MINISTRY OF HEALTH
MANATŪ HAUORA

Memorandum

Cabinet paper: Managing and measuring the health and disability system through public reporting

Date due to MO:	4 December 2019	**Action required by:**	5 December 2019
Security level:	IN CONFIDENCE	**Health Report number:**	20192381
To:	Hon Dr David Clark, Minister of Health		

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Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, System Strategy and Policy	s 9(2)(a)
Nicola Hill	Acting Group Manager Strategy, System Strategy and Policy	s 9(2)(a)

Action for Private Secretaries

Lodge the final version of the attached Cabinet paper by 12 noon 6 December 2019.

Date dispatched to MO:

MINISTRY OF HEALTH
MANATŪ HAUORA

Cabinet paper: Managing and measuring the health and disability system through public reporting

Purpose of report

1. This memo provides you with a Cabinet paper on health and disability system measures which is intended for the Cabinet meeting on Monday 9 December 2019.

2. To meet this Cabinet meeting deadline, the paper will need to be lodged late with the Cabinet Office by 12 noon on Friday 6 December 2019.

Key Points

3. The attached paper is a Cabinet report back on proposals to drive and measure progress on the Government's priorities for the health and disability system [SWC-19-MIN-0059 refers].

4. An early draft of the attached paper was provided to your Office on Friday 29 November 2019. A revised version of the paper is attached which incorporates feedback from your office, the Department of Prime Minister and Cabinet (DPMC), and The Treasury.

5. Talking points have been provided in Appendix One.

6. A table with further information on the 10 high-level 'impact measures' for public reporting has been provided in Appendix Two.

Background

About the measurement framework

7. The Ministry of Health (the Ministry) and the Health Quality and Safety Commission (HQSC) have worked in partnership to develop a framework for health system improvement which incorporates a new approach to measurement.

8. The proposed framework involves:

   a. the Minister of Health/Government setting the priorities for the health system

   b. the Ministry and the HQSC developing appropriate high-level measures with input from the health sector

   c. local providers working with local consumers to agree with the Ministry and the HQSC what local actions are needed to contribute to the high-level goals

   d. monitoring and publicly reporting on local contributions made to the national high level goals by local actions.

9. This approach draws on the success of the approach to the System Level Measures which operate in all District Health Boards (DHBs) and has been built on shared accountability and strong local engagement to achieve results for people.

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About the measures

10. The framework includes three key types of measures - 'impact measures', 'check measures' and 'work measures':

    a. **'impact measures'** help us to understand the extent to which the health system is improving in line with high level goals

    b. **'check measures'** are measures to help ensure that other important outcomes aren't compromised as an unintended consequence of pursuing the impact measures.

    c. **'work measures'** are agreed between local health system actors and the Ministry of Health with input from local consumers for monitoring local initiatives to contribute to improving impact measures.

11. For each "impact" measure, there will be at least one "check" measure of the distribution of that measure among different ethnic and socio-demographic groups. For example, a local intervention to decrease avoidable hospital admissions will not be considered a success if this intervention increases inequity between Māori and the non-Māori population.

12. A set of 10 national impact measures, aligned with your priorities, is proposed for public reporting (online and potentially in print media). These measures are set out in the attached table (Appendix Two) and in the Cabinet paper.

13. In addition to the national level results for the 10 impact measures, users will be able to 'click through' for detail about local performance (including progress towards equity for Māori) and local activity undertaken to support the national measures. This approach will help to strengthen the link between local action and national purpose.

14. 'Check measures' and 'work measures' are also being developed. This is best achieved through engagement with sector experts. We expect this engagement to process to take at least 12 months. The paper recommends that Cabinet authorise you to finalise the impact measures and agree the further work to develop 'check' and 'work' measures.

Implementation timing

15. DHB planning guidance is updated in mid-December 2019. Subject to Cabinet agreement the 10 impact measures could be incorporated into the DHB plans. This would provide an opportunity for DHBs to plan to undertake actions to support the new measure set.

16. It is anticipated reporting could begin with a high level 'impact' measure set in the first quarter of 2020/21. It is anticipated that a full report with all 'check' and contributory 'work' measures could be published in the following year.

17. The paper states your intention to announce the measures via a media release in May 2020.

Risks

Potential for behaviour change in the System Level Measures programme

18. The framework proposed in the Cabinet paper is built using some of the key principles of the System Level Measures (SLM) programme, and the proposed 'impact measure'

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set includes three of the six current SLMs. The SLM programme was co-designed with the sector and has broad sector support.

19. As its reports will be published nationally, the new framework has the potential to introduce a variety of additional interests into the SLM programme, and risks changing the nature of health sector engagement with the SLM programme, which is generally considered to be a success. It will be essential to engage the sector in conversations so as not to compromise the positive aspects of the SLM programme.

Consultation

20. The attached Cabinet paper has undergone consultation with DPMC and The Treasury.

21. Both agencies are generally supportive of the paper but recommended the addition of high-level measures for financial sustainability.

22. The Ministry notes that the purpose of the proposed "impact" measure set is about health outcomes (the key purpose of the system), and that local contributions ('work measures') to these outcomes will be reported at lower level. It is the Ministry's view that the health budget is an input contributing to health outcomes, and therefore need not feature at a high level in this framework. Other publicly available reports on financial sustainability are available including the DHB financials on the Ministry's website and accountability mechanisms to Parliament.

23. s 9(2)(g)(i) [redacted]

24. A click through link from the new framework to other accountability documents, such as the regularly collected and reported DHB financial information, could be incorporated into the framework. This would provide a comprehensive picture while reducing reporting burden.

25. Minor changes to the paper have been made from the version sent to your Office on Friday 29 November 2019, to shorten the paper, improve the flow, and to incorporate comments from your Office, DPMC, and the Treasury.

26. The Treasury has also suggested that HQSC have an ongoing role in the administration of the framework. The Ministry has tested this position with HQSC and HQSC have advised that, while they intend to assist in a technical capacity, this is beyond the intended scope of the organisation and would adversely overlap with the Ministry of Health's monitoring role.

27. The Treasury have informed the Minister of Finance of their position, and raised both of these issues as potential areas that he may wish to test with you at Cabinet.

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Next steps

28. The Ministry understand that your Office has requested a late lodging with the Cabinet Office, and that the paper is due for lodging by 12 noon on 6 December 2019 for consideration at the Cabinet meeting on 9 December 2019.

Bronwyn Croxson
Acting Deputy Director-General
System Strategy Policy

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Appendix One - Talking points

Overview and context

1. A strong and sustainable health and disability system is essential for the wellbeing and prosperity of New Zealanders and is therefore vitally important for us as a government.
2. Good health and wellbeing has strong links with most ministerial portfolios.
3. A key lever at our disposal to drive improved performance across the health and disability system is public reporting on population health outcomes and system activity.
4. What gets measured, gets done. We need to keep our kids out of hospital where conditions are preventable, like rheumatic fever. We are making progress on this and we need to keep the focus on it by monitoring and reporting outcomes.
5. A concerted effort towards improving preventable hospitalisations rates, for example through immunisation or housing based interventions for respiratory conditions, reduces the impact of a range of diseases, and keeps kids, and the rest of the population, out of hospital. This is one way measurement works towards achieving Government goals e.g. improving child wellbeing
6. I came to you in May 2019 to discuss my intention to publicly report on a new set of measures.
7. At that stage, Ministers had concerns about specific measures eg, healthy weight of children, and asked that I provide a better indication of how reporting might look. The intervening period has given me a chance to reconsider my approach.
8. The approach outlined in this paper is a good one. It improves on the previous national health targets, supports the Government's wider approach to wellbeing, and fosters shared accountability among actors in the health system at national and local levels.
9. The approach, designed by the Ministry of Health and the Health Quality and Safety Commission, allows for a wider, more representative picture of the health system, including local level actions to improve health outcomes.
10. It also mitigates "hitting the target, and missing the point" such as increasing low acuity elective treatments to boost elective volumes. It actively works to identify undesirable consequences of measurement by establishing checks and balances, and encourages buy-in from the health system by promoting shared accountability.
11. Today I'm seeking your agreement to the top level national 'impact' measures for reporting for the first quarter of 2020/21. Further work in close consultation with the health sector will be required before reporting of all levels of the framework.
12. Reporting will be primarily online but given previous experience I expect that the media will be interested in the high-level measure set, so they may also appear in print. Reporting will also include local performance, activity underway within the health system, and progress towards achieving equity.

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The following material has been provided in case it comes up during the meeting

A high-level measure for financial sustainability

13. I would not recommend including a measure for financial sustainability in the measure set for high-level reporting.

14. s 9(2)(g)(i) [redacted]

15. My view is that the health budget is an input contributing to health outcomes, and while an essential factor in providing sustainable healthcare into the future, is not in itself a health outcome that is meaningful to New Zealanders.

16. Other publicly available reports on financial sustainability are available including the DHB financials on the Ministry's website and accountability reporting to Parliament.

17. A click through link from the new framework to other accountability documents, such as the regularly collected and reported DHB financial information, could be incorporated into the framework. This would provide a comprehensive picture while reducing reporting burden.

Involvement of the HQSC in the framework's administration

18. There has been some suggestion HQSC have an ongoing role in the administration of the framework.

19. The Ministry of Health has tested this position with HQSC. HQSC have advised that, while they intend to assist in running the framework in a technical capacity, this is beyond the intended scope of the organisation and would adversely overlap with the Ministry of Health's monitoring role.

End

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Appendix Two: Overview of the 10 impact measures

Note that the impact statements are typically phrased in terms of a number of more people experiencing good health outcomes. It is proposed that reporting will take into account the forecast of the likely level of any particular measure, and compare the result for a given reporting period to the forecast. That is, "more" refers to "more than forecast".

Priorities	Measure of impact	Measure	Rationale	Technical description
Improving child wellbeing *"Keeping kids out of hospital"*	Xxx more children got every immunisation they needed by their second birthday	Immunisation rates for children up to two years old	Keeping infants and children safe from vaccine preventable illnesses is vital for a healthy start in life. Completing all vaccinations is important for immunity. A target level of 95 per cent is consistent with herd immunity. Measles can be more severe in young children so maintaining high immunisation rates in this age group is a key priority in responding to measles outbreaks.	***Numerator:*** Eligible children enrolled on the NIR who have turned two years of age during the reporting period and have completed all age-appropriate immunisations ***Denominator:*** Eligible children enrolled on the NIR who have reached the age of 2 years within the reporting period (three-month reporting period) ***Frequency:*** Quarterly ***Source:*** National Immunisation Register Data Mart, PHO Enrolment Register (data extracted into NIR Data Mart)
	Xxx children didn't have to go to hospital	Ambulatory sensitive hospitalisations for children (age range 0-4)	This is a measure of the impact of prevention and access to primary health care services and treatment in the community, and good and appropriate co-ordination of services between primary and secondary care. Links with cross-agency activity to reduce drivers of hospitalisation (eg, Child & Youth Wellbeing Strategy). Age 0-9 is being considered as hospitalisations are still significant for Māori children between five to ten years old.	***Numerator:*** Number of ASH admissions for 0-4 year olds ***Denominator:*** Number of children aged 0-4 years ***Frequency:*** Quarterly (presented as rolling 12 months as there are seasonal effects on ASH admissions) ***Source:*** National Minimum Dataset (NMDS), and Statistics New Zealand Population Projections
Improving mental wellbeing *"Better mental health and wellbeing for everyone"*	Xxx more people got to see a primary mental health carer	Access to primary mental health services	Improving access to primary mental health services is a government priority and supports a focus on prevention and responding to mental health concerns as early as possible to improve outcomes.	***Under development:*** *The proposed is the percentage of the population accessing primary mental health and addiction services funded through the Budget 2019 initiative to expand access and choice of primary mental health and addiction support. The earliest reporting for this initiative at NHI level is anticipated as the 4th quarter of the current financial year, with information available in late August 2020 for the April-June period.*
	Xxx more young people got to see a mental health specialist fast	Under 20s able to access specialist mental health or addiction services within 3 weeks of referral	Reducing wait times for young people with mild-to-moderate mental health concerns supports early intervention. Timely services reduce the adverse impact on individuals and their whānau.	***Numerator***: People aged 0 to 19 years old, referred for non-urgent mental health or addiction services that are seen within 3 weeks ***Denominator***: Total number of people referred for non-urgent mental health or addiction services ***Frequency:*** Quarterly ***Source:*** DHB accountability reporting
Improving wellbeing through prevention *"Keeping people well"*	Xxx avoided deaths of New Zealanders	Amenable mortality	Amenable mortality is a way of measuring the effectiveness of the health and disability system. It is defined as premature deaths (under the age of 75 years) that could potentially be avoided, given effective and timely use of health services. Improving prevention, early intervention, and supporting people to better manage conditions at home and in the community is vital to reduce amenable mortality rates, address health inequities, and to increase the number of years New Zealanders live in good health. Note this measure could be amended to exclude to coronial cases that delay the timeliness of the measure	***Numerator:*** Deaths from specified causes (list needs revising to exclude coronial cases that delay timeliness of measure) for people aged under 75 years ***Denominator:*** Population aged under 75 years ***Frequency:*** Annual ***Source:*** Mortality Collection and Statistics New Zealand population estimate
	Xxx more people screened for bowel cancer	Participation in bowel screening programme	Bowel cancer is a leading cause of health loss from cancer in New Zealand. Screening helps to identify cancers, supports early intervention and increases survival rates.	***Numerator:*** Eligible people aged 60-74 screened within appropriate period ***Denominator:*** Eligible population: age range 60-74 years ***Frequency:*** Quarterly ***Source:*** National Screening Unit

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Appendix Two: Overview of the 10 impact measures

Strong and equitable public health system *"Great hospital care when you need it; home again when you're ready"*	New Zealanders spent xxx fewer days in hospital	Acute bed days	At least some acute hospital bed days are preventable and these reflect the number of admissions to hospital (our ability to prevent admissions by good out of hospital care), length of stay (efficiency and effectiveness of hospital services, and effective integration and care planning between hospital and out of hospital care) and readmissions (safety and effectiveness of discharge planning and effective integration and care planning between hospital and out of hospital care). Hence this measure, in total, reflects the working together of the entire system and the quality of individual parts of it.	***Numerator:*** Bed days associated with hospital stays that started with an acute (i.e. non elective admission) ***Denominator:*** Population ***Frequency:*** Quarterly (12 month rolling averages) ***Source:*** National Minimum Dataset (NMDS), and Statistics New Zealand Population Projections
	Xxx patients received their planned care procedures, (XX more/less than planned)	Access to planned care (volumes)	Increasing the number of planned care interventions (such as inpatient surgeries, minor procedures, & non-surgical alternatives) means more people benefit from improved health functioning and quality of life.	***Numerator:*** Number of planned care interventions delivered ***Denominator:*** Agreed number of planned care interventions in DHB plans ***Frequency:*** Quarterly ***Source:*** NNPAC (National non-admitted patient collection)
Primary health care *"The right care at the right time for everyone"*	Xxx more people reported having their need for care met	Unmet need in primary care (HQSC Primary Care survey)	Primary health care plays a key role in prevention, access to diagnostics, medicines, and is the gate to secondary level care. Reducing barriers to accessing first contact health services in the community is central to improving overall system outcomes.	***Numerator:*** Number of people answering no to the question: In the past 12 months was there a time when you wanted healthcare from a GP or nurse but you couldn't get it? ***Denominator:*** Number of people who answered the question: In the past 12 months was there a time when wanted healthcare from a GP or nurse but you couldn't get it? ***Frequency:*** Quarterly ***Source:*** HQSC primary care patient experience survey
	Xxx % of patients said they were treated with kindness and respect by their GPs	People report being treated with kindness and respect (Primary Care survey)	Treating patients with kindness and respect is a minimum acceptable offering for the health service, and closely associated with overall experience of care (we also know that experience of care is closely associated with patient outcomes). These two particular measures are routinely high, as they should be, so for this reason we propose reporting this as a percentage. Reduction in this percentage nationally (or variation locally) should be seen as an important early warning and cause for concern.	***Numerator:*** Number of people answering "yes, always" to both questions: Does your GP or nurse treat you with respect? Does your GP or nurse treat you with kindness and understanding? ***Denominator:*** Number of people who answered the questions ***Frequency:*** Quarterly ***Source:*** HQSC primary care patient experience survey

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