

Briefing to the Incoming Minister of Health

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MANATŪ HAUORA

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Executive summary

This briefing provides you, as the incoming Minister, with information on challenges and opportunities facing the New Zealand health and disability system, and how the Ministry can advise and support you to implement your Government's priorities for health. The Ministry looks forward to discussing with you how to progress your health policies, including: providing high-quality health services; healthy communities; a strong and engaged health workforce; quality aged care and mental health services.

The New Zealand health and disability sector provides world-class services, is driven by a trusted, passionate and skilled workforce, across a spectrum of public, NGOs and private providers, and serves a population that can generally access the care it needs, when it needs it. There are, however, many pressures and environmental changes that require both immediate management and longer-term strategic change. As Minister, you have a number of levers at your disposal to guide system change through setting policy direction, legislation and regulations, funding models and performance management, as well as influencing culture and leadership.

Every New Zealander will, at some point in their lives, rely on our health and disability system. It is a large and complex system with multiple decision-makers and mixed public and private ownership models. It operates in a dynamic, continually changing environment characterised by well-known global and local challenges, including:

- changing population health needs and burden of disease (especially the rising impact of long-term conditions and risk factors, such as diabetes and obesity)
- the growing impact of health-care associated infections, antimicrobial resistance and emerging infectious diseases, eg, Ebola
- rapid advances in technology, developments in personalised medicine and changing public expectations
- an ageing population, and a workforce that is ageing along with the population
- a constrained funding environment for the foreseeable future
- a growing fiscal sustainability challenge as health consumes an increasing proportion of total government expenditure.

These challenges are placing pressure and new demands on the way public health and disability services are currently delivered. Significant gains in the overall health of New Zealanders could be achieved by concentrating on people who have poorer health outcomes, complex health needs or who need a stronger voice. These might include vulnerable children, older people, people with long-term conditions, people with mental health and addiction problems and people with disabilities.

Health and disability services need to build on current progress and adapt to future needs. The health system's ability to provide a sustainable, quality public health service depends on keeping ahead of the challenges. This briefing provides some suggestions for where we could work with you to meet these challenges.

There are opportunities to make better use of existing resources, people, facilities and funding, through new ways of delivering services that keep people well with better prevention and early

intervention. Significant gains could be made by developing a longer-term focus on preventing disability and illness in the first place.

There are new opportunities for the health workforce to work in different ways with a broader range of colleagues across the health and wider social sectors, and with partners in the community.

To better equip the New Zealand health and disability system for the future, we suggest focusing on four areas.

- 1 **Better integrate services within health and across the social sector:** Strengthening integration within health and across government to support the most vulnerable, reduce inequities and address issues outside the health and disability system that impact on health.
- 2 **Improve the way services are purchased and provided:** Ensuring funding models support change, building and supporting the key enablers and drivers of change: workforce, health information and capital.
- 3 **Lift quality and performance:** Driving performance through measuring and rewarding the right things to improve quality.
- 4 **Support leadership and capability for change:** Supporting strong governance, clinical and executive leadership and capability across the health sector.

Welcome to the role of Minister of Health

This briefing is to provide you, as the incoming Minister, with information on the challenges and opportunities facing the New Zealand health and disability system, and how the Ministry of Health can advise and support you to implement your Government's priorities for health.

The Ministry of Health provides whole-of-sector leadership for the health and disability system. Our goals are to ensure that:

- New Zealanders are healthier and more independent
- high-quality health services are delivered in a timely and accessible manner
- the health and disability system is sustainable.

As Minister, you can lead and steer the health sector by setting strategic direction through the New Zealand Health Strategy and other key policy directions, legislation and regulations, funding and payment systems and related performance management and improvement, as well as influencing system culture and leadership.

This briefing identifies future opportunities where these approaches can support the ongoing development of quality health and disability services.

Your Government's priorities

The Ministry looks forward to discussing with you what the health and disability sector has been doing to address the challenges and opportunities we are facing, and supporting you to meet your Government's goals.

We understand from your Policy 2014 documents that your priorities in health include:

- **providing world-class, high-quality health services**, by investing in reducing pain and providing more elective operations; setting up a new cancer treatment target; and increasing hospice and palliative care funding
- **keeping communities healthy**, by providing free GP visits and prescriptions for all children under 13; continuing to improve care for people with long-term conditions; reducing the incidence of rheumatic fever; rolling out Healthy Families NZ and investing in information technology to improve services for patients
- **ensuring a strong and engaged health workforce**, by continuing to increase doctor and nurse numbers while containing back-office costs; expanding the voluntary bonding scheme; creating new palliative care nurse specialist and educator roles and expanding opportunities for nurses (eg, for specialist nurses to perform colonoscopies)
- **securing the future of quality aged care**, by putting in place a new model of care for older people to deliver care that is tailored to the individual
- **providing world-class mental health services**, by continuing to provide New Zealanders with high-quality mental health services; continuing to implement relevant action plans; and providing better mental health support for those with cancer.

Three of the bigger policies that stand out as early priorities for implementation include:

- investing \$50 million extra over three years to reduce pain in bones, muscles and joints; and providing more orthopaedic operations, general surgery, multi-disciplinary early intervention and elective surgery (an increase of 14,500 by 2016/17)
- setting a new cancer treatment target: that 90 percent of patients, where a doctor has a high suspicion of cancer, will see a specialist within two weeks, and get their first treatment within 62 days
- providing free GP visits and prescriptions for all children under 13 from July 2015.

We note that you may also agree to further health priorities through Confidence and Supply Agreements or other negotiations.

The health and disability system has generally performed well in tight financial times

New Zealand's public health and disability system provides quality care for individuals and their families and whānau; improves the wellbeing of communities and the wider population; and largely provides services efficiently, effectively and sustainably, providing value for money for taxpayers. The health system is also a significant contributor to the New Zealand economy and economic growth. For example, district health boards (DHBs) contribute to the local economy as employers and purchasers of supplies, and innovation in the health sector can bring commercial opportunities both nationally and internationally.

High-quality care is provided for individuals and their families. Ninety percent of New Zealanders report they are in good, very good or excellent health, and for those aged over 75 this is over 80 percent.

People are largely happy with the services they receive. Eighty percent of adults report they are satisfied with the care they receive from their usual medical centre and 83 percent of patients rate their care in emergency department (ED) services as good or very good.

Care is generally well-coordinated and provided where and when people need it. The Commonwealth Fund ranks New Zealand first for primary care physicians receiving information back from specialists, and second for primary care physicians being notified that a patient has been seen in the ED.

From April to June 2014, 94 percent of patients were admitted, discharged or transferred from an ED within six hours. All patients who were ready for treatment waited less than four weeks for radiotherapy or chemotherapy.

Services are generally safe and effective. Amenable mortality (deaths that could have been prevented by timely access to health care) is falling. From 2000 to 2011, the rate dropped by about one third.

New Zealand compares well to other OECD countries for many measures of safe care (such as the five-year relative survival rate for breast cancer and the mortality rate within 30 days of admission for myocardial infarction). However, there is room for improvement on other measures where New Zealand falls below the average, such as post-operative complications.

Public health initiatives to improve health are showing results. Cancer screening programmes help to identify individuals at risk of cancer, allowing prevention or early treatment. Breast and cervical screening rates have improved over the last five years (from 63.2 percent to 72.6 percent for breast cancer, and 76 percent to 76.6 percent for cervical

cancer). Rates for Māori and Pacific women have increased faster than for the general population, reducing disparities in screening take-up.

The health target for childhood immunisation has seen an increase in the proportion of two-year-olds who are fully immunised from 80 percent in 2009 to 93 percent in 2012. The focus has now shifted to younger children.

Services are provided efficiently and sustainably. New Zealand public health services provide good value for money by international standards. New Zealanders enjoy relatively high life expectancy at birth, for a relatively modest health expenditure per capita, compared with other OECD countries.

PHARMAC's approach to managing the pharmaceutical spend is world leading, and New Zealand has one of the highest proportions of generic medicines by volume, at 73 percent in 2011, compared with the OECD average of 41 percent, which helps keep costs down.

DHBs meet the health needs of their populations while operating within tight budget constraints. The health sector has shown itself to be adaptable by reducing deficits while improving performance in targeted areas. DHBs have reduced their deficits from a forecast of \$200 million five years ago to approximately \$19 million in 2012/13. The Ministry has reduced departmental spending from \$189 million in 2011/12 to \$176 million in 2012/13, to release resources for reinvestment. However, continuing this level of fiscal constraint will be harder in the future without changes to how the system operates.

However, we face pressures

New Zealand's health and disability system, like most similar health systems, continues to face a set of pressures that include:

- some populations have poorer health access or outcomes than the general population, or complex needs that require increased collaboration with the community and across the health and wider social sector
- changing population health needs and patterns of health and ill-health (eg, the growing impact of long-term conditions such as diabetes and risk factors such as high body mass index, multiple comorbidities that increase with age, population growth and ageing)
- an ageing and unevenly distributed workforce, which does not currently match the anticipated future demand for health and disability services
- more expensive treatments and increasing costs, and changing public expectations of services and treatments
- a constrained funding environment and a growing fiscal sustainability challenge as health continues to consume an increasing proportion of total government expenditure.

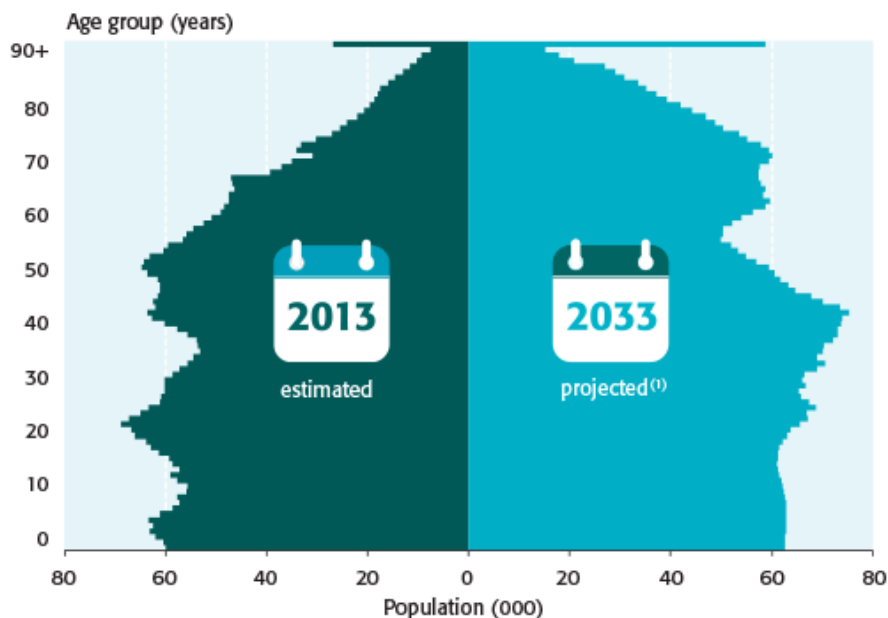
These challenges mean that our approach will need to keep evolving, and health and disability services will need to build on progress to date and adapt for future needs. Modest increases to health funding have been indicated in the short to medium term but we still need to make better use of existing resources, people, facilities and funding, and at times make difficult decisions. The health and disability system's ability to continue to provide the level, coverage and quality of services we do now will depend on how well it keeps ahead of the challenges.

Demand-side challenges

Changing populations and impacts of diseases on people's lives

New Zealand's population is ageing, with the proportion of New Zealanders aged 65 and over predicted to increase from 14 percent of the general population in 2013 (approx. 630,000 people) to 22 percent in 2033 (approx. 1.15 million people). In 20 years' time, 11 percent of New Zealand's population (approximately 600,000) will be aged 75 and over, compared with 6 percent (approximately 290,000) now.

Age structure, 2013 and 2033



1. Based on mid-range projection.

Source: Statistics New Zealand

Different population groups have different age structures; for example, Māori and Pacific peoples have more youthful populations. The Māori median age of just under 24 years remains significantly younger than both the national and European median age (38 and 41 years respectively). Although Māori and Pacific populations are more youthful, many health conditions are more common for Māori adults than for other adults, including heart disease, stroke, diabetes, chronic pain and arthritis. The overall youthfulness of the Māori population masks the fact that the number of Māori aged 65 and older has grown rapidly over the last decade and will continue to increase at a faster rate than in other ethnic groups.

There are a number of implications of an ageing population. The shift towards older age groups may drive up health expenditure. New Zealanders are living longer, but over one third of the additional years gained are spent in poor health. By age 75, two thirds of adults have at least two long-term conditions; 15 percent have four or more.

An ageing population also means there may be a relatively smaller base of tax-paying adults to fund the services provided in the health and disability system.

Rates of disability are also increasing. The 2013 Disability Survey found that 24 percent of New Zealanders had a disability (physical, sensory, psychiatric, intellectual impairment). This is an increase from 20 percent in 2001.

The burden of disease is shifting, much of which can be attributed to recognised risk factors

Burden of disease is a measure of the impact of diseases on people's lives, both through shortening them and diminishing them.

Cancer is the biggest cause of illness, disability and premature mortality (17.5 percent). Ischaemic heart disease and stroke are significant but falling (9 percent and 4 percent respectively). Ongoing and new challenges include mental health disorders, neurological conditions (including dementia), musculoskeletal conditions (including osteoarthritis and back disorders), chronic pain syndromes, sleep disorders and reproductive disorders. Many of these conditions have an impact outside the health and disability system, for instance the impact of mental health and musculoskeletal conditions on employment and the uptake of welfare.

About one third of illness, disability and premature mortality is associated with risk factors that are modifiable through interventions such as prevention and treatment. For example, tobacco use (9.1 percent) was the leading risk to health in 2006, followed by high body mass index (7.9 percent), high blood pressure (6.4 percent) and physical inactivity (4.2 percent). By 2016, it is projected that high body mass index will overtake tobacco use as the leading risk to health, making obesity a significant issue for New Zealand. This is not to diminish the continuing impact of tobacco use with over half a million smokers.

There are persistent inequities in outcomes and access

While the health and disability system performs well for most New Zealanders, persistent inequities exist. A number of groups have significantly worse health outcomes.

Population-based funding and additional sources of targeted financial assistance aim to reduce the various barriers to access. However, access to health care continues to be an issue for some groups, with cost affecting some people's access to primary care and prescription medicines.

Low socioeconomic position is associated with poorer health. Poor health is less frequent in the most advantaged social group and becomes increasingly common as disadvantage increases. This relationship indicates a social gradient in health, which applies across many health outcomes, risk factors and access to health services and is evident across all measures of socioeconomic position, such as deprivation (NZDep), education, employment and income.

According to the 2012/13 Health Survey, about 35 percent of adults living in the most deprived areas experienced one or more types of unmet need in the past year, compared with 23 percent in the least deprived areas. People in high-deprivation areas are twice as likely to report cost as a reason for not visiting a GP or after-hours clinic, and are more likely to report cost as a reason for not collecting a prescription. Subsidised GP visits and prescription costs help in addressing the cost issue.

Life expectancy at birth is 83.0 years for females and 79.3 years for males, and has increased by 0.8 years for females and 1.3 years for males since 2005–07. The gap between Māori and non-Māori life expectancy at birth is narrowing, but is still 7.2 years for females and 7.4 years for males. Ongoing effort will be required to maintain this improvement.

People with intellectual disability have, on average, far lower life expectancy than other New Zealanders: 18 years lower for men and 23 years lower for women. There is also a well-established association between serious mental illness and relatively poor physical health outcomes. People living with a serious mental illness are at greater risk of a range of chronic conditions and have a shorter life expectancy than the general population.

New Zealand's population continues to grow and to change. As well as the demographic effects discussed above, New Zealand is becoming increasingly diverse, with the population identifying as Asian growing faster than any other group. This diversity means that the services the health and disability system provides, and the way it provides them, will need to change in response.

The rate of growth and change in the population is not the same everywhere. The three Auckland DHBs are expected to grow at twice the rate of other DHBs. This presents a set of challenges for how services are planned, funded and provided in different districts.

Changing public expectations

Health professionals and the health sector are faced with an environment of rapidly changing services and technology. Advances in technology and people's expectations for convenience and connectedness mean that emerging eHealth solutions and health care technologies will play an increasing role in supporting our health and disability system to offer the best possible care in a timely way. eHealth can support access to the right information, by the right people, at the right time.

Consumers increasingly require convenient access to their health information to support them to make decisions about their health and treatment and better manage their own health and wellness. eHealth is a powerful tool to make health services more people-centred.

With increasing access to a variety of tools and information, eHealth and other new technologies can raise public expectations about the range of treatments and services that could be available beyond what is known to be effective, cost-effective or affordable for New Zealand. While they can increase costs through the development of new services, eHealth and new technology can also reduce costs through efficiencies in the way existing services are provided.

Supply-side challenges

Health services must be provided within fiscal constraints

Health spending has been growing at a faster rate than gross domestic product (GDP) in New Zealand for much of the last 60 years. Real spending has increased from \$583 per person in 1950 to \$2987 per person in 2011 (in 2011 dollars). Vote Health is now approximately 21 percent of core Crown expenditure.

The Treasury projects that, unless the health and disability system changes its approach, government will need to spend a much higher percentage of GDP on health services (which will begin to crowd out other government activity or consumption), or reduce access to services, or require patients to pay a greater share of costs. For example, they project that health spending could increase from 6.8 percent of GDP in 2012 to 7.7 percent of GDP in 2030.

The health and disability system has shown it can adapt to slower funding growth: since 2010, DHBs have successfully reduced deficits while new Vote Health operational funding has reduced from 6 to 9 percent of baseline between 2002 and 2009, to under 3.5 percent of baseline since

2010. As New Zealand emerges from the global financial crisis and out of deficit, the health sector will need to continue to demonstrate the adaptability and fiscal discipline it has recently shown.

Clinical and workforce sustainability will continue to be a focus

Providers and planners must be able to maintain safe, high-quality services for the population they serve. This is a wider issue than one of financial sustainability – clinical sustainability requires a sufficient workforce with the right skills to meet demand for health services.

Like the population it serves, New Zealand's health workforce is ageing. For example, 46 percent of the nursing workforce is aged 50 or over and some regions have significantly larger proportions of older nurses. As these health professionals retire, this will have an impact on capacity in the health and disability system.

Internationally trained medical graduates make up 43.6 percent of New Zealand's medical workforce and internationally qualified nurses make up 26 percent of the nursing workforce. Changes in the international labour market affect us. For example, a shortage of nurses in New Zealand is expected, prompted by a projected Australian nursing shortage in the near future.

The workforce needs to provide services that remain appropriate and accessible to a changing population. Pacific peoples make up 11.8 percent of the population, but only 1.8 percent of doctors and 2.5 percent of nurses; Māori make up 15 percent of the population, but only 3 percent of doctors and 6.6 percent of nurses.

To respond to the changing burden of disease, the health and disability workforce will need to work in different ways. There will be greater emphasis on working with a wider range of colleagues (within the health sector and the broader public services including local government) and partnering with individuals, their whānau and communities to ensure services are delivered in a way that meets people's needs. The changing needs of people with long-term conditions require a workforce prepared to provide services that include coordinated care plans and a higher number of contacts. It will also mean a greater focus on wellness and prevention in addition to treating acute episodes.

These pressures mean that the New Zealand health and disability system needs to build on current progress and adapt to future needs

The combined impact of these challenges means that we can't stand still – the New Zealand health and disability system needs to build on progress to date and adapt to future needs. The health and disability system's ability to provide sustainable quality public health services will depend on active management that keeps ahead of the challenges and makes wise investment and affordability a strong focus.

The health and disability system needs to continue to improve access, effectiveness and quality of treatment services, while also strengthening preventive and early intervention efforts to respond to the growing pressures of changing health needs. The focus on wellness, prevention and building individual and community resilience means that a health and disability system needs to change how, where, when and what services are provided and with whom it partners and collaborates.

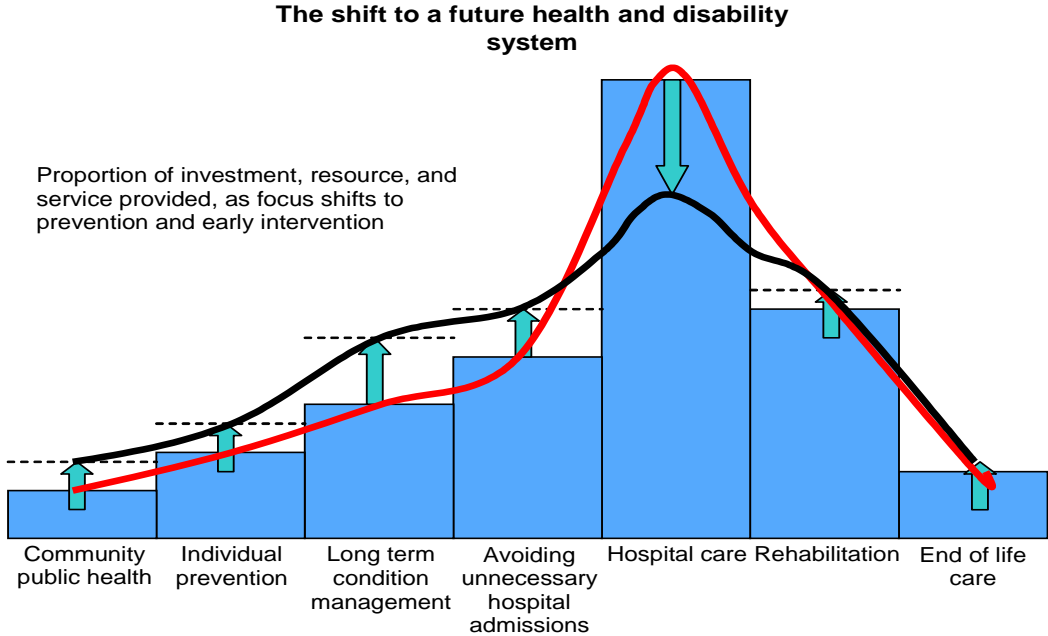
This shift can be described in the following way.

- Health service responses are shifting toward people being well and staying well through prevention and early intervention at individual and population levels, based on a strong foundation of primary and community services.
- High-quality acute and elective services will continue to be provided while specialist services evolve to ensure their clinical and financial sustainability.
- Rehabilitative and palliative care services need to expand and respond to our ageing population and changing burden of disease.
- The needs and futures of people will be at the centre of decision-making in the health and disability system. Providers will need to think about how best to respond to the changing needs of their populations and adapt accordingly.
- Individuals, whānau and communities will have greater participation and better information about the services they receive and in the management of their health and wellbeing, supported by new and emerging technologies.
- There is greater integration of services to improve health and social care pathways within health, and across health and the wider social sector.

To achieve this we are rebalancing where, how and by whom services are provided and over time this will be matched by a rebalancing of the proportion of investment:

- a greater proportion of health expenditure spent on keeping people well and intervening early to prevent long-term conditions
- a reduction in unnecessary hospital admissions supporting a reduction in the rate of growth for hospital-based secondary and tertiary specialist services, thus freeing up resources for investment in different areas
- an expansion in the provision of rehabilitative and end-of-life care.

The picture below highlights this.



Source: Adapted from Helen Bevan, Chief Transformation Officer, NHS Institute for Innovation and Improvement *Delivering Cost Reduction through Quality Improvement: a one day master class for senior leaders 2011.*

Strengthen the focus on wellness, prevention and early intervention

For most New Zealanders, most of the time, the parts of the health system that they see are for treatment and management of episodes of illness or injuries. The health and disability system does much more than that – it prevents illnesses through ensuring clean water and a safe environment; it brings people a whole continuum of services that cover the life course from before birth to palliative care, including prevention of long-term conditions, specialist treatment services, support and rehabilitation services, and palliative care for those at the end of their life. It leads cross-government programmes to address complex health issues, and contributes to the work of other social sector agencies where health is a factor.

Because New Zealanders are living longer, they are more likely to spend a period of their later years with one or more long-term conditions. Investing in preventing or delaying the onset of long-term conditions is a priority, as is working with people to give them the tools to live well with their conditions. The following is an example of the type of long-term condition that would benefit from a strengthened focus on wellness and prevention.

Case study – Type 2 diabetes

Changing burden of disease

Diabetes is one of New Zealand's fastest growing long-term conditions – 243,125 New Zealanders (5 percent of the population) have been diagnosed with diabetes and another 2 percent may have undiagnosed diabetes.

Twenty-five percent of New Zealanders aged 15 and over have a high likelihood of developing type 2 diabetes. Diabetes is the only chronic disease in New Zealand projected to increase in both incidence (number of new cases) as well as prevalence (due to declining mortality rates as people live longer with the disease).

Inequitable effects

Prevalence is particularly high among Pacific, Indian and Māori populations. The Māori mortality rate for diabetes is almost five times higher than for non-Māori. Adults living in the most deprived areas are 3.1 times more likely to report having been diagnosed with diabetes than adults living in the least deprived areas.

Pressure on resources and adverse effects on quality of life

Complications of diabetes such as kidney failure, blindness and amputations impose costs on scarce inpatient resources in secondary care and have adverse quality-of-life effects.

Opportunity to strengthen the focus on wellness and prevention

Randomised controlled trials suggest that the risk of progression from having a high likelihood of developing diabetes to being diagnosed with type 2 diabetes can be roughly halved through weight loss, diet changes, increased exercise and/or drug treatment. Effective prevention, delay and management of diabetes can reduce the personal, social and financial burden of this disease, but this type of behaviour change is very hard to achieve and requires considerable support.

The direction of travel and strategy for the health system, like most developed health systems, lies in shifting the system towards a wellness model.

Reducing the impact of long-term conditions will rely on promotion and prevention programmes, strong broad primary health care and community-based services, and effective cross-agency initiatives. Preventing and intervening early has benefits for individuals and the population as a whole, as well as for affordability (especially when targeted to those most able to benefit).

The health sector plays an important role in preventing and managing communicable diseases, such as measles and tuberculosis, as well as health-care associated infections and antimicrobial resistance. The Ministry is leading the cross-government programme to reduce the incidence of rheumatic fever.

The Ministry is an active participant in a wide range of cross-agency programmes and initiatives for tackling complex problems, as are DHBs and NGOs, who are integral to programme implementation and effectiveness.

A wide range of programmes are being implemented to keep people well and independent for longer, and to build individual and community resilience. For example, programmes are in place to:

- promote healthier lifestyles (eg, Healthy Families NZ, Smokefree 2025)
- protect people from becoming unwell (such as infant immunisations and screening programmes)
- support people being well and staying well (including health literacy programmes, and the Prime Minister's Youth Mental Health project and *Rising to the Challenge* mental health and addiction service development plan)
- protect vulnerable children (eg, through implementing the Children's Action Plan)
- support people with disabilities to continue to live in their community and maintain their independence through home and community-based services.

One of the constraints is the limited evidence base available about interventions and prevention programmes that work and are cost saving or cost effective. The focus therefore needs to remain on implementing those activities where there are proven preventive measures, learning as we go and building a strong evidence base.

We suggest collective effort in four areas

1 Better integrate services within health and across the social sector

The Ministry and wider health sector works with partners across the public services, with other social services, and local and regional governments, to deliver a wide range of cross-agency programmes and initiatives to support vulnerable populations and people with complex needs, such as vulnerable children.

Effective cross-agency collaboration is essential to achieving positive outcomes for New Zealand's most vulnerable populations. While many people successfully navigate the health and social services they need, individuals and families with complex needs, or who are hard to reach, need a different approach to achieve the best possible outcomes.

Successfully integrating the activities of the health and social sector services can have a significant impact on health and social outcomes, such as child poverty. This is because people's health, wellbeing and independence are influenced by a range of factors, including income, employment, education, housing quality, recreation and transportation. These factors cross departmental boundaries and the health and social services sectors. Therefore, the best solutions are likely to cross these same boundaries, and services provided in one area may lead to benefits in another.

Inequities can be reduced by providing effective universal services that are responsive to all population groups with specific additional services for vulnerable groups. This could be achieved by increasing the intensity of investment to match rising need and focusing on providing services for key vulnerable populations who are often less able to voice their concerns or navigate the health and social sectors.

This will require a strongly integrated and collaborative system able to provide additional support to those who most need it. This requires strong networks because care is provided in multiple settings and by different organisations. There are opportunities to further strengthen integration within the health sector, across health and the wider social sector, and with partners in the community as a means to support the most vulnerable, reduce inequities and address determinants outside the health sector. Better integration can be achieved by working collaboratively within primary and community care settings, amongst hospital and community providers, between primary and secondary care, and across health and the wider social services sector.

For example, the successes of programmes to reduce smoking rates have shown the benefit of an integrated, multi-tiered approach, using evidence to inform the right combination of legislative amendments, national programmes, community efforts, local council assistance and individual interventions.

Working across organisational and professional boundaries is not always straightforward. Health and wider social sector agencies are responding to the need to do things differently by testing and adapting new approaches to working with vulnerable populations and hard-to-reach groups. Agencies are using a range of improvement methodologies with the aim of accelerating learning from innovation to improve practice and enhance consumer experience.

The case study below on the Auckland Wide healthy Homes Initiative is an example of a cross-agency initiative that is providing valuable learning for agencies as we go about implementing initiatives to support our most vulnerable populations.

We have learned that too many programmes and services can make it hard for the public, and vulnerable populations in particular, to access the services and programmes that best meet their needs; we need to make better use of the data and information we have to inform best practice; we need to find more effective ways of working with existing organisational structures and governance arrangements; we need to relook at the funding models and contracts used and make it easier for NGOs and communities to do their jobs by freeing up funding approaches and simplifying contracts.

Improved effectiveness and value may be achieved by streamlining programmes with a focus on evidence-backed services shaped by local experts and governance; using joint-commissioning and integrated contracts across social sector agencies for vulnerable families and population groups; and focusing investment on those groups where it achieves the greatest impact.

Data and analytics are needed to underpin wise investment in health and social sector programmes. A lot of useful data is held by health and social sector partners; there is an opportunity to make better use of it, taking into consideration privacy issues.

The Ministry is an active participant in the Social Sector Forum (comprising chief executives from seven social sector Ministries) and will continue to work collaboratively with the social sector to deliver better results for the public through innovation and collaboration.

Examples of actions in place

The Ministry and health sector are involved in a wide range of cross-agency activities at different levels, often as a way of addressing inequity:

- integrated national planning and decision-making, such as a programme working in schools, health care, community services and online to deliver improvements for young people (Prime Minister's Youth Mental Health project)
- integrated planning or co-location of services at a local level to help solve complex local social and health issues, such as providing health services in schools, and healthy housing advocacy for families with children at risk of rheumatic fever to reduce rheumatic fever incidence
- cross-agency programmes that provide wrap-around services, help people navigate health services and encourage locally driven provision of joined-up services for at-risk populations (Whānau Ora and the Social Sector Trials)
- Well Child services, where extra contact is made available based on a nurse's assessment of need
- initiatives to protect vulnerable children (eg, through implementing the Children's Action Plan)
- health targets that focus on lifting the performance of services for the total population have had a positive benefit for Māori and Pacific peoples, such as immunisation.

Case Study – Auckland Wide healthy Homes Initiative (AWHI)

Reducing household crowding and rheumatic fever

Household crowding is a key risk factor for repeat strep throats that can lead to rheumatic fever. Household crowding is particularly prevalent in the Auckland region where half of New Zealand's rheumatic fever occurs. A new collaborative service, AWHI, has been set up to link Auckland families with children at high risk of rheumatic fever to practical government and community interventions that reduce household crowding. A broad range of partners (government, local government, community groups, businesses and charities) help to provide the goods (eg, curtains, beds, insulation) and services (eg, income support, help with finding a suitable house or paying power bills) that help to reduce each family's household crowding and their children's risk of rheumatic fever.

AWHI has already helped more than 900 families

Since December 2013, AWHI has worked with a large number of partner organisations to achieve significant living improvements for families. The three Auckland DHBs systematically identify children at high risk and refer their families. AWHI, a partnership of two primary health organisations, arranges a case manager for each family to assess their housing situation and identify the changes that will help keep that family warm, uncrowded and well. Changes are achieved as the AWHI hub assists families by engaging directly with government and not-for-profit services to coordinate and deliver the housing related interventions. The case manager stays involved to ensure the family receives and benefits from the interventions.

Other DHB areas with significant rheumatic fever incidence are now developing similar services that will work in their communities.

Vulnerable families require services that can deliver comprehensive responses

For families with complex needs, service delivery is reconfigured so that a child's identified need triggers a response that addresses their and their family's wider and more complex needs. An anchor service (such as housing) allows access to a wider range of social support services. An experienced and qualified support worker helps families to find local solutions, access services and build capability and natural supports. Services are designed to focus on outcomes for families within a framework of changing a population condition (poor housing; lack of or insufficient employment) and supporting families to build their literacy and skills and find their own solutions in the future.

Opportunities you may wish to consider

Streamline integration initiatives

- Streamline health and cross-government programmes across the social sector to make it easy for vulnerable populations and people with complex needs to find the help they need from government and community services, for instance through joint commissioning and integrated contracts.

Make better use of data and analytics

- Invest in capability and infrastructure to turn available data into useable knowledge that will better inform and evaluate health and social sector investments at a population level. Use this

knowledge to direct more intensive support where it can best meet need and raise the ability of vulnerable individuals and families to live well.

Further invest in preventing long-term conditions

- Build on current prevention activities by developing a comprehensive approach to addressing the four main risk factors for long-term conditions: poor nutrition, lack of exercise, alcohol misuse, and use of tobacco; and their effects on conditions including type 2 diabetes, cardiovascular disease, cancer and respiratory illness.

Expand on housing improvement programmes

- Build on successes working with housing as part of a package of work around vulnerable families and communities, and look for opportunities to increase the pace of improvements and to do more with our central and local government and community partners.

2 Improve the way services are purchased and provided

We need to improve efficiency, and enable innovation and change, by building the flexible funding and policy environment the future needs, supported by a strong workforce and reduced duplication of organisations' roles and responsibilities.

It is important for the system settings and funding models to be well-designed and aligned in order to support the shift to a more coordinated and people-centred system. Altering the range of institutional arrangements and funding systems is an important lever you have at your disposal to steer the health and disability sector.

New Zealand's health system is made up of a complex and diverse network of organisations and people working together to deliver health and disability services to New Zealanders. The number of organisations, some owned publicly, some privately and some in mixed models, and the alliances and networks that operate between them can at times make for complex and ambiguous relationships. These institutional arrangements can pose both challenges and opportunities for Ministers and the Ministry in our leadership roles.

In recent years, the health and disability sector has performed well in an environment of relative structural stability. A greater focus on regional collaboration across DHBs has provided an opportunity for DHBs to work together without the need for formal mergers or structural change. Alliancing is being implemented, bringing together DHBs, primary care, allied health providers and others to plan integrated services that provide better coordinated care for the public. There are still challenges to be addressed to ensure clear governance, accountability and reporting for organisations working regionally or participating in alliances.

New or refocused organisations have been developed to support the transition to a quality affordable health system:

- Health Benefits Limited to achieve procurement savings for all DHBs
- National Health Committee to prioritise new and existing technologies.

As the new organisations bed down, there are opportunities to strengthen them by further defining their purpose and improving governance arrangements.

Significant structural change is an option, but would come at a cost in terms of instability and disruption to current programmes and priorities.

Funding models to support change

How services are funded and contracted impacts on how services are provided, what outcomes are achieved for individuals and populations, and how well the system as a whole performs. Well-designed, flexible funding and contracting arrangements can drive change in when, where, how and to whom services are delivered by creating the right incentives, reducing transaction costs and encouraging innovation to support the desired shifts in the system. They are therefore an important lever for Ministers to make changes in health service delivery.

DHBs are the major purchasers of services, and the Ministry also contracts directly with providers of some services such as disability support and some maternity services. In order to achieve a range of specific goals, a mix of funding models is used: capitation, fee-for-service, pay-for-performance and individualised funding, as well as a range of financial and non-financial incentives. For example, capitation based funding in primary care was implemented to improve access to services and individualised funding in disability support services aims to increase consumer choice and control over the services they receive.

The majority of health and disability funding arrangements tend to be focused around traditional patterns of service delivery (eg, acute care provided in hospitals or general practice), and are specific to providers or professional groups (eg, pharmacy, diagnostics, public health) rather than following the patient's care pathway. They also tend to focus on activities or outputs rather than the overall outcomes for the patient or consumer.

The mix of purchasers and the different funding models can lead to fragmentation in how services are purchased and delivered and can be a barrier to collaboration across DHB services or into wider social sector programmes.

As a result, current funding arrangements may not always be aligned to government goals, may not enable the desired shifts in the system toward a greater focus on wellness and prevention nor enable an overall picture of health's investment strategy.

Opportunities exist to make better use of funding models and approaches to contracting to support the shifts in service delivery and increased value for money, for example, in-between travel time to support the transition to new models of care. Funding models can support goals such as improved integration of health-care pathways and services at all levels (across primary care, across primary and secondary care, across health and wider social services); greater regional collaboration across DHBs; and greater patient choice, for example, with individualised funding in disability support services.

Examples of actions in place

In recent years the Ministry of Health has made changes to funding models and key contracts to improve performance and quality and encourage local innovation and better service delivery. For example, we have implemented a small flexible funding pool in primary care, some individualised funding in the disability sector (as described in the case study below) and a new funding model for ambulance services.

Case study – Disability support services

Rates of disability are increasing

The 2013 Disability Survey found that 24 percent of New Zealanders had a disability (physical, sensory, psychiatric, intellectual impairment). This is an increase from 20 percent in 2001. People aged 65 and over have the highest disability rate.

Growing focus on quality and safety

The review of New Zealand's disability support services – Putting People First – has prompted a renewed focus on quality and safety and reinforced the importance of the regulatory environment to better support the quality of services.

The Ministry, in partnership with disabled people and service providers, is reviewing the regulatory framework for quality and safety in disability support services to ensure that it supports new and emerging service funding and commissioning models.

Using funding models that support the direction of change

The funding models used are currently somewhat fragmented – some disability support services are provided by DHBs themselves, while DHBs or the Ministry contract directly with providers of other services. However, new individualised funding models are being trialled to address this. Individualised funding enables people to make their own choices about the disability support services they want to purchase. This enables people to have greater choice and control.

For example, Enabling Good Lives is a cross-government initiative that combines funding from the Ministries of Health, Social Development and Education to offer people greater choice and control over the supports they receive and the lives they lead. The initiative focuses on working with school leavers with high and very high needs, to help this group decide on the next steps for themselves, whether it be support to attend further education, gain employment or link into their community through their hobbies and interests.

Opportunities you may wish to consider

Improve funding models to support change

- Develop and implement a robust investment approach relevant for health that incorporates an understanding of wider social sector investments at a population level and to better meet the targeted needs of individuals and families.
- Review how health services are funded. A review of the Population Based Funding Formula is under way. There are opportunities to align this with a review of other funding streams such as primary care funding mechanisms, and centrally-purchased services to support how services are delivered.
- Investigate new funding mechanisms or expand existing mechanisms to support change, in three ways:
 - the expanded use of individualised funding to improve user experience and choice, for example, in aged care and for people with long-term conditions
 - further use of additional funding and financial incentives, as occurs now in electives, to encourage regional collaboration and/or additional effort to lift performance
 - further use of pay-for-performance to improve quality and outcomes.

- Examine the use of multi-class output appropriations on a regional basis to encourage increased regional collaboration across DHBs.
- Investigate further ways to incentivise, measure and monitor better management of long-term conditions and avoidable hospital admissions.

Enablers and drivers of change

Workforce, health information and capital are three important enablers and drivers of change. How they are planned and delivered sends strong signals about the direction of service delivery and key strategic priorities. All three enablers have been strengthened as a result of the oversight of dedicated committees – the National Health IT Board, the Capital Investment Committee, and Health Workforce New Zealand. Bringing about the desired changes in the health system requires an understanding of the interrelationships between these enablers, and improved integration across them to ensure they are driving the health and disability system in the same direction.

Building and supporting the workforce

Health and disability services in New Zealand are provided by a diverse workforce, ranging from highly trained health professionals to care and support workers who may have limited training. Health Workforce New Zealand was established in 2009 and since then has provided strategic leadership in a sector-wide response to workforce challenges. Overall, the health workforce is in good shape, although challenges remain to balance future needs with short-term goals.

The changing demands on our system will require new ways of providing services and therefore changes to the workforce. Ensuring we have the right workforce for the future will rely on good data and information to guide workforce planning.

According to figures from Health Workforce New Zealand, the total reported health workforce in 2011 was 165,000. Two-thirds of Vote Health operational funding is spent on the workforce, which amounted to \$9.3 billion in the 2013/14 fiscal year. Most of the wide variety of workforce groups in the DHB sector currently have their employment relations covered by 22 multi-employer collective agreements. A number of these agreements will be in bargaining in late 2014 and early 2015. Over the last three years, wage settlements have been restrained. The changing economy may result in changed expectations for wage settlements.

Traditionally, most of our workforce investment has been in the support and development of the medical workforce. However, the future models of care require a shift in the focus of services towards teams that involve nursing, allied health (such as physiotherapists), and care and support workforces.

These workforces, including new roles, will improve prevention and self-care and work with New Zealanders to help them play a greater part in their own health and wellbeing. In particular, an ageing population with increasingly complex needs will require more and better-trained home-based and residential carers to support older people with long-term conditions, either living in their own homes or in residential care, as described in the case study below.

Providers in the community (including nurses, physician assistants, GPs, occupational therapists and others) will have a broader or more general scope of practice; for example, a generic role such as rehabilitation practitioner may exist, rather than specific roles such as physiotherapist, occupational therapist and speech therapist. This will allow them to support more people in the way they need and help to future-proof the workforce.

Many traditional roles will continue to be important, even though they may change. GPs will remain pivotal to community care, but they will be supported by an enhanced team of health professionals. A specialist workforce will complement more generalist staff by providing advanced advice and services. With everyone working to the breadth and top of their scope of practice, and with greater flexibility, this will enable our limited and more expensive pool of specialist clinicians to concentrate on providing highly specialised services.

Examples of actions in place

Key workforce programmes have focused on:

- recruitment, retention and distribution initiatives (eg, the Voluntary Bonding Scheme and the Advanced Training Fellowship Scheme)
- targeted training opportunities (such as the General Practice Education Programme)
- removing barriers to innovation and establishment of new roles (eg, primary care practice assistant).

Opportunities you may wish to consider

Build and support the workforce

- Further develop workforce intelligence to better understand the workforce and to guide workforce capacity planning. This would include developing and making better use of workforce data; understanding the long-term career pathways of health professionals; and managing the medical and nursing career pathways to ensure the long-term sustainability of the health workforce.
- Develop, support and better utilise the non-regulated workforces to improve New Zealanders' independence and self-care, particularly with aged care and disability support.
- Continue to expand the opportunities for health professionals to work at the top of their scope of practice in a team environment.
- Introduce the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill to reduce barriers to workforce flexibility.

Case study – Aged-care services

Pressures from an ageing population

Older people use more health and support services than younger age groups, with service use increasing markedly with advancing age: people aged 75 and over receive approximately 90 percent of support services for older people.

In 20 years' time, 11 percent of New Zealand's population (approximately 600,000) will be aged 75 and over, compared with 6 percent (approximately 290,000) now. There is already a high investment of public funds in support services for older people (approximately \$1.5 billion of Vote Health funding in the 2013/14 fiscal year).

Currently, 75,000 older people receive home support over a year and around 31,000 are in aged residential care. Aged residential care facilities are owned by a variety of listed companies, private equity investors, NGOs, community trusts and individual owner-operators. Five DHBs own a small number of facilities.

Dementia units have been the fastest growing type of residential care, indicative of dementia becoming a more important issue. There are an estimated 50,000 people with dementia in New Zealand.

Focus on wellness

Services are increasingly person-centred, supported by access to services through more standardised, comprehensive assessment and development of individualised care plans.

Older people are supported to 'age in place' through provision of services that enable them to remain at home for as long as it is safe and they are willing to do so. Good home-based care reduces demand for aged residential care and can be lower cost, depending on the level of support required.

More consistent quality and safety

There has been considerable work over the last few years to improve assurance of quality and safety in both aged residential care and home support services.

Improvements have included the implementation of audit frameworks in aged residential care and home and community support services, the publishing of audit reports online, and the introduction of comprehensive clinical assessment (interRAI) in those care settings.

The Ministry published the *New Zealand Framework for Dementia Care* in collaboration with the sector to help achieve a working and integrated system. DHBs are now progressively developing dementia care pathways so that people with dementia can receive best-practice care and support from diagnosis through to end of life.

Better support for the right workforce

The largest proportion of workers in the support sector are non-regulated support workers, who are predominantly female, unqualified and paid the minimum wage or close to it. These conditions mean that this workforce is prone to high turnover especially during periods of low unemployment.

By increasing the focus, funding (eg, in-between travel time funding) and utilisation of the allied health and non-regulated workforces, and by supporting all parts of the workforce to work to the top of their scope, we can sustainably improve the quality of care.

Improving health information, access and use

The National Health IT Board is driving the implementation of integrated national, regional and local eHealth solutions to support access to the right information, by the right people at the right time. The National Health IT Plan sets the direction for integrated eHealth solutions to allow the best use of data. IT infrastructure investment is being aligned alongside national, regional and local services priorities and new ways of delivering services. Priorities such as primary health care, quality improvement and fiscal sustainability provide the focus for the Ministry's IT intentions. Implementation of the plan will require increased regional collaboration across DHBs, greater clinical and consumer engagement and improved capability in IT skills and leadership.

Well-designed information technology solutions enable us to work smarter, reduce costs, improve efficiency and deliver better, safer care to patients. As such eHealth is a strategic asset that enables and drives new and improved models of care, better measurement of performance, and greater innovation through research and access to information.

Integrated eHealth solutions enable the timely sharing of information between clinicians at the point of care and with patients. Successful implementation that supports access to information across primary care and between primary and secondary care include GP2GP, provider portals and eReferrals. These solutions provide a starting point for sharing relevant information with other public social service agencies.

eHealth is a powerful tool in making health more people centred. Consumers increasingly require convenient access to their health information to support them to better manage their own health and wellness, for example, patient portals and shared care plans. The use of social media and mobile devices will become increasingly important in an environment where consumers have greater knowledge about, involvement in and control over health care and lifestyle choices. Telehealth is an example of using health IT to deliver care when patients and health professionals are not physically in the same location. This improves people's access to services and can reduce patient travel time.

Increased use of eHealth to support health care delivery creates considerable growth in the amount of raw or 'big' data available to funders, planners, providers, and patients. The challenge is to collect, organise, access and use this information wisely, to drive improvement.

Opportunities you may wish to consider

Improve health information, access and use

- Implement with pace the critical priorities identified and agreed in the National Health IT Plan. This will need agreed DHB regional governance and decision-making processes.
- Grow information capability, including IT skills and leadership to enable efficient service delivery and support outcome measurement.

Sharing relevant information

- Develop and implement solutions to share relevant information with public social service agencies.

Infrastructure and capital

The infrastructure projects that are supported by the Government or the Ministry send strong policy signals about strategic priorities. New construction of facilities or IT projects should reflect the kinds of services the health and disability system needs. For example, big hospitals or smaller clinics; the right mix of national/regional/local services; services that work for the communities that they serve and support community-based care; unified IT systems or bespoke IT solutions; lowest upfront cost, best return on investment and/or environmental impact.

There is significant public investment in health capital and assets. DHBs manage \$10.1 billion worth of land and buildings and are responsible for managing their own capital assets and developing business cases for health capital projects. Both the Canterbury Hospital redevelopment and the West Coast redevelopment have used a new partnership approach involving the DHB, The Treasury, the Ministry and external experts. Southern DHB is the next major development that may benefit from such an approach. There are also ongoing discussions with the three Auckland DHBs about their future capital programmes.

The Ministry is working with The Treasury on a review of health capital processes and decision-making, which will look at governance and management of capital project implementation; funding decisions; and asset management practices. A key issue for the future is determining at what level of the system – central and local – that key capital decisions will be made.

Opportunities you may wish to consider

Infrastructure and capital

- Ask the National Health Board to focus on better integration of the key enablers – workforce, capital and information management systems.
- Consider a partnership approach for major infrastructure projects, such as for Southern DHB's hospital redevelopment.
- Build on the findings of the Ministry and The Treasury review of health capital processes, investigating opportunities to improve decision-making in capital, through changes to process and approval rights.

3 Lift quality and performance

Continuing to lift the performance of the sector and Ministry of Health remains a priority to sustain a quality, affordable public health service over the long term and manage the rate of growth of health spending. Optimum performance is multifaceted and needs to capture the relationship between patient's experience of care, quality, safety, equity, population health outcomes, resource utilisation and staff who contribute to care. A balanced set of measures (a balanced score card) is therefore critical to demonstrate these relationships and act as a comprehensive performance framework.

An overemphasis on any one measure risks a distorted view of performance and may result in unintended consequences. A balanced score card is not simply a set of measures; it is a tool to be

available and utilised at all levels of the health system for clinicians, managers and policy makers to guide strategic decision-making and quality improvement.

Understanding how the health and disability system as a whole, and its component parts, is performing is key to improving overall service provision and health outcomes, and central to the transparency needed for public service accountability. Currently there are a range of performance frameworks and measures across many areas of health, such as mental health, maternity and elective services. There is also the Integrated Performance and Incentive Framework – this is focused initially on primary and secondary care integration but expanding over time to become a performance framework that will enable a whole-of-health-system view.

The opportunity exists to consolidate and streamline existing frameworks and develop a comprehensive framework that could be used by all services and would provide a system-wide balanced score card. This could improve national consistency in service provision and be used for quality improvement and increased public reporting on provider performance.

A comprehensive framework will rely on improving data collection and involving managers, clinical leaders, frontline staff and consumers in using the information. Continuous quality improvement will depend on utilising a balanced scorecard to move towards greater consistency of care, supported by strengthened staff capability in continuous quality improvement methodologies. The transparent collection of data and open reporting will play a key role in enabling peer review, performance comparisons and holding providers accountable for doing the right things.

Improving quality is therefore dependent on having clear goals that are supported by health practitioners and reinforced by improvement methodologies and systematic measurement of progress. Regional and national service planning, greater clinical integration and the use of clinical networks are mechanisms the health sector has used to engage clinicians in improving the quality of care, reducing waste and unwarranted variation, and reducing service vulnerability and cost. There are also opportunities to reduce disparities in outcomes between different population groups across all elements of quality improvement.

There is ongoing potential for significant gains from DHBs continuing to work collaboratively on national and regional service planning and delivery, and quality improvement programmes.

In recent years, financial and non-financial incentives have been used to lift performance and improve quality. Health targets have proven successful in lifting performance in defined government priority areas. The use of open reporting of performance information to the public through MyDHB and MyPHO has acted as a non-financial reputational incentive. There is scope to increase the use of public reporting, based on a wider set of measures, to inform the public about the performance of services and incentivise quality improvement.

The Mid-Staffordshire review in England and the quality review of disability support services – Putting People First – in New Zealand have prompted a renewed focus on quality and safety. The Chief Executives of the Ministry of Health, Health Quality and Safety Commission and the Accident Compensation Corporation, and the Health and Disability Commissioner have established a cross-agency Quality Forum to maximise the effectiveness of quality and safety focused activities across their respective organisations and the health sector by improving alignment and the flow of information.

Examples of actions in place

The Ministry of Health has modified financial incentives in electives to support improved performance and encourage regional collaboration in delivery.

The Health Quality and Safety Commission is introducing patient experience surveys, which are internationally recognised as an important quality improvement tool.

We have focused on a few select health targets as non-financial performance measures and have seen impressive gains, for example, in immunisation.

Opportunities you may wish to consider

Measure and lift the performance and quality of the whole health system, using a balanced scorecard approach

- Continue to develop a comprehensive performance framework for the health sector that consolidates and streamlines existing performance measures and frameworks and takes a balanced scorecard approach to performance. Measures to be developed should be both “trailing” (looking at past performance) and “leading” (looking at potential future performance). This involves balancing fiscal performance and affordability with an assessment of quality and performance across customer experience and outcomes, equity, the effectiveness of models of care and workflows, and workforce productivity. To do this we could:
 - ensure we only collect and report the most relevant data for system improvement that will be meaningful for the sector and really demonstrates performance, including for vulnerable population groups
 - extend public reporting to increase public awareness about the whole consumer experience (including quality, performance and outcomes of their health services) and as a non-financial incentive for quality improvement
 - invest to capture and disseminate the information that will increase consistency of care, further develop health pathways and clinical networks to support quality improvement, and eliminate waste and unwarranted variation.

4 Support leadership and capability for change

Strong governance and executive and clinical leadership are required at all levels throughout the health and disability sector to achieve the changes needed in the system. The public entrusts significant funding to organisations – public, private and NGOs – to provide public health and disability services. Good governance and management across all organisations is therefore critical to ensure quality, safety and financial probity.

The health and disability system is large and complex with multiple decision-makers and mixed public and private ownership models. Implementing new ways of working requires the ability to influence key decision-making across that whole system and an explicit ability to incentivise the shift. It requires an integrated approach to align the different moving parts, such as workforce, models of care, information systems, clinical and corporate governance arrangements, regulatory and funding settings. It requires the removal of barriers, the support of clinicians, and a clear understanding of potential unintended consequences, and it may require challenging

decisions to be made around prioritisation. Increasing the pace of change requires leadership from the centre and support for management of the change process itself.

Health sector leadership is needed that has a shared understanding of where the health and disability system is heading, access to the information and analysis needed to support effective decision making, and the ability to:

- work with individuals, families, whānau and communities to help them manage their own health and wellbeing
- work collaboratively across the health and wider social sector
- make the most of the opportunities that new and emerging technology and eHealth solutions provide
- create the environment in which change can happen while managing today
- innovate, take managed risks and make hard decisions where needed while staying focused on the longer-term view
- work smartly in a fiscally constrained environment where challenging trade-offs may need to be made.

DHB boards and management are responsible for large budgets, workforces and populations. A key area of focus for the Ministry will be to support the leadership and performance of DHBs and other crown entities to provide the clinical, management, governance and change leadership needed across their districts, and bring about the shifts needed in the system.

Performance management and accountability arrangements for DHBs have evolved over time and the opportunity exists for further evolution to strengthen DHB Board governance and the performance of DHBs. A performance improvement programme could be used, including an assessment of organisational capability, such as information provided for board decision-making, service performance and sustainability, quality of care, community, workforce and clinician engagement.

Consumers and the public increasingly want greater choice and control over their care, and greater involvement in co-designing services around the needs of the public and patients rather than professions and organisations. The sector will need to continue to find ways to ensure greater community and consumer voice in a people-centred system.

Examples of actions in place

There are a number of programmes of work under way that support greater public choice and strengthened leadership capability.

Clinical networks, such as the cardiac network are being implemented across the sector to better support clinical leadership and improve the quality of services.

Patient portals are providing access to information and enabling greater self-management. The public have more information available to them about the performance of their DHB and primary health organisation (PHO) and the key services provided, and there is greater transparency about quality.

Developments in advanced care planning respond to growing public expectations to enable more people to take control of their future medical treatment, including end-of-life care discussions.

Opportunities you may wish to consider

Support the leadership and performance of DHBs and other Crown entities

- Introduce a performance improvement programme tailored for DHBs and other health sector crown entities. The State Services Commission's Performance Improvement Framework (PIF) is a tool used by government departments and some crown entities to assess organisational capability, measure performance and drive improvements; it could be used in the sector.
- Improve the performance of DHB boards by specifying clearer requirements of the skills and competencies expected of appointed Board members (eg, financial, performance management and clinical), providing a development programme for all Board members, and consider increasing the number of appointed members and Chairs that sit on more than one DHB (ie, select people with key skill sets and use them across a number of boards).
- Investigate mechanisms for balancing the mix of specialist and governance skills, and community and consumer voice on crown entity boards.
- Help improve the performance of DHBs by ensuring DHB CEOs and their management teams are accountable to DHB boards, for example, through the use of contractual key performance indicators.
- Continue to performance manage DHBs' financial, non-financial and health target performance, as well as quality indicators (in liaison with the Health Quality and Safety Commission), and consider options for strengthening performance monitoring in the current Monitoring and Intervention Framework. Increase support for DHBs to improve performance through targeted reviews.

Strengthen sector-wide governance and capability

- Develop a national programme for health sector leaders to boost executive and corporate capability – aligned with the State Services Commission run talent management programme.
- Provide support for NGOs in management, governance and change management.
- Continue to build Ministry leadership and management culture, expertise and ability to lead change through programmes such as Building for our Future and Growing Leaders.
- Build leadership for change in the digital era in the sector and Ministry to ensure programmes can advance at pace and information can be used to support decision-making; and develop standards and guidelines to ensure information is collected, stored and shared consistently and securely.

Conclusion

The health and disability sector has made considerable gains over the past six years, and more work remains to be done.

To meet the challenges faced we need to focus on people who have poorer health outcomes and more complex needs; we need to look at what services we provide and how we provide them to best meet peoples' needs. We need to continue to work collaboratively with a wider range of partners, individuals, whānau and their communities, the wider public services, and local and regional government.

This briefing has discussed four areas where additional focus could help support your Governments goals for the health and disability sector and improve outcomes for vulnerable populations.

The Ministry looks forward to discussing this briefing with you and working with you to achieve your Government's goals.