The Treasury

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Briefing to Incoming Minister

Health

October 2014

New Zealand Government

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Contents

1. Introduction 1
2. Overview of the Health System 3
3. Performance and Quality 10
4. Responding to Changing Demand 21
5. Institutional Structure 29
6. Summary of Recommendations 36

1. Introduction

This briefing provides an overview of New Zealand's health system, including the challenges it faces and options for improvement.

Our system is comparable to those of other OECD countries in terms of fiscal cost and a number of key indicators of overall performance, although there is evidence of ethnic disparities in health outcomes. We do not currently see a case for moving away from the broad policy framework of mainly tax-funded services managed through district health boards (DHBs). A high-level overview of the system is provided in section two.

Health accounts for more than a fifth of government spending. This is a major investment of public money, every year. It is important that this investment delivers the best possible health outcomes for New Zealanders. This means having a clear focus on the quality of services provided and the experience of patients, and ensuring that services are accessible to all population groups.

There is scope to improve the way the system is organised and managed to achieve this goal. Overall, we think that the success of New Zealand's public health system should be measured in terms of the health outcomes it delivers for New Zealanders, rather than how much new money is invested each year or how many new procedures are performed. Following discussions with a range of different organisations and individuals in the health sector, sections three to five set out a number of ideas for improving the system.

Performance and quality (section three): Systems for managing and improving performance and quality are under-developed. [3]

Progress towards a new integrated performance and incentive framework (IPIF) is a start, but a significant and sustained effort will be required to further develop and embed this approach.

Adapting to changing demand (section four): Demands on healthcare are changing, with chronic, long-term conditions increasingly important as sources of ill health. In order to meet this change in demand, the system needs to rebalance towards primary and community-based care. For this to happen, we need to address barriers that prevent people from accessing primary care. The composition and flexibility of the workforce will also need to change.

Institutional structure (section five): Reforms introduced following the 2009 report of the Ministerial Review Group have delivered improvements in specific areas, but have not addressed core weaknesses in commissioning and assurance. Clearer structures are needed to manage national and regional services. Establishing these requires leadership from the centre. There is a case for separating policy, operational and

assurance functions to improve planning and oversight. Management arrangements for [3] major capital projects should be reviewed.

Box 1: The Triple Aim: quality, equity and value

The Triple Aim is an internationally-recognised framework for optimising health system performance, originally developed by the Institute for Healthcare Improvement and adapted for New Zealand by the Health Quality and Safety Commission. Its three dimensions are:

- improved quality, safety and experience of care
- improved health and equity for all populations
- best value for public health system resources.

We think these are appropriate long-term aims for New Zealand's health system. Implementing the Triple Aim requires comprehensive performance measurement, rebalancing the system towards primary care settings, and stronger arrangements for commissioning services and monitoring performance. Importantly, the Triple Aim requires a focus on all three dimensions simultaneously. A singular focus one dimension is likely to generate negative results on one or both of the other dimensions.

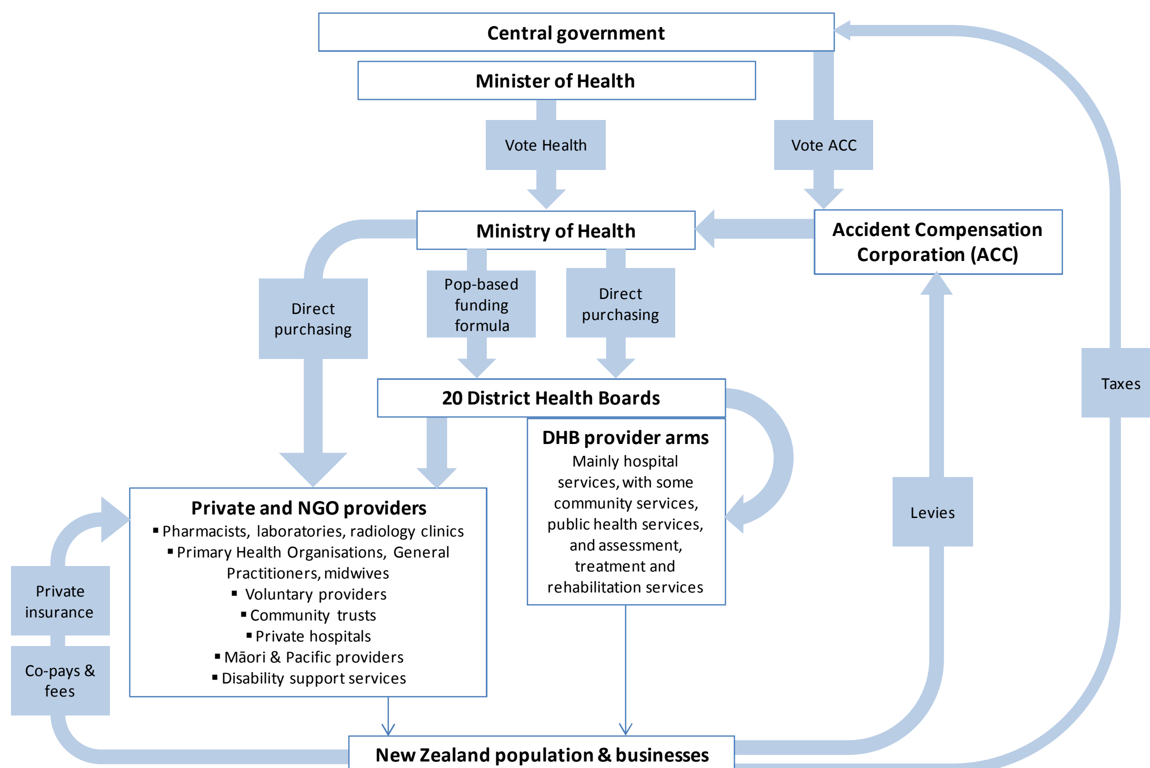
2. Overview of the Health System

Most health services in New Zealand are publicly funded …

Health services in New Zealand are provided through a network of government, non-government and private organisations (figure 1). Total (public and private) health spending is around the OECD average both as a proportion of national income and in terms of purchasing power parity. Public funding accounts for around 83% of total health expenditure; this is relatively high by OECD standards, although not wildly so.

The public health system is fairly comprehensive. Hospital services are free, with prioritisation used to manage demand for elective services. Co-payments apply to some community services, including pharmaceuticals, general practice and some diagnostics. Certain services are not subsidised. These include optometry, orthodontics and most adult dental care.

Figure 1 – Structure of the New Zealand health system



Source: Ministry of Health

… through DHBs, ACC and the Ministry of Health

The main purchasers of public health services are the twenty DHBs, the Ministry of Health and the Accident Compensation Corporation (ACC). DHBs together manage three quarters ($11.4 billion) of Vote Health. They are responsible for providing hospital-level care and for purchasing most primary and community health services for

their local populations. General practice and aged care services are funded by DHBs but provided by non-government organisations and private businesses. PHARMAC works on behalf of DHBs to manage the prioritisation and procurement of pharmaceuticals.

The Ministry of Health is responsible for directly managing around $2.8 billion of non-departmental operating funding which it uses to purchases certain services directly, including disability support services for people under the age of 65.

ACC provides no-fault injury insurance cover. As well as earnings compensation, this includes medical treatment and rehabilitation services. In 2012/13, ACC spent around $1.8 billion on treatment and rehabilitation costs, including $0.8 billion for medical and hospital treatment and $0.4 billion in bulk funding to DHBs for accident and emergency care. A further $0.9 billion was spent by ACC on earnings (and other) compensation payments.

Our overall health outcomes are broadly in line with international norms …

New Zealanders enjoy health outcomes comparable with those of people in other developed economies. Life expectancy is around the OECD average and has risen steadily over the last 50 years in line with international trends. Infant mortality rates have declined over time, but more slowly than in other OECD countries and New Zealand's performance on this measure is now slightly below the OECD average. These indicators reflect economic and social conditions as well as the characteristics and effectiveness of the health system.

… but performance in some areas is mixed …

New Zealand performs well by international standards against some important measures of healthcare quality. For example, in-hospital mortality rates have improved steadily over the last decade and are now amongst the best in the OECD, and admission rates for uncontrolled diabetes are around the OECD average despite our higher prevalence rates for this disease. We do less well against some other indicators of performance, with relatively high levels of hospital admissions for asthma and chronic obstructive pulmonary disease (lung disease).

… and there is evidence of clear ethnic disparities

There are clear disparities in health outcomes and access to care for particular population groups. Amenable mortality rates measure deaths from diseases that should be preventable given effective and timely healthcare. Avoidable hospital admissions provide a broad measure of the accessibility and quality of primary care provision. Both indicators show marked and persistent ethnic disparities (figures 2 and 3). There is evidence of barriers to accessing health care for Māori and Pacific people and those on low incomes.

Figure 2 – Amenable mortality

Age standardised rate per 100k population

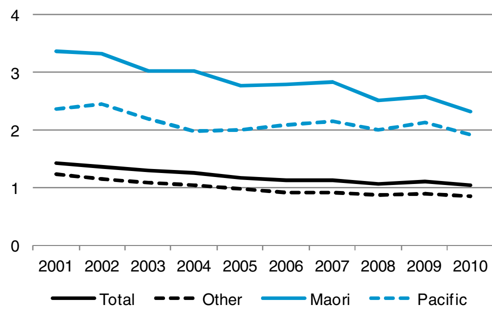
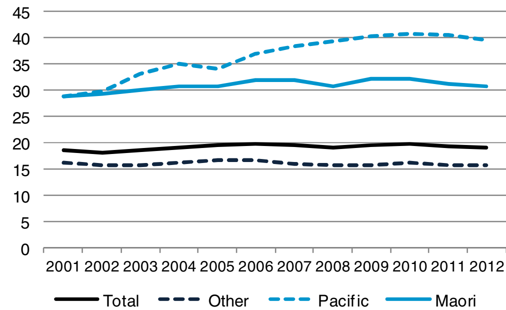


Figure 3 – Avoidable hospital admissions

Age standardised rate per 100k population

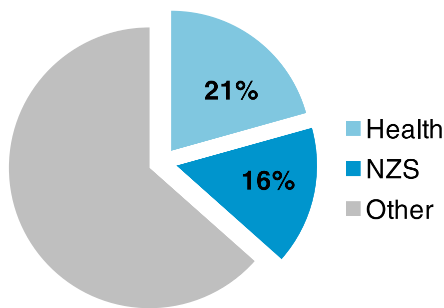


Source: Ministry of Health

Health is a major component of government spending …

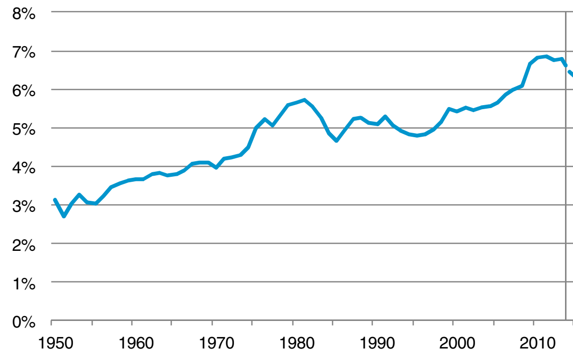
The health system absorbs more than a fifth of government spending (figure 4). Core Crown health expenditure for 2013/14 was $14.9 billion, increasing to $15.1 billion in the current year. This is funded from general taxation on a pay-as-you-go basis and includes some funding for ACC, mainly for non-earners. ACC also raises revenue directly, through levies on employers, workers and motorists; these amounted to a further $3.4 billion in 2012/13 (some of which was used to fund earnings compensation rather than health services).

Figure 4 – Core Crown expenses 2014/15



Source: The Treasury

Figure 5 – Health spending as a percentage of GDP



Source: The Treasury

… presenting fiscal challenges over the medium and long term

Public health expenditure has been increasing faster than national income for most of the last sixty years, rising from 3% of GDP in 1950 to almost 7% by 2010 (figure 5). During the mid to late 2000s, Vote Health operating spending grew very rapidly, at an average rate of almost 9% per annum. Over the last few years, lower spending growth has been achieved without major changes to the structure of the health system or the range of services provided. A key factor is likely to have been the benign domestic and international wage environment.

Without structural adjustments to manage costs, we expect funding pressures to return over the medium- to long-term. Factors affecting long-run health spending include demographic demand growth (mainly population ageing), non-demographic demand growth (income and technology-driven demand), and rising unit costs due to low productivity growth relative to the rest of the economy (typical for labour-intensive sectors like healthcare). Although population ageing is likely to play a greater role than it has in the past, we expect its contribution to overall spending growth will continue to be relatively modest. A large proportion of health costs are end-of-life costs, which are deferred by greater longevity.

We do not currently see a case for moving away from a mainly tax-financed, single-purchaser system …

Looking at international comparisons from both a cost control and efficiency perspective, we do not see a clear rationale for New Zealand to move away from its basic policy paradigm of a mostly tax-financed health system, with government acting as the main purchaser of health services. This reflects a judgement about the trade off between the economic costs of taxation and the advantages of the current arrangements. That judgement depends to some extent on the size of the health budget relative to the economy and might be different if spending were materially larger as a percentage of GDP.

Other models are possible, but no particular structural configuration stands out as being consistently more successful in practice. New Zealand's health system as a whole is not obviously underperforming those of other developed economies. There is evidence that systems like ours, where government is able to impose a top down limit on funding, make it easier to contain overall spending growth.

There are robust policy and practical arguments for government involvement in healthcare. Individuals face considerable uncertainty about the timing and magnitude of potential healthcare costs. This means that some form of insurance (public or private) is desirable. Private insurance does not cater well for certain groups, particularly older people, people with chronic conditions, and those on low-incomes who may be unable to obtain appropriate cover. Public healthcare, or social insurance, shares these risks across a large pool and ensures universal coverage.

Public health systems and private insurance schemes both face problems of moral hazard (where people face less incentive to manage their healthcare costs because they do not pay at the point at which they access services) and supplier-induced demand (since health workers know a lot more about conditions and the range of treatments than their patients). Both public and private systems can therefore lead to over-consumption of health services.

About 17% of total health spending in New Zealand is privately funded, mainly through insurance and out-of-pocket payments. The private health insurance market is relatively small, funding only about 5% of total spending and supporting a more limited range of services than the public system. Private insurance also struggles to provide

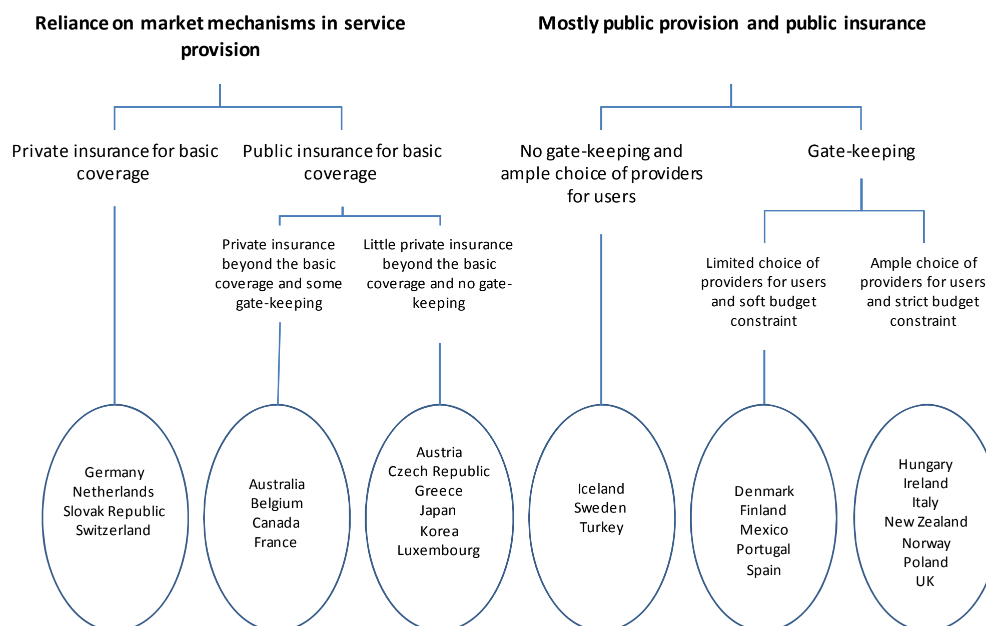
the same comprehensive cover as ACC. A review by independent actuaries in 2011 concluded that private insurers would need to find 20-30% savings to offer the same levies as ACC for workplace levies, and up to 75% savings for motor-vehicle levies, before the large reductions since 2012.

… with services delivered by a mix of public and private providers …

This does not mean there is no role for the private sector. Non-government providers and private businesses already deliver many non-acute services, including general practice, mental health, disability services and aged care. We do not have good information about private hospital capacity. However, New Zealand's small and geographically dispersed population means that opportunities for contestable provision at secondary and tertiary level will be more limited, particularly outside Auckland, with only a single purchaser and a single hospital provider within a geographical area for many services. Using competition to drive improvement may also be difficult at primary care level in low-income, rural areas.

In practice, countries use a number of different combinations of public and private provision and funding (figure 6). There does not appear to be one type of system that systematically outperforms the others in terms of efficiency.

Figure 6 – Health system design



Source: Joumand, I., André, C. & Nicq, C. (OECD: 2010)

… funded mainly through general taxation

ACC operates a social insurance model, with payroll taxes and other levies, supplemented by some general tax funding. A "fully funded" model was adopted in 1999, with levies set each year at the rate necessary to cover the lifetime costs of

every claim occurring in that year. Overall, the scheme is now fully funded for existing claims.

The extent to which the government (current taxpayers) should move further towards pre-funding future liabilities to offset the costs of demographic ageing is a matter of general fiscal policy. Restarting contributions to the New Zealand Superannuation fund as conditions allow would be the logical first step. At least in the short term, it seems unnecessary to consider separate arrangements specifically for health since it is the government's overall fiscal position that ultimately matters.

Beyond this, we are sceptical about alternatives to the current approach of funding the public health system primarily from general taxation. Tax incentives (or other subsidies) for private health insurance would favour those on higher incomes. In addition, the scope for private health insurance to improve fiscal sustainability is likely to be modest in practice, since private insurers tend to focus on lower-risk populations and procedures, leaving high-cost, complex cases to the public system.

Individual "health savings accounts" have also been mooted, possibly as an offshoot of KiwiSaver. These would not address uncertainty about medical cost and the need for risk pooling, and seem inefficient as a mechanism for general pre-funding. Hypothecated taxes and social insurance payroll taxes are taxes nonetheless, and may compound the problem of demographic ageing to the extent they narrow the tax base to the working population.

The ACC system creates boundary issues that are not easily resolved

The fact that New Zealand has separate funding arrangements for injury-related and non-injury related conditions raises some questions about discrimination and horizontal inequity. Injury-related assistance through ACC is provided on an uncapped, demand-driven basis. Medical and support services funded by ACC may therefore be more generous or subject to shorter waiting times than those available to non-ACC clients.

Removing the boundaries between ACC and mainstream health and disability services could only be achieved at substantial fiscal cost or by reducing the generosity of ACC-funded services. More generous treatment for those whose disability resulted from personal injury could in some circumstances be regarded as quid pro quo for their inability to seek damages through the courts. Whether this is sufficient to justify differences in support at an individual level is an open question.

The DHB model creates the conditions for integrated service delivery …

The twenty DHBs are key actors in the provision of health services in New Zealand. They are funded using a form of risk-weighted capitation, and are responsible for ensuring the provision of health and disability services to populations within defined geographical areas. This model has conceptual appeal and seems to command support within the sector.

Non-communicable and chronic conditions are increasingly important as sources of morbidity and mortality. This argues for vertically integrated healthcare, with secondary, primary and social care services managed as complements and substitutes rather than in isolation. In principle, the DHB model creates a framework within which this sort of integration can be achieved.

… but change is needed to realise this potential

This does not mean that the status quo is optimal. Planning and funding responsibilities are highly fragmented, with twenty DHBs serving a population of four and a half million people. No particular number of DHBs is clearly correct, but most people we have spoken to in the health sector consider that there are currently too many for our small population. Some DHBs are facing capacity and sustainability in terms of their ability to purchase or provide a full range of services to the necessary standard within available funding. Where there is a low level of demand for a specialised service, it makes more sense – both from a patient safety and quality perspective and a financial one – to concentrate those services in fewer, larger hospitals.

Fragmentation also results in barriers to the dissemination of best practice in the sector. Institutional arrangements to incentivise and promote best practice are limited and cultural barriers are evident within DHBs (see box 2). In order to continue providing safe, high-quality services into the future, there may be a case for moving to a different configuration over time, potentially with a smaller number of larger DHBs.

Box 2: Refusing to share best practice

The extent of cultural barriers in some DHBs to the sharing of best practice came to light last year, following a request for a well-prepared business case to be shared with the sector as an exemplar. Questions are often raised by DHBs about what a good business case looks like, and to date there are limited examples of health sector business cases prepared under the Treasury's Better Business Case (BBC) format. The DHB in question, which had developed a very good business case, refused the request on the basis that they had invested in the document and that it was part of their intellectual property. While measures are potentially available to require compliance with such a request, the DHB's approach speaks to a broader challenge.

Assuming the DHB model is retained, we think there needs to be a stronger emphasis on quality and consistency of services at DHB level. Accountability arrangements for DHBs should be clarified and refocused on population health outcomes, including through the delivery of primary care services. Monitoring and management of DHB performance at the centre must improve. At the same time, DHBs need to be supported by national and regional planning arrangements for high-cost, low-volume and/or capital intensive tertiary and secondary care. We discuss these themes in the following sections.

3. Performance and Quality

International evidence shows that health services often fall short of best practice, with wide variations in quality within and between countries. This can result in poor health outcomes, unsafe care and harm to patients, and ineffective use of resources. New Zealand is not immune to these problems.

Improving the quality and consistency of care requires measurement of results to ensure provider accountability, identify and manage risk, and promote change. There is scope to strengthen the relevant arrangements in New Zealand. The performance measurement framework should be broadened and refocused, with greater use of outcomes-based performance indicators alongside financial, process and output measures. Information management practices need improvement and lines of accountability should be clarified. Opportunities to use funding more effectively as a lever to raise performance should also be explored.

[3]

A well-rounded performance measurement framework is critical for ensuring good outcomes and patient safety

In recent years, the Mid Staffordshire hospital scandal in England has provided a deeply tragic illustration of what can happen, even in otherwise high-performing health systems, when governance and management fails. There were multiple drivers behind this failure, but one of the key issues highlighted in the public enquiry was an overly narrow focus on meeting national access targets and achieving financial balance. These goals were given priority at the expense of the quality and safety of care, which ended up causing immense suffering to many patients and their families.

The enquiry highlighted the critical importance of focusing on quality and safety indicators alongside financial performance and government targets. [3]

Developing a comprehensive measurement framework for performance and quality in healthcare is a challenging task with a number of complex elements. Earlier this year, an expert advisory group headed by Graham Scott set out some helpful principles:

> … scientific methods [should] be used to design systems and performance metrics, and these should be evidence based, valid, reliable and credible to the extent possible. Measures need to be acted on by clinicians and healthcare professionals, thus their participation and support is critical. Performance measures should be understandable, clinically relevant, useable, timely and updated frequently to reflect changes in knowledge, evidence or technology. …

A basket of measures contributing to continuous improvement and leading to a sustained health system should be pursued. An important principle to avoid is political expediency or short-termism in systems design, performance measurement, indicators, data gathering and the use of data.

[3]

There are signs of progress through the Health Quality and Safety Commission and new integrated performance and incentive framework …

The HSQC has initiated a number of improvements, including the introduction of quality accounts for DHBs, which are now being expanded to include a broader range of nationally consistent measures. The HQSC has also developed quality and safety markers (relating to falls, infections, surgical harm and medication safety) which now form part of the Ministry of Health's monitoring process. DHBs themselves participate in benchmarking of various indicators organised by the Health Roundtable, but the results of these exercises are not made available to the public or the Ministry of Health.

Measurement and monitoring of primary care performance is also limited, although it improved to some extent with the establishment of the PHO performance management programme in 2005. In recognition of the limitations of the current arrangements, the first stage of implementation of a new integrated performance and incentive framework (IPIF) began in July 2014. It focuses initially on only five measures of primary care performance. The intention is that the framework will expand over time to cover the whole of the health system, eventually including a combination of national system-level measures allowing comparison across DHBs and PHOs and locally-determined measures reflecting regional variation in health priorities.

Without a broad range of performance measures, there is a risk that DHBs' dual role as owner-operator of the district hospital as well as funder of healthcare for their local population will lead to an overweighting of resources to secondary care. A comprehensive suite of standardised indicators would include measures of overall population health outcomes and primary care performance. International experience shows that healthcare performance indicators are often developed and tested by independent bodies, to ensure transparency of process and robust, credible indicators.

… but more ambition is needed to ensure change happens and is embedded throughout the sector

The expert advisory group set out a positive vision for the IPIF in its February 2014 report. The ideas and principles behind the framework are promising, but there is a long way to go in terms of design and implementation. The Ministry of Health has set up a project group to deliver the forward work programme. A significant and sustained effort across the sector will be needed to develop and embed the IPIF as the organising framework for the sector. Without momentum, there is a risk that this work may not advance much beyond a modified version of the PHO performance programme which, in the first instance, it replaces.

The HQSC considers that many of the building blocks required for a performance measurement framework to be implemented reasonably quickly are already in place. Making progress will require a commitment at the centre to adopt a more comprehensive and nuanced set of measures, along with the willingness and ability of providers and clinicians to respond to the framework.

- **Recommendation 1:** Build on the IPIF and other work to date to develop a comprehensive performance measurement framework for the health sector. This needs to be based on good information (see below).

Specific targets can be useful in the context of an overall performance management framework

The role of the six health targets and the Better Public Services results should be considered as part of this (see box 3). The risk of using narrowly defined targets is that they have unintended consequences in terms of the trade-offs that managers and clinicians need to make to achieve them. For example, waiting time targets shift focus to patients who have been waiting the longest, rather than those who have the greatest need of treatment. As mentioned above, in the case of Mid Staffordshire, too much focus on targets led to failures in care quality and safety. Nevertheless, targets can be useful in the context of an overall performance management framework and the six health targets have been effective at driving progress in specific areas. They should be evidence-based and reviewed regularly to ensure that they are not having adverse impacts on other parts of the health system.

Better Public Service result 3 deals with infant immunisation rates and the incidence of rheumatic fever. Immunisation rates continue to progress well, with 91% of 8-month olds fully immunised at March 2014, although further improvement is needed to meet the target of 95% coverage. The incidence of rheumatic fever hospitalisation has not been reduced. Rheumatic fever cases are few in number, so they may not provide a particularly reliable indicator of the effectiveness of targeted health interventions. There is also a risk that a focus on rheumatic fever alone may divert resources away from more prevalent conditions which share many of the same socio-cultural determinants, including skin infections. We see a case for broadening this result to include other childhood diseases. More detailed advice on this point, as well as on the

possibility of introducing a new result targeting reductions in obesity, will be included as part of Central Agencies' wider advice on the Better Public Services result areas.

Box 3: Health Targets and Better Public Services (BPS) results

The six health targets:

- shorter stays in emergency departments`
- shorter waiting times for cancer treatment
- better help for smokers to quit
- improved access to elective surgery
- increased infant immunisation
- more heart and diabetes checks

BPS Result 3: Increased infant immunisation and reduced incidence of rheumatic fever.

Better information management to enable good decision-making and empower patients

Good decisions depend on good information

Health systems are complex organisations, with multiple stakeholders and accountability arrangements. Information is necessary for those relationships to function effectively. It is also needed to monitor quality of care, understand patient outcomes, and manage spending. A lack of robust data can lead to false assumptions and poor decision making.

The quality and management of information in the health sector needs to improve …

A performance audit of regional services planning published by the Auditor General in 2013 raised concerns about the quality and availability of health data. The Auditor General found that poor quality data was a key impediment to sound decision making in the health sector. Problems included outdated patient management systems in some DHBs and a lack of connectedness between DHBs and the primary and private health sectors. Issues with the completeness, accuracy and timeliness of data also arose from human action, including from different interpretations about what ought to be recorded and a lack of training and support for those responsible for collecting and reporting data.

The Auditor General's comments are consistent with our own experience. Within the Ministry of Health, ownership of data is dispersed and information does not always appear to be managed consistently or used in a strategic way to monitor and manage the sector. It is important that a more consistent approach to the collection and processing of information is adopted, and that data is used systematically at all levels to assess and improve performance. As the Auditor General noted last year, "Information needs to be sought after, valued and in regular use if accuracy is to improve".

A number of people we have spoken to have commented that New Zealand has considerable advantages in terms of the richness of its health data, with scope for

datasets to be linked and analysed. Existing datasets need to be managed more effectively to realise this potential, including through the incorporation of more clinically useful information. Recent software developments provide scope for contemporaneous, shared analysis of information to inform clinical practice and local management. Developments in this field are being undertaken by Waitemata and Whanganui DHBs

… with more information made available to the public

We also see a case for increasing the transparency of performance reporting. This happens to some extent at the moment with the six health targets but could be expanded to include a broader range of indicators. Both the United States and the United Kingdom have long experience of publishing performance data. There is little evidence that this influences patient choice, but it does appear to encourage performance improvement amongst providers.

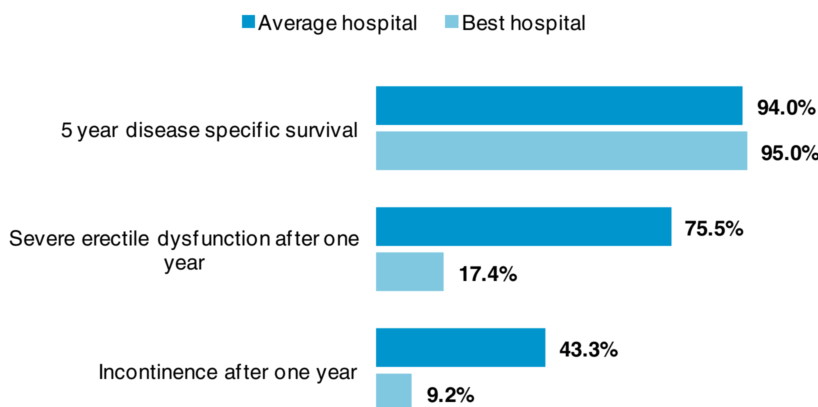
Greater transparency may also help to improve the accuracy of information and increase the rigour of the monitoring process. The publication of performance data would help to inform discussions about the how best to configure services to ensure that all New Zealanders are able to enjoy the highest possible standard of healthcare (see box 4).

- **Recommendation 2:** Make a broader range of benchmarked performance information available to the public.

Box 4: Prostate cancer treatment and the power of measuring outcomes

The chart below shows three different outcome measures for prostate cancer treatment in Germany. If we looked only at the five-year survival rates, we might conclude that there was very little difference between the best-performing hospital and the average hospital, and that outcomes were fairly good overall. However, other measures show that the best hospital is outperforming the average by a significant margin. This example brings the importance of understanding outcomes into sharp relief.

Prostate cancer treatment outcomes: Germany



Source: International Consortium for Health Outcomes Measurement via Michael Porter

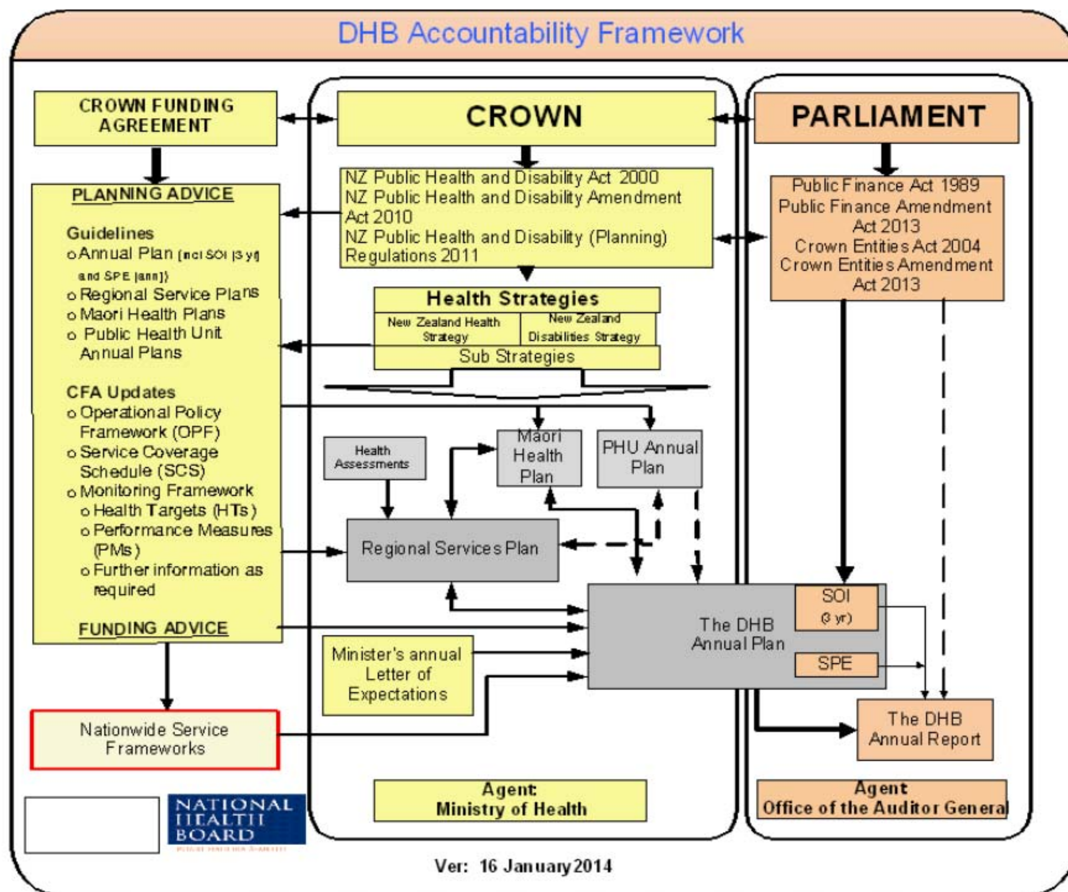
Clarifying lines of accountability

Accountability is important but arrangements in the health sector are currently complex and unclear in places …

An effective performance framework needs to be supported by appropriate accountability arrangements. This means being clear about who is responsible for which outcomes, and ensuring they have the capabilities, decision-making rights and incentives to deliver.

DHBs are subject to a range of formal accountability arrangements (figure 7). Planning and reporting requirements are imposed under the Crown Entities Act, the New Zealand Health and Disability Act, and the Public Finance Act. The Ministry of Health sets out relatively detailed expectations of service coverage and priorities on an annual basis, with sometimes prescriptive requirements about outputs (or inputs). Our discussions with DHBs have revealed differing views about the extent to which these requirements impose significant constraints on their autonomy over operational and funding decisions, but there is a general view that they have become overly complex.

Figure 7 – DHB accountability framework



Source: Ministry of Health

… with an overlap between the responsibilities of DHBs and PHOs

There is an overlap between the responsibilities of primary health organisations (PHOs) and DHBs which makes accountability for primary care outcomes unclear. Primary care includes a range of community services. Some of these are the direct responsibility of DHBs, but general practice services are managed and funded by PHOs.

PHOs were created under the 2001 Primary Health Care Strategy to deliver coordinated services and reduce health inequalities under a capitated funding model. However, DHBs are ultimately responsible for the health outcomes of their local populations and bear the risk of primary care underperformance in terms of flow-on costs to hospitals. A new national service agreement was introduced in 2013 in an attempt to clarify the role of PHOs. This makes PHOs and DHBs jointly responsible for primary care services through alliance contracts. We have heard that alliance arrangements are well developed and working effectively in some areas, but not others.

Reporting arrangements should be streamlined …

As the corollary to introducing a more comprehensive performance management framework for DHBs, we think it would make sense to revisit some of the planning and reporting requirements that currently apply to them. These could be streamlined. They could also be better aligned with the objective of having DHBs operate as outcomes-focused providers of integrated health services. Aligning information requirements more clearly with outcome and performance measures would help with this.

… and the operational autonomy of DHBs adjusted to reflect performance

We also see a case for adjusting the operational autonomy of DHBs according to their level of capability. For high-performing DHBs, this could involve a reduction in output (or input) specifications imposed from the centre, a relaxation of ring-fences on funding, and a greater degree of management control in relation to primary care. Poorly performing DHBs would have less autonomy and be subject to more intensive oversight of their day-to-day operations. (This happens to some extent already, but with limited transparency and a focus on deficit control.)

Comprehensive performance measurement would provide the basis for informed decisions about whether, and how far, to devolve responsibility to individual DHBs. It would also provide a framework for on-going monitoring and assurance under a more devolved model. The IPIF was designed to support such developments and needs to be followed through in implementation.

- **Recommendation 3:** Streamline planning and reporting arrangements for DHBs and adjust their operational autonomy according to performance.

Using funding as a lever to drive performance

Most public funding for healthcare is distributed on a capitated basis

Different funding arrangements create different incentives, so funding is an important way of influencing how the health system functions. Most public funding for healthcare in New Zealand is currently provided on a capitated (population) basis. DHBs are funded using the population-based funding formula (PBFF), with adjustments for specific factors, including socio-demographic characteristics and unmet need.

Most PHO funding is also capitated (using a different formula). There is a performance-related element to PHO funding, but it is currently a very small component. Some community health services – including general practice – impose additional charges on a fee-for-service basis, which are met privately by individuals. A fee-for-service model is also used by ACC to pay for elective surgery.

Neither capitation nor fee-for-service models provide good incentives for providers to target high-cost groups …

A capitated model is relatively easy to administer. It allows the government to impose top-down fiscal constraint. By specifying a fixed funding envelope within which services must be provided, it should in principle encourage prioritisation and prevention. However, it gives providers no reason to reduce spending below the specified limit, and it does not penalise under-provision or poor quality services.

Fee-for-service, on the other hand, rewards GP throughput. This may lift productivity, but it encourages episodic treatment and over-provision, with potential risks to quality and cost control. Neither capitation nor fee-for-service provide good incentives for providers to target high-cost groups: low-income high-need clients are therefore disadvantaged.

… so it is worth exploring alternative funding models …

Alternative funding models are being tested overseas. Two approaches in particular seem worth a closer look: payment for performance and bundled payments. The likely impact of reform should not be overestimated. Available evidence suggests that financial incentives in healthcare have a positive effect, but this is modest and variable.

… including payment for performance …

A number of countries have experimented with performance-related payments in healthcare over the past 15 years. This typically involves bonus payments to reward quality or efficiency. (Fee-for-service is a form of performance-related payment focused on outputs; the limitations of this approach have already been discussed.) Sharing cost savings between provider and funder is another model that has been tried in the United States, with mixed results.

A more sophisticated approach is to target outcomes. This is not straightforward: defining, measuring and attributing responsibility for outcomes is hard. Because of this, some performance-related programmes focus instead on encouraging providers to perform specific, clinically-proven processes. However, measuring and attributing responsibility for outcomes is important in its own right and a larger role for performance-related payments may help to embed the necessary processes.

The principle is already incorporated into the IPIF framework to a limited extent. ACC has also indicated that it wishes to explore a "fee for outcome" approach in some areas, to help ensure that treatment is provided as a package targeted at the ultimate clinical outcomes for clients (see box 5). Some form of risk adjustment or exceptions reporting would be needed to avoid penalising providers that service high-risk (high-cost) populations. A well designed system might create positive incentives for engagement with these groups.

Box 5: ACC is looking to improve the way it purchases services

ACC's most recent Financial Condition Report identified a range of opportunities to enhance performance, including in ACC's role as purchaser of elective surgery and public health acute services. We think it is worth exploring different funding arrangements in these areas as a way of both improving outcomes for clients and getting better value from the system.

Elective surgery: There is evidence to suggest that elective surgery has a limited impact on clients' return to work in some cases. There are no incentives within the system to prevent the over-use of elective surgery as a treatment option, even where lower-risk treatments may be just as effective. ACC is currently reviewing elective surgery pathways to ensure a stronger focus on quality clinical outcomes. We support this focus, including ACC's consideration of a 'fee for outcome' approach to funding providers.

Bulk funding: The public health system receives over $400m a year to fund inpatient, outpatient and emergency department services arising from ACC claims. Improving ACC's access to information about the claims and services this funding covers could help it to monitor client outcomes and enable more strategic investment in injury prevention and rehabilitation. There may be scope for ACC to invoice DHBs for services directly, rather than continuing with the current bulk-billing arrangements.

… and bundled payments

A bundled payment is a single payment for all treatment related to a particular condition or a particular episode of care, based on expected costs. This is a form of case-weighted funding which is designed to align provider and payer incentives. It falls somewhere between fee-for-service reimbursement and capitation. As in a capitation system, providers assume some risk because they receive a fixed payment regardless of the amount of treatment provided. However, because the payment is weighted according to the severity of the condition, and because a new payment may be available for a subsequent episode of care, there are fewer disincentives to engage with and provide services to high-risk populations.

Whether bundled payments would be workable as a mechanism for funding DHBs would need to be explored further. They certainly seem worth considering as an alternative way of funding primary care, particularly for high-cost population groups and people with chronic conditions.

- **Recommendation 4:** Consider alternative funding models, specifically performance related and bundled payments. These need to be underpinned by robust performance measures and information (see above).

Exploring an investment approach in the health system

Valuation of long-term liabilities is used as a management tool in other sectors

In the welfare context, an actuarial approach (using a forward liability) has been introduced to provide an information framework for performance measurement and improvement. Actuarial valuation is also used by ACC to support its fully-funded social insurance model, with insights from the valuation process used to inform policy interventions and as a management tool.

Using an actuarial valuation is less likely to be useful in the health sector …

We think an actuarial valuation is less likely to be useful in the health sector, as well as being more complex and risky. Top-down fiscal constraints already apply to funders in the health system (generally DHBs), so introducing an actuarial model is likely to have less impact than in the welfare system where most expenditure is demand driven and the aim is to leverage a much smaller pool of operational funding to manage that overall spend. Actuarial valuation would not address the problem of moral hazard, whereby neither patients (as consumers) nor doctors (as gatekeepers) bear the cost of treatment and so face limited incentives to economise. As noted earlier, this problem is common to both tax-funded and insurance-based health systems.

At a practical level, devolved budgets and decision rights within the health system would create measurement and accountability challenges for an actuarial model. Future health costs are also harder to define than the forward liability for welfare, since there is no fixed statutory entitlement to healthcare in New Zealand.

There are also conceptual drawbacks. In the welfare system, there is a relationship between lower (statutorily defined, demand-driven) benefit spending and improved employment outcomes. Similarly, there is a relationship between rehabilitation outcomes and demand-driven earnings compensation payments from ACC.

Lower expenditure does not provide a similarly reliable proxy for improved outcomes in the health system. Upfront spending on prevention, primary care and the management of chronic conditions may not be cost saving in the long run. This is because preventing fatal diseases leads to downstream costs as people live longer and develop other conditions, so the costly last year of life is simply postponed. Such spending may nevertheless be worthwhile, and cost effective in terms of the health and

quality of life outcomes it delivers. This argues against the introduction of a fiscal metric (the forward liability) as the primary indicator of overall system performance and key driver for management and investment decisions. Strong financial management is important but needs to be balanced by a focus on quality and patient safety.

… but there are a number of other aspects of the investment approach that are applicable

Other aspects of the investment approach are more readily applicable in a health context and are reflected in our recommendations. Relevant elements include adopting a more comprehensive measurement framework for the health sector, coupled with streamlined planning and reporting requirements and clearer lines of accountability, which would provide the basis for strengthened monitoring and the adjustment of operational autonomy for DHBs according to performance. These measures need to be accompanied by flexible funding models and priorities that align to incentives in the system and encourage quality and efficiency.

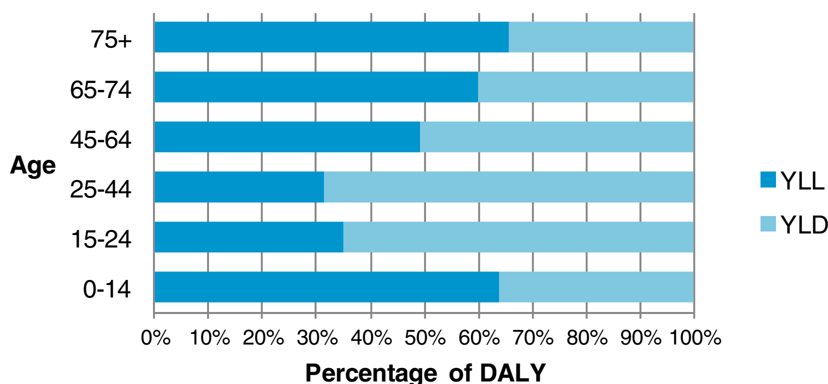
4. Responding to Changing Demand

The health system needs to rebalance towards primary and community care in response to the rising incidence of chronic conditions

It is now well established that the demands on the health systems of developed countries are changing. Systems like ours have evolved to deal best with life-threatening conditions in hospitals, with specialist doctors playing the leading role in delivering care. However, about half of all health loss is now accounted for by non-fatal, disabling conditions (figure 8), and this proportion is projected to increase.

Chronic conditions require sustained management over many years and most of this care will occur outside hospital. Therefore, the system needs to rebalance towards primary and community-based care and patient self-management. Many people with long-term conditions suffer more than one and they need to be cared for in an integrated way. There are some signs that services in New Zealand are beginning to adapt, but progress is patchy.

Figure 8 – Percentage of fatal (YLL) and non-fatal (YLD) health loss, 2007



Source: Ministry of Health

Barriers to accessing primary care need to be addressed

There is unmet need for primary care for certain population groups …

Some people face barriers that make it hard for them to access primary care, which is an issue if we are looking to rebalance the health system in this direction. The problem is more pronounced for certain groups, with the New Zealand Health Survey showing that unmet need for primary health care is greater for Māori and Pacific people and those on low incomes (table 1). For example, people living in the most deprived areas are 1.44 times as likely to have unmet need than those living in the least deprived areas. Māori adults are the most likely to have unmet need for primary care (1.46 times more likely than non-Māori).

Table 1 – Unmet need for primary care and dental problems, New Zealand Health Survey, 2012/13

(Adjusted ratios)	Children	Adults
Unmet need for primary care, past 12 months		
Māori vs non-Māori	1.5	1.5
Pacific vs non-pacific	1.2*	1.1*
Most deprived vs least deprived	1.6	1.4
Tooth removed due to decay, abscess, gum disease of infection		
Māori vs non-Māori	1.7	1.4
Pacific vs non-pacific	1.7	1.8
Most deprived vs least deprived	1.0*	1.5

* Not statistically significant

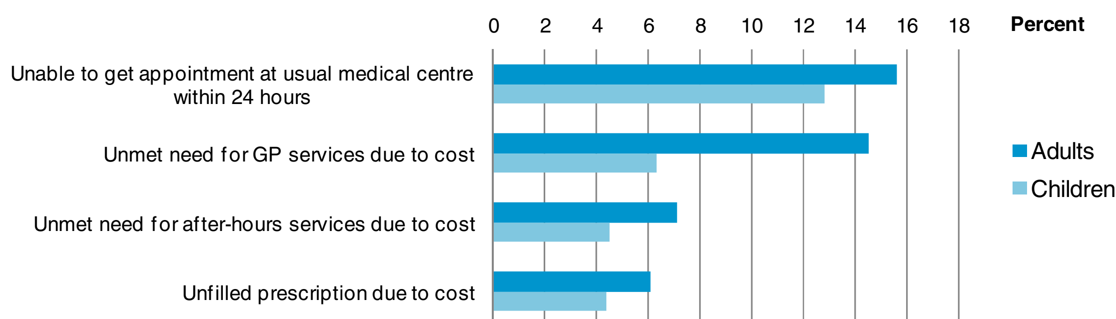
Source: Ministry of Health

… because of difficulty getting an appointment and cost

Barriers that prevent people from accessing care can lead to poor outcomes for individuals and for the health system as a whole. People who do not receive timely treatment may face deterioration in their health status. Alternatively, they may refer themselves to the emergency department, which is free and open 24 hours. In both cases, overall costs to the health system may increase.

Being unable to secure an appointment within 24 hours is the biggest driver of unmet need for both adults (15.6%) and children (12.8%). For adults, this is closely followed by the cost of GP services (14.4%). For children, the cost of GP services currently appears to be much less of an issue than for adults (6.3%).

Figure 9 – Unmet need for primary care, New Zealand Health Survey, 2012/13



Source: Ministry of Health

New service delivery models for primary care are needed to improve access …

The fact that difficulty getting an appointment is identified as the most common cause of unmet health need suggests that current models of general practice lack the capacity and flexibility to meet demand. Typically, the model involves small-scale, GP-led care and a booked appointment system operating within standard business hours. Performance audits by the Auditor General in 2010 and 2014 indicate that, while some progress has been made in increasing the availability and accessibility of after-hours services, ethnic and income-related disparities remain.

Previous attempts have been made to introduce new models of care into general practice. The 2001 Primary Health Care Strategy included additional funding and established PHOs as capitated entities to deliver primary care services focused on improving the health of their enrolled populations and narrowing health inequalities. Separate analysis undertaken by the Health Services Research Centre and the Treasury in 2008 and 2009 suggested that the strategy had increased consultation rates and reduced inequalities to a degree, but had not resulted in significant changes in the way primary care was delivered.

In 2009, the 'better, sooner, more convenient' (BSMC) initiative was introduced. This led to the formation of nine health alliances and the encouragement of integrated family health centres. The aims of BSMC included providing a wider range of services in the community, reducing acute demand on hospitals, and better management of chronic conditions. It is not yet clear what impact this initiative has had as it has not been formally reviewed, but anecdotal evidence suggests the impact has been marginal.

Large multi-practice organisations remain the exception, although there are pockets of change. For example, East Tamaki Healthcare has acquired a large number of practices in Auckland and operates a walk-in no-appointments system, with triaging undertaken by nurses. This approach is not without critics, but it does increase accessibility of care (see box 6).

Box 6: Exploring alternative primary care delivery models

East Tamaki Healthcare (ETHC) is a network of 22 general practices with 174,000 patients spread across the three Auckland DHBs. The network has grown from a single practice started in 1977.

The network has a unique operating model. Compared to the standard GP operating model, this has several advantages in terms of patients' access to care:

- **Fees are very low,** with co-payments of between $10 and $17, and free consultations for under-18s at South Auckland practices.
- **There is no need for an appointment,** so patients can walk in at any time, with an average waiting time of 44 minutes (based on analysis during February and August in 2012 and 2013).
- **After-hours coverage is provided seven days a week,** with opening hours of 8am to 11pm covered across the network.
- **Patients can walk into any clinic,** with every GP in the network having access to a patient's file.

The network has managed to achieve this level of access partly by virtue of its size, which allows financial risk and resources to be pooled, and partly through a triage approach which sees patients interacting with a clinical assistant or reception, and then a nurse, before seeing a GP if necessary.

The walk-in model has advantages for patients with urgent and acute issues. Continuity of care from a single clinician may be more important for other patients, including those with chronic conditions (see NZ Doctor, 21 May 2014). ETHC and other practices, such as **Te Kohanga Whakaora** in Kaitaia, have addressed this issue by offering a combination of walk-in and booked appointments.

ETHC also recently opened a new specialist treatment and rehabilitation centre to deliver intermediary health services in a single location for patients with chronic and long-term conditions.

… with consideration given to how central government can support change

Consideration needs to be given to how best to support further innovation in the delivery of primary care. Soon to be published evaluations of some of the BSMC initiatives should inform this work.

Earlier, we noted that there were overlapping responsibilities for primary care services, but that DHBs were ultimately responsible for the outcomes. If the new alliance contracts between PHOs and DHBs are not successful in changing delivery models and improving accessibility of care, then DHBs may need to consider delivering GP services directly in some areas using salaried staff or direct contracting.

- **Recommendation 5:** Determine next steps for reforming primary care delivery to improve access. Consider giving DHBs more flexibility to fill gaps where necessary.

Various policies have been aimed at mitigating cost barriers …

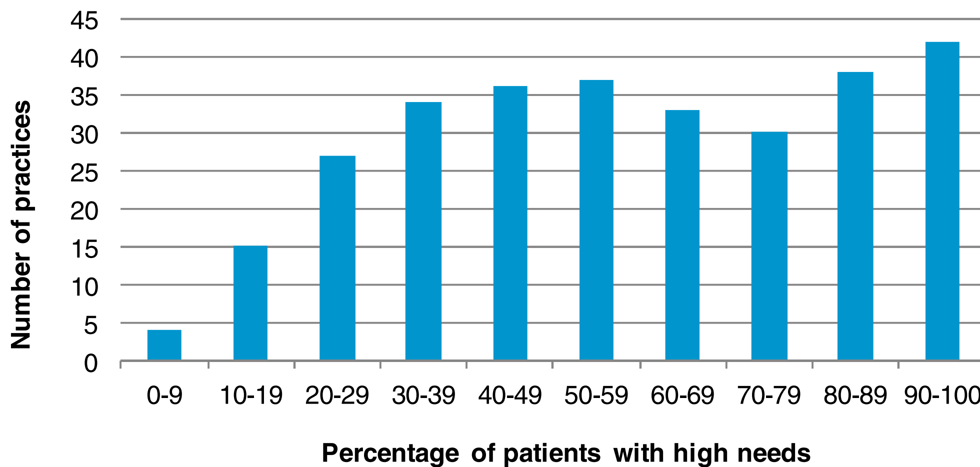
Co-payments for GP visits can discourage people from accessing primary care when they need it, particularly if they are on a low income. Steps have been taken to mitigate this problem for younger children with the universal provision of zero fee access to GPs for under sixes, and its planned extension to under thirteens. For adults and older children, the main mechanism for reducing the cost of GP visits is the Very Low Cost Access (VLCA) scheme, which is intended to provide cheaper access for high needs populations. VLCA funding is provided to PHOs to subsidise practices that voluntarily cap co-payments at specific thresholds.

[3]

The programme began in 2006 and was initially open to any practice. Since 2009, entry has been restricted to practices with 50% or greater high-needs enrolments (defined as Māori, Pacific or New Zealand Deprivation Index quintile 5). Nevertheless, in two-fifths of practices that currently receive VLCA funding, less than half the enrolled population is classed as having high needs. At the same time, high-need patients in practices that do not meet the 50% threshold are unable to

benefit from the scheme. The majority of VLCA funding does go to people living in the most deprived areas: the two most deprived quintiles account for 61% of people receiving VLCA funding. However, a substantial proportion goes to people living in the top three quintiles.

Figure 10 – Distribution of high-needs enrolments in VLCA practices, July 2013



Source: Ministry of Health

Primary care funding should be reviewed to ensure it caters adequately for high-needs populations

We see a strong case for reviewing the way that primary care funding is targeted towards high needs populations in order to reduce barriers to access for these groups. This does not necessarily need to be cost-increasing overall if VLCA funding is redistributed from higher-income groups to lower-income groups. Based on our conversations with the sector, there appears to be support for revisiting the current arrangements.

At the same time, the wider primary care funding formula should be reviewed to ensure that it is providing PHOs with adequate support for high-need populations.

- **Recommendation 6:** [3]

- **Recommendation 7:** Review the wider primary care funding formula to ensure adequate support for high-need populations.

The role of the health workforce

The skill mix of the health workforce will need to change

An increased focus on primary and community-based care will require a different mix of skills and a more flexible workforce. Dealing with this challenge is complex. A large

number of groups within the system influence workforce development and operate at arm's length from government. Professional bodies perform important functions, such as setting professional standards and guidelines and providing training, but their activities can also lead to patterns of workforce development that are sub-optimal from a whole-of-system perspective.

The workforce has stabilised over the last few years …

Prior to the global financial crisis, New Zealand's health workforce was characterised by very high levels of inward and outward migration relative to other OECD countries. The OECD cautioned that our heavy reliance on international recruitment was unlikely to be sustainable in the long term, with similar workforce shortages across the OECD and growing demand from developing countries.

Over the past five years, the situation has stabilised. This is partly due to the economic downturn, with fewer health professionals leaving the country and experienced nurses re-entering the workforce. There has also been an increase in the number of training places and the implementation of initiatives such as the Voluntary Bonding Scheme. It is unclear whether this stabilisation is temporary or structural. However, as a small player in a global market for health professionals, New Zealand remains vulnerable to economic, policy and technological changes worldwide.

… although DHBs still struggle to provide GP services in some areas

Despite positive workforce trends overall, DHBs are struggling to ensure adequate general practice coverage in some areas. The specialist medical workforce is growing at a faster rate than the general practice workforce, and the overall proportion of general practitioners is tracking down, from 38.2% in 2007 to 37.1% in May 2014. If not addressed, this will make it harder to rebalance the health system towards primary and community settings. Anecdotally, the imbalance may be caused partly by declining enthusiasm for the sole practitioner model of general practice. The need for changes to service delivery models has been discussed above.

Nurses could play a larger role in primary and community-based care …

There is scope for nurses and other healthcare workers to carry out a wider range of functions. This would improve the ability of the health system to adapt to the rising incidence of chronic disease, particularly given the shortage of doctors willing to work in general practice.

A number of practices in New Zealand already use nurses to triage care and deal with minor, non-complex issues. Various countries are developing more advanced 'practitioner' roles for experienced nurses with additional training. There are three main objectives: increased access to care given limited numbers of doctors; improved quality of care; and lower costs. In New Zealand, nurse practitioners must complete post-graduate (Master's level) training in a specialised area of nursing. They practice independently and in collaboration with other health professionals.

… and so could other types of healthcare workers …

There is also potential for other types of healthcare worker to improve access to primary care. Dr Lance O'Sullivan's MOKO programme, which is based out of Kaitaia, is a good example of how healthcare workers sitting outside the traditional doctor/nurse roles can improve primary care delivery (see box 7).

We also need to look more closely at the role of the care and support workforce in the aged care and disability support sectors. This workforce is important to the health sector's capability to respond to the ageing population and the increasing prevalence of chronic disease. It is also important to the wider workforce because it allows other health workers such as nurses to concentrate on tasks that make better use of their training. A well functioning, appropriately trained care and support workforce enables people with more complex health needs to be cared for in their homes for longer and facilitates earlier discharge from hospital, freeing up hospital beds with a positive impact on patient flows and efficiency.

Box 7: Innovative workforce practices in the far north: The MOKO programme

The **MOKO programme (Manawa Ora, Korokoro Ora or Healthy Heart, Healthy Throat)** run by Kaitaia GP Lance O'Sullivan is a good example of the potential of the non-regulated health workforce to improve health outcomes by taking care into communities.

MOKO teams go into each primary school within a 25 kilometre radius of Kaitaia three times a week to check for three things:

- Sore throats (swabbing for Strep A to prevent rheumatic fever)
- Itchy scalps (often related to head lice)
- Skin sores (which can be a number of things like eczema, cellulitis and MRSA)

The team members who visit schools most regularly are not nurses or doctors but are trained to undertake a specific set of tasks under Dr O'Sullivan's clinical supervision. Where necessary, they send photos back to the clinic for Dr O'Sullivan to review. One of the helpful things about the team members' regular contact with the schools is that they develop in-depth knowledge of children's broader circumstances (such as who their parents are and their living arrangements), which can assist with treatment. Since there is a very low level of health literacy in some families, the MOKO teams are also teaching basic skills about things like hygiene, wound care, nail clipping, and tooth brushing.

A virtual version of the programme, known as vMOKO, is being used to screen for skin problems in more remote schools of the far north.

… if barriers to workforce flexibility were addressed

Roles must be appropriately regulated and evaluated to ensure patient safety, good clinical outcomes and value for money. However, unnecessary barriers to workforce flexibility should be identified and addressed (see box 8).

One practical step would be to progress the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill to enactment. This would remove

out-of-date restrictions that prevent health practitioners from performing functions for which they are qualified and authorised. Updating this legislation carries a low risk to public safety as the Health Practitioners Competency Assurance Act ensures that only those health practitioners who are competent to perform an activity are legally able to do so. The Bill has been under development for several years. Within the health sector (particularly amongst the nursing profession) there is frustration at the lack of progress. Enacting this legislation would contribute to improving access and managing costs.

- **Recommendation 8:** Identify and remove unnecessary barriers to workforce flexibility, starting by progressing the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill.

Box 8: An example from the Burial and Cremation Act

The Burial and Cremation Act 1964 requires that a Medical Certificate of Cause of Death can only be signed by a medical practitioner. This can lead to delays where doctors are not available, especially in rural areas and outside normal working hours. Certificates can remain unsigned for several days after death.

The effect of this delay is that a funeral director or undertaker does not have the legal right to remove the body of the deceased to prepare for burial or cremation. In aged residential care settings, nurses are more likely to be on site and will often have the best knowledge of a resident's medical history.

5. Institutional Structure

This section looks at the institutional arrangements at the centre of the health system and considers whether changes are needed to support the sector as it adapts to meet the challenges outlined above.

Integration with the wider social sector

Public services need to be better connected to help New Zealanders with complex needs …

Healthcare is one of a number of factors that influence health status. Other factors include individual characteristics (such as age) and broader socio-economic and environmental conditions (such as housing, employment status and education). For the majority of New Zealanders, the health system does a good job of diagnosing, treating and managing illness as it occurs. However, for people facing deprivation in terms of these broader conditions, optimal results will not be achieved through health services alone. In such cases, the health system needs to connect to a wider range of public services to address the root causes of ill health, with those services orientated around the needs of the citizen.

… and agencies are now working together to address this

Work is underway across the public sector to facilitate collective ways of working across government agency boundaries. For example, the Ministry of Health is a participant in the Social Sector Forum, which is looking specifically at how the social sector agencies can work together more closely to achieve better outcomes. As well as achieving better integration across the social sector agencies, there remains significant scope to improve institutional arrangements and integration within the health system itself.

The post-Ministerial Review Group institutional landscape

Reform has delivered improvements in specific areas …

A number of changes were introduced following the report of the Ministerial Review Group in 2009, which raised concerns about duplication of back-office work by DHBs and a lack of regional and national service planning, amongst other things.
The overall impact of those reforms has been limited so far, although there has been progress in some areas.

The National Health Board (NHB). The NHB is an independent board established to advise the Minister of Health and the Director General of Health on funding, monitoring and planning. The Ministerial Review Group envisaged a direct administrative role for the NHB. In the event, all operational responsibilities remained with the Director

General. The NHB lacks visibility within the sector and has had limited impact in shaping its overall strategic direction. Nor does it seem to provide close oversight of the relevant Ministry functions.

Two NHB sub-committees have achieved greater traction, bringing expertise to bear in relation to their more specific mandates:

- **National Health IT Board (NHITB).** The NHITB provides strategic leadership on IT systems across the sector. Its key objective is the implementation of regional IT platforms to manage and share patient information, supported by good regional leadership and governance models. The Auditor General reported in November 2013 that progress with the implementation of IT projects in the health sector was mixed but improving, with the NHITB showing leadership, a clear set of priorities, and a determination to keep people focused on what is important.
- **Capital Investment Committee.** An advisory committee established to examine capital investment proposals. The committee has played a constructive role in relation to the prioritisation of investments and the oversight of major capital business cases, including Christchurch. In the absence of a broader plan for the delivery of health services nationally, it has been difficult for the committee to develop a national asset management plan as required by its terms of reference. The committee would be more effective if it were given greater visibility of baseline capital intentions (we return to this point below).

Regional Service Plans. A new requirement was introduced in 2011 for groups of DHBs to develop regional service plans. The aim was to encourage collaboration and integration without structural change. Progress has been limited. A review by the Auditor General published in November 2013 noted that collaboration had increased to some extent, but found relatively few examples of regional service planning and limited evidence of its effectiveness. It seems doubtful whether this additional planning layer will make a useful contribution in the absence of meaningful regional accountabilities.

Health Workforce New Zealand (HWNZ). This is an advisory committee, with a remit to provide national leadership on the development of the health and disability workforce. Operational responsibility for workforce issues remains with the Ministry of Health, although a branded HWNZ business unit has been created inside the Ministry to support the committee. This leaves boundaries unclear. Over the past five years, HWNZ has focused mainly on data collection, a series of workforce service forecasts, and some small-scale trials of new roles. It also invests in postgraduate training programmes (for specialist nurses and allied health workers, for example) and in schemes to promote recruitment, training and distribution in hard-to-staff areas and specialties. HWNZ has struggled to provide clear direction to the sector or to develop an overall workforce strategy, but there are recent signs that it is beginning to step into a more strategic role. Employers – both public and private – also need to take responsibility for workforce issues, including workforce development.

Health Benefits Limited (HBL). Established in 2010 as a shared service organisation for DHBs, HBL has so far achieved gross savings of over $300 million, mainly through bulk procurement. However, it has run into problems trying to implement national financial management IT infrastructure, making limited progress despite significant (DHB-funded) investment. There has been recent turnover of senior management.

Health Quality and Safety Commission (HQSC). A small independent body with its own staff. It is responsible for leading work to monitor and improve safety and quality. It has no formal powers, and therefore relies mainly on advising other actors in the sector. Specific initiatives include the introduction of 'quality accounts' for each DHB and the development of patient experience indicators. HQSC is making an effective contribution within the terms of its mandate.

National Health Committee (NHC). In 2011, the role of this independent committee was reoriented towards improving value for money and prioritising new technology and interventions. Initial progress was slow, with the NHC focused on its operating model and methodological issues, but it has now started to gain traction with specific analysis. The NHC's preferred approach is to assess a basket of new and existing interventions, focusing on models of care for high-cost conditions. This seems like a sensible approach. The acid test will be implementation, which requires cooperation from DHBs and the Ministry of Health.

PHARMAC. Established in 1993 to prioritise and procure community pharmaceuticals, PHARMAC has a strong track record of allocated resources effectively and managing costs. Its role has recently been extended to include hospital medicines, and it is now also starting to assume responsibility for medical devices.

… but further change is needed

We think some changes to institutional arrangements would make it easier to move the sector as whole towards an outcome-focused, sustainable model with a stronger emphasis on primary and community care. These changes are discussed below.

Commissioning of health services

Commissioning arrangements are currently fragmented …

Commissioning is the process of deciding how to spend available funds to improve health, and includes the planning and funding of services. Commissioning arrangements in New Zealand are fragmented, with 20 DHBs serving populations which vary widely in terms of their size and socio-economic and ethnic characteristics. The Ministry of Health also has a significant commissioning role. Regional and national arrangements for commissioning services are under-developed and unclear.

… and lacking in strategic direction

The various boards, agencies and committees described above have delivered improvements in specific areas. However, there has been limited success in developing an overall strategic direction for the health system sufficient to address medium and long-term challenges. There is a lack of operational independence around commissioning and longer-term planning above DHB level. This has not been addressed by the introduction of various branded business units within the Ministry and inhibits discussion of the challenges facing the sector and possible responses.

The legislation establishing DHBs envisaged that they would collaborate with the Crown to achieve optimal delivery of coordinated services at local, regional or national level as appropriate. As the Ministerial Review Group noted in 2009, progress towards this objective has been slow and fragile. The Group proposed two changes:

- Positively define national services, and plan and fund them centrally.
- Require DHBs to develop regional service plans and establish appropriate commissioning arrangements.

The proposal for a positive list of national services was not taken up by the Government. Regional service plans were adopted, but have failed to gain much traction (see above). Specialist centres do exist at the larger DHBs, funded through inter-district payments. However, these arrangements are not supported by clear planning and reporting mechanisms that ensure services are well coordinated and of high quality.

Clear national and regional commissioning arrangements should be introduced

We agree with the Ministerial Review Group's general conclusion that services need to be commissioned at different levels, reflecting factors such as volumes, capital intensity and workforce availability. We also think that a greater degree of operational independence is needed in relation to commissioning and longer-term planning above DHB level. Specifically:

- We think the proposal for a positive list of nationally commissioned services should be revived, along the lines outlined by the Ministerial Review Group. This would ensure that the most highly specialised services were coordinated and funded appropriately. It would also facilitate national asset management planning by the Capital Investment Committee (see above).
- For other services, we do not think it realistic to expect DHBs themselves to develop regional governance structures in the absence of relevant accountabilities. This is borne out by experience over the last fourteen years. Rather than allocating responsibilities equally to DHBs and relying on inter-district flows with no oversight, we see a case for a graduated approach to commissioning. Services requiring a regional model should be identified, in discussion with DHBs, and

responsibilities then delegated accordingly. This could involve the introduction of regional management and accountability arrangements. More likely, it would mean assigning responsibility for delivering specific regional services to particular DHBs, leaving other DHBs to focus on managing local services.

The risk is that this sort of approach might act as a barrier to full vertical integration of services and increase the risk of cost shifting. Full integration is already beyond the scope of smaller DHBs, which rely on inter-district flows to deal with more complex cases. Continuing to fund regional services through inter-district flow payments from DHBs would mitigate against cost shifting but involves complexity. Top-slicing DHB budgets, as proposed by the Ministerial Review Group in relation to national services, may be a simpler solution.

- **Recommendation 9:** Develop national and regional commissioning structures with an appropriate level of operational independence, and align accountability and funding arrangements accordingly.

Independent monitoring and assurance

Monitoring and assurance arrangements could be strengthened …

Regulatory arrangements in the New Zealand health system seem relatively light touch compared to those of other countries, and they lack independence. The HQSC has no formal powers. Formal certification of health and residential care providers is the responsibility of the Director General, but the work is typically delegated to designated auditing agencies selected by the provider. As discussed earlier, the performance measurement framework that applies to DHBs and other providers is not well developed. An independent Health and Disability Commissioner deals with consumer complaints and carries out a small number of reactive investigations each year.

A recent review by the RAND Corporation noted that regulatory agencies typically operate at arm's length from government. The review also found an international trend towards greater centralisation of regulatory functions, and a move towards greater transparency through making quality and safety information publicly available.

… by making them the responsibility of an independent agency

The Ministry of Health is currently responsible for assessing the performance of the system it is charged with administering, and in relation to which it also provides policy advice to Ministers. Clearly, there are synergies here, but in our view these arrangements create conflicts of interest and contribute to a lack of contestability in the system, with weak incentives to identify and highlight areas of concern.

We see a case for making an independent body, outside the policy and commissioning processes, formally responsible for monitoring the system and providing assurance about its financial and non-financial performance. Monitoring financial and non-financial performance together will allow for a holistic view of sector performance that

recognises constraints and tradeoffs. Having a monitoring body at arm's length is also consistent with the investment approach adopted in the welfare system, where the valuation (the overarching performance report) is calculated outside Work and Income, and is used as the basis of monitoring by Treasury (the external monitor).

It is worth noting in this context that the HQSC attributes its success partly to the fact that it plays a quality improvement and advocacy role rather than having a formal monitoring and compliance function. Folding the HQSC into a larger monitoring agency would obviously have some attractions in terms of administrative simplicity and efficiency. However, this would also carry the risk of the monitoring role coming to dominate and overtake the quality improvement role (as happened with the Commission for Health Improvement in England).

- **Recommendation 10:** Consider arrangements for establishing an independent body responsible for providing assurance about the financial and non-financial performance of the health system.

Shared service arrangements for DHBs

The role of HBL needs to be reviewed

There needs to be a thorough review of the approach taken to DHB shared services before additional savings initiatives are undertaken. Execution by HBL has been poor, although the context within which it has been asked to operate will not have helped. It was given a target of $700 million gross savings over five years. In hindsight, this was too ambitious. Setting a gross target may have encouraged HBL to focus on maximising overall savings through large scale reforms, with insufficient regard for the net impacts and risks for individual DHBs.

The relationship between HBL, DHBs and central government also needs to be examined. HBL's ability to make progress on significant change depends on achieving consensus amongst DHBs which (understandably in some cases) has been slow to emerge.

- **Recommendation 11:** Review the approach to DHB shared services.

Oversight and funding of major capital projects

Large capital projects are not core business for DHBs …

Affordability of major capital builds is an ongoing concern in the health sector. Past projects have led DHBs into large deficits as increased capital costs have not been sufficiently offset by efficiencies or increased revenue.

Planning and building major hospital infrastructure is not consistently part of the core business of DHBs and, as the Auditor General has observed, there is a shortage of people in New Zealand with the skills needed to prepare business cases and manage

and govern large capital projects. Repeatedly contracting out these functions is expensive and means that experience gained on one project is not retained and transmitted to the next.

… so management and oversight should be centralised...

The Canterbury and West Coast redevelopment processes have demonstrated the benefits of a new governance and management model, with an external partnership group working collaboratively with the DHBs to oversee the project, coupled with support from the centre (see box 9).

Box 9: A Partnership Approach to Major Hospital Redevelopments

The Christchurch redevelopment introduced a new model of capital planning and implementation, with the establishment of a Hospitals' Redevelopment Partnership Group. The Partnership Group fast-tracked the detailed business case for redevelopment of Christchurch and Burwood Hospitals and has continued as construction gets underway. Recently, the remit of the Partnership Group was expanded to include governance of the implementation of the DHB's earthquake repair programme. The partnership approach is also being used for redevelopment of Grey Hospital on the West Coast.

This approach, which brings external expertise into the governance and management of projects, provides enhanced transparency for the centre and additional support for DHBs. By increasing the comfort of decision-makers that proposals have been subject to robust external challenge and scrutiny, it allows decisions to be expedited. Greater knowledge transfer between projects within the sector is also being realized as project management expertise is retained at the centre.

We recommend that a project management office is established with formal responsibility for the planning and building of major capital projects in the future.   To improve network-level visibility of investment in the sector, we also recommend that the mandate of the Capital Investment Committee is expanded to include the oversight of DHB baseline capital intentions.

… and a consistent (equity) funding model applied

Since 2002, Crown debt has sometimes been provided to DHBs instead of equity. This affects their cost of capital because interest rates on Crown debt are lower than the capital charge. The intention of providing Crown debt was to incentivise good financial performance by reducing the cost of capital, but the end result is not particularly coherent. Capital costs vary widely between DHBs in a way that does not reflect their underlying financial performance. By insulating DHBs from the full cost of capital, access to Crown debt distorts their investment decisions. It also creates inconsistencies in capital decision-making across government, since other sectors cannot normally access debt funding. Given these issues, our view is that the health sector should move to an equity-only model, consistent with the rest of government, provided the transition can be accomplished in a cost-neutral fashion.

- **Recommendation 12:** Strengthen arrangements for managing and funding health capital projects.

6. Summary of Recommendations

- **Recommendation 1:** Build on the IPIF and other work to date to develop a comprehensive performance measurement framework for the health sector. This needs to be based on good information.
- **Recommendation 2:** Make a broader range of benchmarked performance information available to the public.
- **Recommendation 3:** Streamline planning and reporting arrangements for DHBs and adjust their operational autonomy according to performance.
- **Recommendation 4:** Consider alternative funding models, specifically performance related and bundled payments. These need to be underpinned by robust performance measures and information.
- **Recommendation 5:** Determine next steps for reforming primary care delivery to improve access. Consider giving DHBs more flexibility to fill gaps where necessary.
- **Recommendation 6:** [3]
- **Recommendation 7:** Review the wider primary care funding formula to ensure adequate support for high-need populations.
- **Recommendation 8:** Identify and remove unnecessary barriers to workforce flexibility, starting by progressing the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill.
- **Recommendation 9:** Develop national and regional commissioning structures with an appropriate level of operational independence, and align accountability and funding arrangements accordingly.
- **Recommendation 10:** Consider arrangements for establishing an independent body responsible for providing assurance about the financial and non-financial performance of the health system.
- **Recommendation 11:** [3]
- **Recommendation 12:** Strengthen arrangements for managing and funding health capital projects.