally competent and well co-ordinated and ongoing service quality improvement processes are in place.

Efficiency and value for money
The system operates efficiently and services deliver relatively large gains in health status for each unit of resource.

Intersectoral focus
Social, environmental, economic and cultural factors are influenced to reduce their negative impacts and increase their positive impacts on end outcomes for the health and disability system.

Healthy New Zealanders

Ministry of Health - ensuring the system works for all New Zealanders

Direction of leadership
There is a coherent stable and widely understood direction for the system, informed by evidence and horizon scanning, and resourcing and incentives are aligned with this direction (including collaboration, co-ordination and service development).

System funding
Financial resources are secured for the system and are allocated on a fair and transparent basis within it.

System capability
Ensuring (within the ambit of the Ministry’s functions) that the key inputs – including physical structures, workforce, and information – are in place.

Operating environment
Unnecessary constraints on participants in the system are minimised and there are widely understood mechanisms and structures in place to protect public safety and equity.

System monitoring
Monitoring of the performance of the system and of specific organisations within it is used to improve the design and operation of the system including the performance of organisations within it.
As Figure 8 illustrates, the Ministry of Health has developed an outcomes framework to help clarify its contribution to the goal of healthy New Zealanders and to guide future activities. This framework is designed to show how the Ministry influences the health and disability support system and how it uses this influence.

The framework shows four outcomes that make up the ultimate outcome of healthy New Zealanders. The Government, Ministry of Health and health and disability support sector seek to achieve these four outcomes. The second tier of the framework presents the five outcomes that a fair and functional health and disability support system must achieve. These outcomes are all within the control of DHBs and the wider sector. The third tier identifies the outcomes the Ministry needs to achieve in its key areas of influence.
Financing and Funding

New Zealand’s health system is predominantly public funded. In 2002 public sector funding accounted for 78 percent of all health expenditure in New Zealand. The other main contributors are private insurance and out-of-pocket payments. In 2003/04 government expenditure on health is expected to be just over $8.0 billion, or 20 percent of total government-budgeted expenditure ($41.7 billion).

Most health care in New Zealand is provided free of charge. Primary care is the one exception, where a fee-for-service system exists (although the Primary Health Care Strategy is modifying this). In addition, individuals may also use private health insurance if they wish. The majority of private sector funding of health comes from out-of-pocket expenditure by private households. This accounted for 16.8 percent of total health expenditure in 2000/01, while health insurance accounted for 6.2 percent. Between 1989/90 and 2000/01 the proportion of health expenditure financed privately rose 22.1 percent to 23.3 percent of total health funding. As Figure 9 shows, this rise has been within health insurance and out-of-pocket payments.

Figure 9: Total health funding(%) in 1989/90 and 2000/01

From 1991/92 to 2000/01 total per capita real expenditure on health increased at an average annual rate of 3.4 percent, rising at an average annual rate of 3.0 percent for public expenditure and 4.6 percent for private expenditure.

Many disability support services are targeted at certain sectors of the population. For example, home help is often only available to those with a Community Services Card, while aged residential care is currently income and asset tested. However, at the time of writing, legislation was being developed to progressively remove asset testing (but not income testing) for older people in long-term residential care. Environmental support services are targeted in a number of ways, including income and asset testing and whether a person is in work or education.

While the Ministry of Health is the predominant government funder of disability support services, other support services are funded through agencies such as the Ministry of Education, ACC and the Ministry of Social Development’s work and income service. Approximately 20 percent of the government’s expenditure on health and disability support services is used to fund disability support services. Figure 10 shows that expenditure on disability support services has increased steadily from 1995/96 to 2001/02 by between 2.5 percent and 7 percent each year.

**Figure 10: Disability support services expenditure 1995/96–2001/02**

Source: Health and Independence Report 2002, Ministry of Health
Approximately 90 percent of disability support services expenditure in 2001/02 was on five main service areas, as shown in Figure 11.

**Figure 11: Disability support services expenditure, by service area, 2001/02 forecast**

Source: *Health and Independence Report 2002, Ministry of Health*

In 2001/02 government funding for specialist mental health services increased by $45 million, or 6.1 percent, from $743 million to $788 million. Figure 12 shows mental health spending by service category for 1999/2000 to 2001/02.
Figure 12: Mental health spending, by service category

$Million

Source: Implementing the New Zealand Health Strategy, Ministry of Health, 2002

It is informative to compare health expenditure internationally as a proportion of gross domestic product (GDP). This comparison is shown for OECD countries in Figure 13. The level of funding for New Zealand is at the level one would expect for its level of GDP, although there is no ‘correct’ level of expenditure on health.

Figure 13: Relationship between health expenditure and GDP in the OECD, 2000

Health expenditure (US$PPP per capita)

Source: Health and Independence Report 2002, Ministry of Health
The proportion of the New Zealand population aged over 65 years is expected to rise dramatically over the next 50 years, from 12 percent to 25 percent. Figure 14 shows the much higher-than-average cost of providing health and disability support services for older people. As the number of older people increases, increased funding will be required to provide the same level of service in the future. Although some areas of government expenditure are likely to decrease due to an ageing population (eg, education), the extra costs in superannuation are likely to overshadow these.

**Figure 14:** Estimated annual per capita Vote:Health expenditure (GST excl.) on health and disability support services, by age group and gender, 2001/02

Source: Health and Independence Report 2002, Ministry of Health
A competent, adaptable health and disability support workforce is a crucial ingredient for high-quality health and disability support services. By international standards the New Zealand health and disability support workforce is highly skilled and knowledgeable, and well equipped to provide the wide range of technical and complex health services available.

Over the last decade many health workforce issues have reflected domestic and international labour market issues, such as factors influencing the supply and demand for labour, and the time lags for training. Perceived shortages and surpluses during the period have reflected a lag in labour market response to rapid policy-driven changes such as the expansion of mental health services. In this environment, the employers of health professionals managed short-term difficulties in filling vacancies by bringing in personnel from overseas. Greater difficulty was experienced in areas of international shortage; for example, of psychiatrists, experienced registered nurses and, more recently, medical radiation therapists.

The changing demographic profile of New Zealand also has implications for the health and disability support workforce. As ethnic diversity in New Zealand increases, there is increased demand for a knowledgeable and culturally appropriate workforce that can deliver high-quality services to diverse communities. The ageing population will also lead to greater demand for health and disability support services.

In 2001 the New Zealand health and disability support workforce comprised more than 100,000 people. This figure includes approximately 67,000 health practitioners and an estimated 30,000 support workers. Around 10,000 alternative and complementary health workers offer services directly to the public.

Some of the issues related to the health workforce that need to be addressed are:

- ensuring there are appropriately trained health professionals to accommodate an expanded role for the provision of primary care
- encouraging the training of Māori and Pacific health professionals to deliver services to their people
• ensuring a collaborative approach to health workforce education and training to guarantee a competent and responsive health workforce.

• building the health and support workforce for people with disabilities.

HWAC (see page 10) provides information and advice on workforce issues.

There are also a number of initiatives under way which aim to address specific workforce and provider issues.

• Māori provider development – the Māori provider development scheme and Clinical Training Agency funding has been supporting Māori workforce development.

• Pacific providers – a Pacific provider development fund has been established and will be used to contribute to strengthening the Pacific health and disability workforce.

• DHB initiatives – DHBs are undertaking a number of initiatives aimed at addressing workforce issues.

• Nursing initiatives – a number of initiatives are being developed aimed at developing the role of nurses. These include training enrolled nurses in limited scopes of practice, the development of nurse practitioners, extending prescribing rights to nurses, and a national framework for primary health care nursing.

• Mental health initiatives – workforce development is crucial to the successful implementation of the Mental Health Blueprint. A workforce development strategy has been developed to help understand the labour market in more detail. Current activity is also focused on the Māori mental health workforce, the child and youth mental health workforce, and developing the non-government organisation sector through grants for training.
Information Systems

Good information systems for data collection, supporting decision-making by practitioners, and administration are central to improving the safety and quality of services and to strengthening the delivery of community-based primary health care. Collecting good data also allows population health to be measured, while access to information about the health and disability system is crucial for public participation in decision-making.

New Zealand is recognised as a world leader in health information management. Key elements of the information infrastructure in place now in New Zealand are described below.

• National data collections covering many key services include the National Minimum Data Set of secondary and tertiary health data, the national Cancer Registry and the national Mortality Register. The Ministry of Health regularly publishes health statistics as well as a larger number of analytical reports. Much of this is available on the Ministry’s website (www.moh.govt.nz). The latest statistical information and data dictionaries are provided on the New Zealand Health Information Service website (www.nzhis.govt.nz).

• A unique patient identifier, the National Health Index, is used to identify each individual who uses the publicly funded health care system in New Zealand by assigning them a unique identifying number. The National Health Index number itself is assigned randomly to an individual by a computer. No part of it has any other meaning or significance.

• A national allergy and adverse reaction system – the Medical Warning System – tells an authorised practitioner of any information or known risk factors that might be important in making decisions about the care of a patient. Not everything within the Medical Warning System is a warning, but the name was selected because it conveys the main purpose of the system.

• The Privacy Act 1993 and the Health Information Privacy Code 1994 require that when any information is collected from an individual, the individual must be informed who is intending to use the information and for what purpose. The Health Information Privacy Code allows individuals to review any health information held about them and to have any corrections they wish noted, by appending them to the original. The code does not give them the right to delete information if it has been legitimately collected.
• Implementation of a national health intranet, the Health Network, allows the secure exchange of health information by health providers. It is designed to assist in the delivery of integrated health care by connecting, for example, general practice and secondary care clinicians, and enabling access to administrative systems such as the National Health Index.

• Work is ongoing on developing a National Practitioner Index (NPI). This will allocate each practitioner a unique identifier and will also contain information on those practitioners. The NPI will have many different uses: organisations sharing information (eg, for hospital referrals) will not have to maintain their own lists of each referring professional; and health professionals will have only one number to identify themselves to ACC, a DHB or pharmacy. Identifiers will be published for every agency that makes claims, or receives and gives health funding, and for each site where health services are delivered.

• A website was launched in November 2002 to provide information on elective services. This website, www.electiveservices.org.nz, reports on DHB performance against a small number of key elective services performance indicators. This information can be viewed both nationally and by DHB. The performance indicators help DHBs to assess their performance and address any areas that need improvement, while the publication of the performance indicators provides the community with an opportunity to gather information about the provision of health services.
Activity in the Health and Disability Sector

The health and disability sector is large and complex. Some summary statistics are provided below, although there are many other interactions that people have with the sector (eg, through accessing clean water or health promotional material). DHBs are a crucial part of activity in the health and disability sector. Information about the services they provide can be found on their websites (see page 45).

On a typical day:

- 98,630 prescriptions are filled
- 40,000 people visit a general practitioner
- 29,100 older people will be in long-stay residential care
- 2000 people are seen in accident and emergency departments of public hospitals
- 1700 people are admitted to a public hospital
- 1100 cervical smears are taken
- people with disabilities will make 264 applications for environmental support services
- 261 people are accommodated in community residential mental health care facilities.

In 2000/01 there were approximately 14.6 million individual consultations with GPs, excluding ACC visits. Figure 16 provides a breakdown of the age and gender of those visiting GPs. It indicates that most consultations involve the very young or the elderly. Females are also more likely to visit a GP than males of the same age, in all age groups except children under five years.
Over 36 million prescriptions were dispensed in 2000/01. The breakdown of this total by age and gender is shown in Figure 16. On a per capita basis, pharmaceutical services are predominantly used by people over the age of 45, with the number of prescriptions increasing rapidly with age thereafter. As with GP visits, females obtain more prescriptions on average than males of the same age, in all age groups other than children under five years.
Hospitals are treating more patients than they have in the past. Raw discharge rates have increased, and even after adjusting for changes in the age and sex structure of the population there has been an increase in the number of discharges. The raw number of day patients rose by 13.5 percent per year from 1988/89 to 1996/97, and by 4.1 percent from 1996/97 to 2000/01. The average length of stay of patients decreased from 6.6 days in 1988/89 to 3.3 days in 2000/01.
Outcomes

The main outcome for the health sector is an improvement in health status at both the individual and population levels. This section describes the health status of New Zealanders and health outcome measures.

The actual measurement of outcomes attributable to health services is complicated, because health status is affected by a wide range of factors, many of which are outside the influence of the health and disability sector. Mortality (deaths) and morbidity (illness) are two measures affected by factors such as ethnicity, sex, income and employment status. Nevertheless, these measures provide a useful indication of health status and allow comparisons to be made both internationally and over time.

Mortality

Mortality is a very direct indicator of the overall health of a nation, although the rates do not measure the quality of life. Overall, mortality rates in New Zealand have declined dramatically over the last half-century, and life expectancy at birth reached 76.0 years for males and 80.9 years for females in 2000. Life expectancy at birth for the total population was 78.4 years in 2000. Mortality is now concentrated into old age, with 74 percent of deaths occurring after the age of 65 and 54 percent occurring after age 75. The probability of survival to 45 years now exceeds 95 percent for the population as a whole. Over 85 percent of people who survive to age 45 will reach their 65th birthday, and more than 75 percent of those reaching 65 will survive to 75 or beyond.
In terms of international comparison, Figure 17 shows that life expectancy in New Zealand is above that in the USA and the UK, but below that of Australia.

Overall life expectancy figures do not give any indication of the quality of life, however. Health-adjusted life expectancy (HALE) measures the number of years of healthy life that an individual in a particular country can be expected to live. Figure 18 illustrates that New Zealand fares better than Canada and the USA and slightly worse than Australia.
Overall life expectancy figures hide disparities between different social groups. Within New Zealand there are marked discrepancies in life expectancy between different ethnic and socioeconomic groups. Within New Zealand a deprivation index has been developed, known as NZDep96. This index classifies neighbourhoods into one of ten bands, from 1 (least deprived) to 10 (most deprived) in terms of material and social deprivation. Figure 19 shows differences in life expectancy at birth for different ethnicities and NZDep96 deciles.
As in all OECD countries, most New Zealanders now die of (often multiple) chronic diseases. Cancer, ischaemic heart disease and stroke were the leading causes of death in New Zealand from 1997 to 1999. Figure 20 summarises, by sex, the main causes of death.
Morbidity

Morbidity is a term for illness. Illness ranges from minor colds during winter months, through to chronic diseases such as heart disease and trauma (injury) caused by accidents.

About three-quarters of the population will experience illness or injury in a two-week period, although the majority of these will not be serious and will be fairly easily resolved. Fewer than 1 in 10 will result in consultations with a GP or other primary care provider. Fewer than 1 in 100 of the GP encounters will then result in referral to hospital. Table 1 shows the main reasons for hospitalisation.
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Percentage of all public hospital day and inpatient discharges</th>
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<tbody>
<tr>
<td><strong>Infectious diseases</strong></td>
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<td>Maternal and infant conditions</td>
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<td>Complications of pregnancy, childbirth and the puerperium</td>
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<td>Perinatal conditions</td>
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<td>Congenital anomalies, chromosomal abnormalities, and hereditary disorders</td>
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<td><strong>Injuries</strong></td>
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<td>Unintentional injuries</td>
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<td>Intentional injuries</td>
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<td>Adverse effects</td>
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<td><strong>Chronic diseases</strong></td>
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<td>Cancer (all sites)</td>
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<td>Endocrine disorders (including diabetes)</td>
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<td>Cardiovascular diseases</td>
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<td>Respiratory diseases</td>
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<td>Diseases of the blood and lymphoid tissues</td>
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<td>Kidney diseases</td>
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<td>Skin diseases</td>
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<td>Dental disorders</td>
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<tr>
<td><strong>Ill defined disorders</strong></td>
<td>7.4</td>
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</table>

Source: *Our Health, Our Future: The health of New Zealanders*, Ministry of Health, 1999
Excluding normal pregnancy and childbirth, the leading reason for hospitalisation is management of chronic diseases, with the leading one being cardiovascular disease.

Injuries made up approximately 20 percent of discharges in 1997, with the highest rates found among older people, as shown in Figure 21.

Figure 21: Hospitalisations for unintentional injury, by age and injury type, 1997

Source: Our Health, Our Future: The health of New Zealanders, Ministry of Health, 1999
Other Information

For further information about the New Zealand health sector, including access to publications, please refer to the Ministry of Health website: www.moh.govt.nz.

For general statistics about New Zealand, including many useful health statistics, please refer to the Statistics New Zealand website: www.stats.govt.nz

District Health Board websites:

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