

Section C: Services / Ngā Ratonga

5 Services introduction / Ngā ratonga tīmatanga

Introduction

New Zealand's health and disability system delivers prevention, care and treatment through an extensive range of home, community, and hospital-based services. Services are the touchpoint that people have with the system, directly impacting New Zealanders' health and wellbeing throughout their lives. What services are delivered, when, why, how and by whom is significant for the health outcomes that are achieved.

Too often in the past however, the system's focus has been on funding and process, rather than on the needs of people and designing services that will serve them well. If better health and wellbeing and more equitable outcomes are to be achieved, particularly for Māori whānau, Pacific peoples, disabled people and rural populations, the way the system approaches service delivery must change.

Framework and definitions

The Interim Report framed services within four groups: population health, Tier 1, Tier 2 and disability. These groupings have been kept for this report, using the following definitions.

- ▶ **Population health services:** The terms 'public health' and 'population health' are often used interchangeably. In this report, 'population health' and 'population health services' are used with the understanding that they incorporate the broad definition and meaning of public health. Population health services include population health action, population health policy, surveillance, health promotion activities and preventative services such as screening programmes. As an approach to service design, population health shifts the focus to prevention, influencing the determinants of health, health equity, intersectoral action and partnerships, and understanding needs and solutions through community outreach.⁷²

- ▶ **Tier 1:** Encompasses a broad range of services and other activities that take place in homes and communities, in marae and in schools. They are the services that most people need, most of the time. Tier 1 includes, but is not limited to, self-care, mental health services, general practice, maternity services, Well Child / Tamariki Ora, outreach services, oral health services, community pharmacy services, medicines optimisation, health coaching, nursing (eg primary care, district, public health and community nursing), aged residential care, hauora Māori services, community paramedic services, school-based services, home-based care and support, rehabilitation, and palliative care. It also includes laboratory and radiology services and other allied health care that takes place outside of hospital, such as podiatry, physiotherapy and dietetics. Most kaupapa Māori services are located in Tier 1.
- ▶ **Tier 2:** The part of the health and disability system focused on delivering public and private hospital and specialist treatment, and specialist diagnostic services. Tier 2 includes services delivered for a local population or regional catchment, those provided for more than one region and, in some instances, all of New Zealand. Tier 2 boundaries are blurred, as specialist services are also delivered in the community or homes and Tier 1 services can be located in hospitals, particularly in rural communities.
- ▶ **Disability:** Disability services in this report are those that specifically support and enable disabled people to live well and participate fully in their community. These services are often delivered in Tier 1 settings. This definition does not include all of the services that are accessed by disabled people and their whānau, who are also consumers of other population health, Tier 1 and Tier 2 services.

Global trends: opportunities and challenges

The [People and Communities Chapter](#) describes New Zealand's changing population: age, ethnicity and geographic spread. In addition to demographic changes, the impact of climate change, technological and research advances, evolving consumer expectations, and social and cultural changes, provide both opportunities and pressure for New Zealand's population and wellbeing.

Many of these changes could have a positive impact, opening up new options for promoting wellness, better self-monitoring, greater access to health services and care coordination, medical breakthroughs, and smart transport and housing. Other changes, however, such as rising sea levels, extreme weather events, global migration, antimicrobial resistance, pandemics and demands on water supply and the natural environment, are creating new and additional challenges to health services.

The challenge for the Review was to look for improvements that can be made to the system as it is now, while also looking ahead to a very different future. While it is not possible to predict exactly what that will be like, there is a strong sense of the attributes of a system that is well placed to respond to change. How services are connected and delivered will have an important part to play.

Figure 5.1: Global trends



Source: Interim Report

Organising the system to work better together

The following service area chapters each focus on four common themes:

- ▶ connected and whānau-centred services
- ▶ more services planned locally
- ▶ the system recognises different populations and needs
- ▶ transparent and evidence based planning.

Connected and whānau-centred services

The Interim Report concluded that services need to be more connected, more varied, simple to access and easy to navigate, and provided in settings, locations and time of the day that values the consumers and whānau that they serve. Services, including Tier 2 services, need to reach out more to where people are at home, school or work, and use population health management to identify where there is unmet need. Services should be connected, working between and beyond traditional boundaries, as a single system to treat the person or whānau.

Key to this vision is shifting from the current, often fragmented, health and disability system to one that is more connected and whānau-centred, with a strong focus on populations and clear accountabilities for improving health outcomes and equity. Service delivery would continue to take place in primary, community and hospital settings, but increasingly, at homes, marae, schools and virtually, for example, using telehealth. Boundaries between different workforces would become blurred, with consumers and whānau interacting with a wider range of clinical and non-clinical workers. Figure 5.2.

In the proposed system, all New Zealanders and their whānau would be a part of a locality (see further detail in the Tier 1 chapter), with access to a connected and whānau-centred network of services, along with digital tools to provide the choice for greater control over their own care.

Services provided at home and in the community would be supported by a network of hospitals with specific roles, locally and nationally.

To connect services and people together would be:

- ▶ shared data systems
- ▶ a more mobile and multi-disciplinary workforce
- ▶ proactive outreach
- ▶ telemedicine
- ▶ agreed pathways and protocols
- ▶ and new funding arrangements.

See the [Enablers section](#) for specific discussion on these areas.

Figure 5.2: Services in the future system would be more connected and whānau-centred



¹ Includes: Aged Residential Care and Disability Residential Care.

More services planned locally

The challenge for the Review was to determine an organising structure that would enable a connected and whānau-centred system.

The System Settings Chapter outlines the significant structural, planning and funding level changes that the Review is proposing. The most significant change proposed for services is how these would be organised and commissioned and for a population health approach to be embedded.

Specifically, the Review is proposing to bring together accountability for population health outcomes and authority for local commissioning, into next generation district health boards (DHBs). This would include contracting directly for Tier 1 services currently purchased nationally or through nationwide arrangements, such as for general practice services, maternity services and Well Child / Tamariki Ora.

Next-generation DHBs would have the mandate to target resources to particular communities and populations where it is based on evidence and is equitable. This responsibility would be underpinned by a locality planning approach for primary, community and home-based services, discussed further in the Tier 1 chapter.

Within each locality, networks of services, managed by the responsible DHB and comprising non-governmental organisations, businesses and directly provided services, would work together to meet the health needs of the population. Services would be jointly accountable for agreed health and wellbeing outcomes.

Implications for institutions and workforces

Shifting to these arrangements would have significant implications for some providers and workforces delivering these services, and dedicated investment would be needed to support the change. Some might question why the Review have opted to give these powers to DHBs, when their record of performance in the past has not been ideal. The Review has heard many calls to abolish DHBs, to reduce their number, or at least rebrand them.

The Review does recommend that the system has fewer DHBs. But analysing the functions that DHBs were established to perform makes it clear that these functions would still be needed.

Irrespective of their recent performance, the institutional form of what are currently labelled DHBs is critical to a well-functioning health and disability system.

For this reason, the Review has focused on recommending changes to the way DHBs are governed and expected to perform, rather than creating whole new agencies, or simply rebranding them.

The system recognises different populations and needs

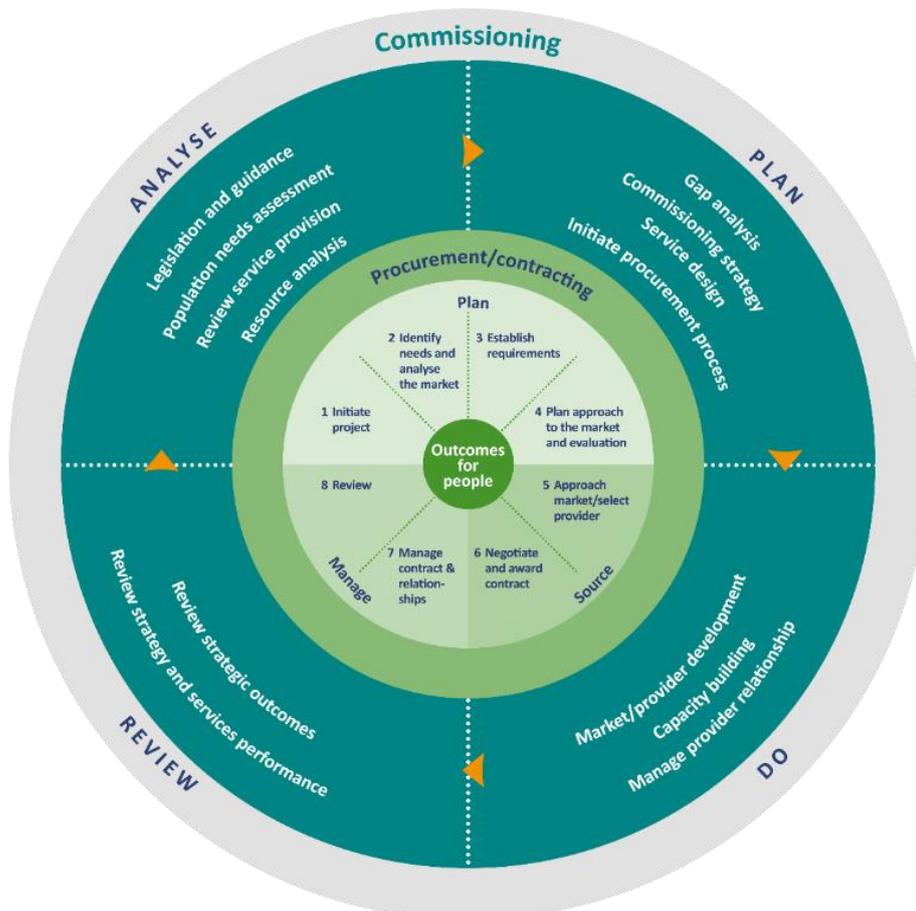
A population health approach recognises and responds to differences in population needs. While all New Zealanders should have access to a guaranteed set of services, the Review considers that more services should be defined locally according to the specific needs of the population, and delivered in ways that reflect what matters for individual communities. This means the system accepting differences in service design and delivery where this is evidence based and serves equity. It also means resources should be targeted deliberately to particular populations or services.

It is important that Tier 1 services would be contracted differently than in the past for populations with the highest needs, particularly for, but not only, Māori.

Commissioning

Commissioning is a strategic and ongoing process to translate population health objectives into effective, responsive services.⁷³ Commissioning involves purposefully planning, developing, sourcing and monitoring service delivery systems to achieve the best outcomes for the population.⁷⁴ Commissioning works hand-in-hand with the population health and locality-planning approaches touched on already and discussed throughout the following chapters.

Figure 5.3: The commissioning cycle, including procurement and contracting⁷⁵



Commissioning employs both purchasing and non-purchasing strategies to shape how the health and disability system and services respond to a population's needs and aspirations. It requires advanced skills in strategy, service design, business analysis and population analytics, as well as expertise in modern procurement and contract management practices such as strategic sourcing, supplier relationship management and innovative contracts.

Commissioning has been widely discussed within the health and broader social sector for more than a decade but has not been implemented in a consistent or structured way within the health system. In recent years, there has been greater attention to the nuances of social services procurement, but so far there appears to have been a relative underdevelopment of this specialist expertise in the health and disability system.

Developing commissioning practices and talent within the system is crucial if future aspirations are to be realised. It would require a clear policy framework for commissioning, providing consistency where this is warranted, guidance for local tailoring, and deliberate investment in the people, skills and technological capabilities to implement commissioning practices.

Health NZ should be responsible for developing the policy framework and capability strategy for commissioning, growing in-house capability in commissioning for particular populations or service areas, and working with the Māori Health Authority and other agencies, building on the following recommendations.

More commissioning should happen locally

If services are to be organised locally, the balance of commissioning powers should be weighted towards local decision-making. This would mean shifting more responsibility and capability to regional and DHB level, so that models of care could be commissioned according to the needs and priorities of specific populations.

Services commissioned locally should be those where a higher level of responsiveness is needed to local populations, where there is benefit to the system in investing in local service providers, and where local relationships are important for planning and delivering quality services.

Tier 1 maternal and child health services, mental health and addictions, medicines optimisation, and general practice have been identified as services currently funded through nationwide arrangements, but which the Review recommends be commissioned locally.

Health NZ and the Māori Health Authority should work closely together

Local commissioning would be supported by the guidance and expertise of Health NZ, for example, in commissioning for hauora Māori, mental health and addictions, rural populations and disability support services.

This would be particularly important for Māori communities and contracting for kaupapa Māori services. In the past it has too often been assumed that kaupapa Māori services should ‘comply’ with the same contracting and outcome frameworks as other services. The health and disability system needs to build the expertise to commission and contract to suit the community being served. This means Health NZ and the Māori Health Authority would develop models that work for Māori.

Some services would be commissioned nationally

The commissioning policy framework should also guide when to commission services nationally, either through a joint process by health system entities, or by Health NZ on behalf of the system.

In general, the Review considers that nationally commissioned services should be those where:

- ▶ consistency, uniformity of service access and delivery is desirable
- ▶ economies of scale mean better terms can be secured through a nationwide agreement
- ▶ nationalising a service may be appropriate
- ▶ joint purchasing with ACC could be indicated.

To that end, the provisions under the Commerce Act 1986 should not be a barrier to joint purchasing between DHBs (or Health NZ) and ACC where this is in the interests of equity and health outcomes. At present, legislation prohibits joint purchasing with the health and disability system in all but a very few circumstances, as set out in the Accident Compensation Act (2001) (eg, emergency services). The Review is aware that ACC is also developing its own commissioning capabilities and, although there are differences in the drivers and responsibilities of ACC and the public health system, there is value in pooling efforts to build talent and skillsets that can work across the health ecosystem.

Procurement and contracting

A diversity of service models, particularly in Tier 1, is important within the health and disability system to respond to different needs and enable innovation through collaborative efforts. There is a continued and growing role for NGOs, kaupapa Māori services, and different business models such as joint ventures. Procurement and contracting practices would therefore be an important element of commissioning.

NGOs are an integral part of the health and disability system

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‘The team at Mapu Maia have dual roles – they are health promotors and counsellors. Often these roles are not integrated, and this is mainly because of funding models and service specifications.

‘An integrated role allows counsellors to be in the community delivering health promotion messages and engaging and participating in community groups and projects. This interaction allows the building of rapport and trust with the community which in turn leads to the opening of doors for a conversation to happen (a clinical intervention). We know that clinical interventions don’t need to only happen in an office or a counselling room. Allowing counsellors to be immersed in communities, educating and raising awareness increases access to services and decreases stigma.’

- ▶ The NGO sector is an integral part of the health and disability system, and the wellbeing of many New Zealanders. Health and disability NGOs include a wide range of organisations that provide flexible, responsible and innovative service delivery, and a voice for consumers and whānau, including those who have been underserved by other parts of the system. NGOs deliver services across primary health care, mental health, personal health and disability support, and include kaupapa Māori services and Pacific providers. NGOs are often also providers of social services and can deliver support with a holistic view of an individual or whānau’s aspirations and needs.
- ▶ The Interim Report described feedback from the NGO sector that current practices in contracting and performance reporting are constraining service providers to be able to fully support the families for which they are contracted to provide services. Addressing these barriers through changes in funding arrangements, together with commissioning and improved contract management practices are key to ensuring the sustainability of the health and disability NGO sector, and delivering on the proposals in this report.

Procurement and contracting practices should enable health outcomes

Changes are needed in contracting if the health and disability system is to shift in the directions being proposed. The Review has heard that contracting practices and related funding arrangements can create undue transactional burden on service providers and difficulties in financial sustainability for NGOs and smaller providers, can favour larger incumbents, and constrain investment in new service approaches. Organisations that fund services sometimes do not have the capability to assess whether providers are culturally safe and able to meet the needs of Māori.⁷⁶ Academic research has also shown that Māori Health Providers have shorter contracts, higher compliance costs and are more frequently audited than non-Māori providers.⁷⁷

Services should be enabled to focus on outcomes and have the incentives and capital to invest in innovation. For example, longer term contracts⁷⁸ should be used wherever possible (eg, in line with the proposed five-yearly planning cycle) and seed funding should be available to enable measured risk taking in service design by, for example, Māori Health Providers and other NGOs whose access to capital is limited.

At the same time, commissioning teams need to have the tools to work with services, workforces and consumers more collaboratively and over longer periods of time to shape a service landscape that would best deliver equity and improved health outcomes.

Used responsibly and with skill, there is a place for a modern approach to relationship management, contractual innovation and sourcing services that should be encouraged rather than inhibited. Guidance exists for public sector procurement of social services that already allows for some of these practices. However, the experiences of service providers shared with the Review suggests this may not be well understood or applied in practice.

As part of developing a commissioning policy framework for the health and disability system, consideration should be given to public sector rules and guidance for social services procurement (or the interpretation thereof) to ensure these allow for pro-equity and population-focused commissioning practices.

Standard contract terms should support system goals

In return for public funds, contracts for services should require providers to behave in ways that embed a population-focused, connected and whānau-centred system. These would include:

- ▶ providing data to their DHB and/or Health NZ for the purpose of outcomes and measuring performance
- ▶ agreeing to accept location and hours defined through locality plans
- ▶ meeting the system's expectations for employment remuneration and conditions.

Within Tier 1 services, this would also include accepting joint responsibility with other providers in the service network for certain health and wellbeing population outcomes.

The priority for these requirements would be services that are entirely publicly funded in the first instance. However, over time all public funding would become contingent on accepting these conditions. Health NZ would have a key role in managing this transition. The Māori Health Authority would have a key monitoring function to ensure that kaupapa Māori services and Māori Health Providers are not systemically disadvantaged by contracting arrangements.

Growing commissioning and procurement capability

Commissioning requires bringing together advanced skills across a range of disciplines and the Review has seen no evidence to suggest that this is widespread in the health and disability system. Advanced practitioners in contemporary procurement and contracting skillsets such as strategic sourcing, category management, and supplier relationship management, would also be important for the system to have the capabilities to provide collaborative and outcomes-focused services.

A deliberate strategy and commitment to investment would be required by the health and disability system to acquire this expertise in the short term, ensure it is accessible equitably (eg, located regionally in the first instance), while also investing in growing these skills across the system.

Transparent and evidence-based planning

The world is rapidly changing. Not only are new technologies and medicines being released at an unprecedented pace, but how people interact with government, services and their expectations of these has evolved considerably since the current system and its institutions were established. Investment decisions need to be made with sometimes only partial information available or little precedent, responding to new science, natural disasters, pandemics, disruptive innovation, or the promise of life changing therapies.

Almost all decisions made in the health sector are, to some extent, prioritisation decisions. We live in an environment of limited resources; not only money, but also time, space, and available staff all constrain the ability of both the system to provide and people to access, health care services and health promotion programmes. Consequently, these resources need to be allocated in some fashion, and unless we allocate them completely randomly – and arguably even then – we are engaging in prioritisation.⁷⁹

Invariably, choices need to be made about what and where new investment and disinvestment should occur, whether it be spending, effort or talent. Types of investment decisions include:

- ▶ medicines (eg cancer drugs)
- ▶ individual new clinical procedures, including clinical devices (eg clot retrieval, left ventricular assist device)
- ▶ clinical guidelines (eg lung cancer treatment)
- ▶ systems of medical and surgical service delivery (eg new models for early discharge)
- ▶ expansion of scope (eg adding adult dental to funded services)
- ▶ individual patient access (eg elective procedure thresholds)
- ▶ capital (eg facilities and technology – see the Enablers section).

The challenge for the health and disability system is to make these decisions in a way that is evidence-based and transparent so that the right balance is struck between the variety and level of services that are clinically and financially sustainable, while reflecting the system's wider values and what is important to New Zealanders.

Making investment choices in the future system

‘The system will need to become more transparent and evidence-based, leveraging international thinking where appropriate, to improve decision-making regarding what and where new investment and disinvestment should occur.’ [Interim report](#)

Currently, the health and disability system operates without an overall or common prioritisation framework or forum for national decision-making.⁸⁰ Decisions about new investments and services are made every day at multiple levels, from nationwide Budget initiatives, to individual services and therapies. However, without an overarching set of principles or framework, these are made without a shared ‘true north’ that can be readily understood by consumers.

While a return to the Core Services Committee / National Health Committee models of the 1990s and 2000s is not recommended, the Review does consider that greater transparency in the framework for planning and investment decisions is needed so that New Zealanders can understand the rationale for where and how services are being delivered.

A clear framework to provide consistency and transparency

As discussed in the Systems Settings section, the proposed system should have a nationwide planning framework with clear decision-rights so that investment (and disinvestment) decisions are strategic, evidence based, and made with present and future demands in mind. The NZ Health Plan would provide this framework and the system priorities, the ‘true north’ that District Strategic Plans, regional plans, and locality plans would need to be consistent with. See the Tier 1 and Tier 2 chapters, and Enablers section for further details about specific planning requirements.

A requirement of the new system would be to give communities, iwi partners and consumers relevant information about priorities, plans and outcomes achieved, and meaningful opportunities to influence them. This requirement would be for planning at each level from the NZ Health Plan down to locality plans and be a key mechanism to improve transparency of the system for all New Zealanders.

Health Technology Assessment

Health Technology Assessment (HTA) is a specific expertise to assist planning and investment decisions about technologies and interventions. In New Zealand, the capacity and capability for HTA is dispersed in different public, private and academic organisations, rather than concentrated within a single organisation or network as it is in some other countries - notably the United Kingdom’s National Institute of Clinical Excellence (NICE).

While greater capability and capacity for HTA should be developed by Health NZ in the future system, a separate agency is not recommended. The mechanisms for HTA, and for developing guidelines and approaches to assist with decision-making about services and interventions, used by leading institutions internationally are well known and established. Appropriate use of international assessments and guidelines should become the norm in New Zealand, as a complement to domestic capacity and locally specific assessments.

6 Population health / Te hauora taupori

Improving population health must become the driver of all planning within the system. Without successful population health strategies, individual treatment services will not be able to achieve equity or significant improvements in the overall health and wellbeing of New Zealanders.

A proactive approach to promoting and protecting health is required, with an explicit focus on equity - understanding which groups are most impacted, recognising the commercial and socio-economic determinants of health that underpin inequities and designing and implementing comprehensive strategies to eliminate or ameliorate them.

Core health protection competence and capacity within the system needs to be strengthened to ensure the system has sufficient resilience to cope with the increasing frequency of incidents that threaten population health.

This would require a determined and ambitious shift towards prevention and promotion of health and wellbeing with strengthened national capacity and capability.

A population health approach drives all parts of the system

The terms 'public health' and 'population health' are often used interchangeably. In this report, the term 'population health' is used with the understanding that it incorporates the broad definition and meaning of 'public health'.

Population health takes a proactive approach to promoting and protecting health, keeping individuals and populations as healthy as possible and reducing threats to health.

It recognises that the health of populations is shaped by the social, economic, cultural and environmental contexts in which people live, learn, play and work, and that responses are required across the health and disability system, and other sectors, to promote health and wellbeing and create environments that support health and wellbeing.

Core population health functions that are considered necessary for a high-functioning health system include:

- ▶ **health assessment and surveillance:** gathering evidence about health status, determinants of health, how illness is distributed across the population and how to improve it
- ▶ **health promotion:** working with a range of sectors (including health) and communities to create physical, social and cultural environments that support health and wellbeing
- ▶ **preventive interventions:** population programmes delivered to individuals such as immunisation, well-child checks, cancer screening, and help to quit smoking
- ▶ **health protection:** organising to protect communities against population health threats and hazards
- ▶ **population health capacity development:** enhancing the system's capacity and ability to improve population health.⁸¹

These functions are interconnected and, when combined, can deliver comprehensive programmes to address particular risk factors or health conditions.

Population health approaches draw on a broad range of disciplines and skills. These include epidemiology, nutrition, health promotion, infectious disease control, microbiology, vaccinology, risk assessment, oral health, environmental health, toxicology, public health engineering, public health informatics, economics, health law, policy and emergency management.

As with the core population health functions, these skills are most effective when they are well coordinated and are part of a comprehensive evidence-informed approach.

The case for investing in population health

The Interim Report set out a compelling case for investing in prevention and applying population health approaches, particularly for health conditions and associated risk factors that contribute to significant health loss and inequity of outcomes in New Zealand.

Like many health systems around the world, New Zealand's health system is facing new threats and growing challenges. There will almost certainly be new global and domestic threats to health, such as those arising from climate change, terrorism, geopolitical instability, pandemics and antimicrobial resistance.

The current COVID-19 pandemic has demonstrated our vulnerability to international risks and shown once again that we face an uncertain future.

Demographic changes and the increasing proportion of our population living with chronic conditions will place increasing demands on our health system. Non-communicable diseases are the leading cause of health loss and health inequity in New Zealand, yet many risk factors associated with them (such as obesity, poor diet, harmful alcohol consumption, physical inactivity and tobacco use) are largely preventable. The burden of these challenges often falls most heavily on those who face disadvantage and experience discrimination.

Current configuration of population health services

The Interim Report described in some detail the broad range of entities currently involved in delivering core population health functions, both within and outside the health system. An overview of the current configuration of services is set out in Table 6.1 below.

Table 6.1: Current configuration of core population health functions and entities

Ministry of Health	<ul style="list-style-type: none"> ▶ Ensuring compliance with public health legislation and international obligations. ▶ Collaboration internationally and with central government agencies and other sectors to influence health. ▶ Policy advice, strategy setting, guidelines and standards development. ▶ Leading, planning and responding to emerging risks. ▶ Leadership and commissioning for national programmes such as screening and immunisation. ▶ Commissioning national, regional and local population health services.
DHBs	<ul style="list-style-type: none"> ▶ 12 public health units, operating within DHBs but contracted directly by the Ministry, deliver core health protection and some health promotion and population health planning services. PHUs vary in size, scope, number of DHBs they cover and size of population served. Designated officers, such as medical officers of health and health protection officers, carry out regulatory roles on behalf of the Director-General of Health. ▶ Commission additional initiatives and services to prevent illness and promote health for their population.
Crown entities	<ul style="list-style-type: none"> ▶ The Health Promotion Agency (HPA) has a national role to lead and support activities that promote health and wellbeing, encourage healthy lifestyles, prevent disease, illness and injury, enable environments that support health and wellbeing, and reduce personal, social and economic harm. It also has specified policy advice and research roles in relation to alcohol. HPA is funded from Vote Health and a levy on alcohol. ▶ The Institute of Environmental Science and Research (ESR) provides surveillance, applied epidemiology and reference laboratory services under contract to the Ministry of Health.
Population health service providers	<ul style="list-style-type: none"> ▶ A broad range of population health services are delivered by a range of providers, including non-governmental organisations, schools and universities.
Primary Health Organisations	<ul style="list-style-type: none"> ▶ Primary Health Organisations are funded through the flexible funding pool to deliver some health promotion services to their populations.
Primary health care practitioners	<ul style="list-style-type: none"> ▶ As a component of their role, primary health care practitioners deliver some preventive population health services, such as Well Child / Tamariki Ora checks, immunisation and screening.

Significant population health functions are also delivered and funded by agencies and entities outside the health sector.

- ▶ **Local government:** Under the Health Act 1956 local government has a duty to ‘improve, promote and protect public health within its district’. The Local Government (Community and Wellbeing) Amendment 2019 reinstated local government’s role to promote the social, economic, environmental, and cultural welling of their communities. Key health-related activities include emergency planning and response, waste management, drinking-water, housing, recreation, libraries, transport, environmental health, food safety, alcohol and gambling policies, resilience and community capacity building.
- ▶ **Other government agencies:** Several central government agencies and Crown entities hold core population health functions such as the Ministry of Primary Industries (food safety and biosecurity), ACC (injury prevention), WorkSafe (workplace health and safety), Ministry of Justice (alcohol policy, crime prevention), Environmental Protection Authority (environmental safety), Ministry of Housing and Urban Development (quality and availability of housing stock, social housing), Kāinga Ora – Home and Communities (housing), National Emergency Management Agency (emergency management), and the Ministry of Transport and New Zealand Transport Agency (safe roads, active transport).
- ▶ **Community organisations and businesses:** These have an important influence on the health of communities and populations. This may include faith-based organisations, schools, marae, cultural groups, arts, sporting and recreational clubs. Some, such as the fitness, food, and alcohol sectors, can either have helpful or harmful influences on health.

Embedding the change

In spite of the compelling case for a population health approach, the current investment in population health remains low. In 2018/19, the Public Health Services Appropriation within Vote Health was \$433 million. In addition to this, DHBs funded a range of population health services.

A recent analysis by a regional collaboration of DHBs estimated that the combined spend by the Ministry of Health and DHBs for population health services in their region was approximately 2% of total DHB expenditure. While there are some caveats on this estimate, it was clear that population health expenditure was a small proportion of overall spend, and that this result is probably replicated around the country.

The Review heard of multiple barriers to the shift to a more population health-focused system. These included:

- ▶ focus on measuring the success of short-term impacts or throughput (such as elective surgery targets) rather long-term population health gains
- ▶ lack of an independent voice, and filtering of information and advice by decision-makers
- ▶ pressure of public demand to access acute services
- ▶ siloed funding arrangements
- ▶ lack of long-term planning and forecasting
- ▶ lack of critical expertise in some areas
- ▶ complexities of working in partnership with different sectors.

New Zealand, like other jurisdictions, has struggled to shift the focus from illness and treatment, to improving health outcomes by prevention of disease and promotion of healthy behaviours. The Review believes that the system should focus much more on the population, not just the individual who presents for treatment.

Population health informs planning

Population-level information drawn from the systematic collection, analysis and interpretation of health data (and related factors such as risk factors and hazards) must inform the entire system: policy, planning, prioritisation, implementation and evaluation.

The expectation for the future is that:

- ▶ the system would be well informed by population health data and have the capability to interpret this information, respond decisively to emerging trends and health threats, recognise where there have been successes, and understand where to direct further action
- ▶ population data would be readily available for DHB and community health outcomes and needs assessment processes which, in turn, would drive DHB district and regional strategic plans. DHBs would be accountable for reporting progress against these plans and implementing actions to ensure that there is a greater focus on prevention and population health outcomes.

This would be supported by:

- ▶ reinstating long-term health outcomes and services planning
- ▶ regional and local plans that are shaped through engagement with communities, clinical experts and agencies from other sectors.

Funding and contracting arrangements

DHBs have a statutory role under the New Zealand Health and Disability Act 2000 to provide services to improve and protect the health of individuals and communities. However, the Ministry of Health has retained responsibility for planning and funding the vast majority of population health services at national, regional and local levels.

Some have argued that the decision not to devolve funding to DHBs was important to prevent funds from being redirected to personal health ‘treatment’ services, particularly where DHBs may face pressures to meet short-term targets or address deficits. In practice it has:

- ▶ slowed population health approaches being fully integrated into DHB planning and service delivery
- ▶ added significant administrative costs and contributed to unwarranted variation in service delivery
- ▶ limited investment in population health as the only increase to the Public Health Services Appropriation since 2010 has been for specific new services or initiatives.

If population health is to drive the planning and delivery of local services, then funding should be part of DHB revenue. Thus, the Review recommends that funding for district level population health services is devolved to DHBs. It would be the role of Health NZ to monitor DHBs to ensure they invest strongly in population health approaches and services. Health NZ would also have an explicit role to support DHBs to make the shift towards a greater focus on prevention and population health.

It would work closely with the Māori Health Authority, drawing on its population health expertise in the design, monitoring and evaluation of the impacts that population health approaches are having for Māori.

A focus on equity and the determinants of health

Inherent in a population health approach is an explicit focus on equity. Working to eliminate systematic inequities in health outcomes requires:

- ▶ looking at which groups are most impacted
- ▶ understanding how and where inequities are evident
- ▶ recognising the upstream factors (the social, economic and commercial determinants that underpin health inequity)
- ▶ implementing comprehensive strategies to eliminate or ameliorate upstream factors
- ▶ an intelligent, equity driven and data informed health and disability system.

A strong body of evidence shows that tackling the determinants of health and wellbeing improves equity across a variety of societal outcomes.⁸² Factors such as cultural identity and language are protective for health and wellbeing. However, there are also negative impacts of racism and colonisation that need to be addressed.

Figure 6.1: Factors that influence our health and wellbeing



Source: Institute for Clinical Systems Improvement 2014.

Around 80% of a person's health status is determined by factors outside health care services.

These are the conditions in which a person is born, grows, lives, learns, plays, works and ages. These factors are even more important in relation to health equity, where evidence suggests the impacts arising from outside the health sector may be even higher.⁸³ With the right conditions, people can lead long, healthy and productive lives⁸⁴ and potentially reduce demands on the public health system.

The determinants of health are complex, interactive and cumulative. Seeking opportunities for illness prevention and health promotion requires an understanding of how the determinants of health operate and a recognition that many factors impact health outcomes.

Working in partnership

As part of the mandate to prevent illness and promote health, the health and disability system has a responsibility to work collaboratively and form partnerships to ensure health concerns are firmly considered alongside economic, social and environmental considerations in key policy and planning decisions.

Healthy Auckland Together

Healthy Auckland Together (HAT) is a coalition of partners working together to improve the social and physical environment so that people living in Auckland can eat well, live physically active lives and maintain a healthy body weight. Led by the Auckland Regional Public Health Service, HAT is made up of 26 organisations representing the health, local government and transport sectors, as well as iwi, academia, NGOs and consumer interest groups.

By combining their resources, knowledge, skills and networks HAT works strategically across all key environments – transport, urban planning, food, education and business.

HAT uses its collective voice to advocate and speak out to influence policy and decisions related to food and physical activity related environments at national, regional and local levels. It raises the profile of key issues with decision-makers and the community. HAT also produces annual monitoring reports to track progress and give the public, policy makers and its stakeholders clear information on Auckland's environment and health outcomes.⁸⁵

Effective action to address the drivers of ill health and to enhance opportunities to promote wellbeing requires multiple interventions at national, regional and local levels. Health promotion offers pathways and tools to connect national policies to local implementation. While there are some excellent examples of successful cross-sectoral approaches throughout New Zealand, there is a need to scale up and expand these if there is to be sustained improvements in population health.

Stronger population health leadership is needed at all levels. Currently, the Ministry has the lead role in working alongside other government agencies to influence policy, funding and prioritisation decisions that impact health and wellbeing. Some issues may be time limited, while others require sustained partnerships and commitment. It may also involve supporting other sectors to understand how their policies or activities impact health outcomes and inequities.

Health in all policies

Health in All Policies (HiAP) is an approach that has been widely promoted by the World Health Organization to ensure that health and wellbeing outcomes are systematically considered in all policy and planning decisions.^{86 87} International experience has found that without an explicit process, such as health impact assessments (HIA), the availability of technical information on the expected health and wellbeing impacts is unlikely to be sufficient to influence decision-making to any significant degree.

Many countries have embraced HiAP. In New Zealand, HIAs have been carried out on, for example, air quality, electricity supply, urban design and transport planning projects. Some DHB public health units have been particularly active in promoting a HiAP approach, such as Canterbury and Hawke's Bay, with positive results.

Scaling up health promotion efforts on non-communicable diseases

In 2017, non-communicable diseases were the leading category of health loss, making up over 82% of total disability-adjusted life years (DALYs) in New Zealand. More than a third (38.6 %) of health loss is potentially avoidable by reducing modifiable risk factors. Although tobacco use has been declining for many years, it is still the leading risk factor, contributing to around a 10th (9.7 %) of New Zealanders' health loss.⁸⁸

Non-communicable diseases (NCDs) such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are the major cause of death, illness and disability, globally and here in New Zealand. Much of this health loss and health inequity is related to common risk factors, such as tobacco use, unhealthy diet, physical inactivity, obesity and harmful use of alcohol.

Looking at current trends, for example increasing rates of obesity, there is an urgent need to accelerate efforts to address these risk factors, and promote interventions to prevent and control them.

Comprehensive and sustained action is required across multiple levels and multiple sectors, including health, transport, local government, housing, education and the natural environment, as well as commercial sectors such as the food and beverage industries. Alongside policy and regulatory levers there is a need to engage and empower local communities to support and promote change.

The system would need to take a greater leadership role in driving these efforts, from setting national policy and strategy through to supporting local community action. This would require population health approaches to be embedded at every level of the system, both inside the system and working in partnership with those outside of it.

This approach would have an explicit focus on addressing the determinants of health – creating more supportive physical and social environments that promote health and wellbeing and make the healthy choice the easy choice. For example, promoting water-only policies in schools, creating safe cycle ways to promote active transport, and community gardens and markets to increase access to healthy food.

Health promotion involves a broad set of actions to foster good health and wellbeing. It is much more than just providing information to people to encourage them to adopt healthy lifestyles.

The 1986 Ottawa Charter for Health Promotion is a global health promotion framework. The five health promotion strategies set out in the Ottawa Charter that are essential to success are:

- ▶ build healthy policy
- ▶ create supportive environments
- ▶ strengthen community action
- ▶ develop personal skills
- ▶ reorient health services.⁸⁹

New Zealand's approach to health promotion builds on the Ottawa Charter with a strong focus on equity, community development, the incorporation of Māori aspirations and world views te Tiriti o Waitangi.⁹⁰ Te Pae Mahutonga⁹¹ and Kia Uruuru Mai a Hauora⁹² are two frameworks for conceptualising Māori health promotion that use Māori world views, beliefs, values, preferences and needs as a starting point and that acknowledge identity and cultural integrity as fundamental components to good health as Māori.

If applied comprehensively and in a sustained way health promotion strategies can change lives, have an impact on the broader determinants of health and make important contributions to the wellbeing of individuals and society.⁹³ However, sometimes the push for simple solutions can undermine the broad vision of health promotion and focus on changing the behaviours of individuals at risk of disease and illness, rather than looking to address the upstream factors that underpin risk behaviours across communities or populations. Interventions with a downstream focus are more likely to increase inequity.⁹⁴

Some have suggested that the Health Promotion Agency (HPA), whilst having a broad brief, has not fully utilised the range of health promotion activities, but instead, has a predominant focus on social marketing. The Review believes that all aspects of health promotion must be strongly led and driven by the agencies that are at the centre of the health system.

Addressing commercial determinants of health

Alcohol, tobacco, and unhealthy foods contribute to more than a third of poor health and premature death and disability, but continue to be marketed and made widely available by those with commercial interests, to the detriment of New Zealanders' health.

Faced with growing challenges from NCDs, the Review is clear that there is a need for much more concerted action at national, regional and local levels to address the commercial determinants of health.

The commercial determinants of health have been defined as the “strategies and approaches used by the private sector to promote products and choices that are detrimental to health”⁹⁵

Approaches to health promotion need to be developed in the context of the comprehensive approach set out in the Ottawa Charter, with strategies for coordinated action across all levels: policy, environments, community, individuals and the health sector. This would require:

- ▶ a clear direction to be set by the Ministry, which must utilise all its available levers to influence policy change across numerous sectors
- ▶ Health NZ to provide leadership and coordination of evidence-based health promotion activities across DHBs
- ▶ The Māori Health Authority to be the source of Māori population health intelligence for the health and disability system
- ▶ DHBs to drive evidence-based, context appropriate local approaches at district levels that complement regional and national actions
- ▶ active collaboration with research institutions
- ▶ engagement with communities and the private sector.

Alcohol is one of the main risk factors for poor health globally and in New Zealand. Yet despite compelling evidence of its serious social and health effects, population health measures to reduce harmful use of alcohol are often judged to be in conflict with other goals like free markets and consumer choice.

New Zealand's history of tobacco control is a useful illustration of what a comprehensive multi-level health promotion approach can look like. While there is still much more to be done to achieve the 2025 Smokefree vision, experience has shown how a broad policy, regulatory, pricing and community action approach can have significant impacts.

It has also shown us that one approach does not work for all populations - there is still much to be done to improve the health outcomes for Māori that are attributable to smoking. In the future, it is envisaged that the Māori Health Authority would play a key role in prioritising, designing, piloting and evaluating screening approaches for Māori and would partner with Health NZ to ensure services were commissioned in a way that delivers improved outcomes for Māori.

Population health within Tier 1 networks

The Review recognises that health promotion and the prevention of illness needs to become a fundamental part of how Tier 1 and locality networks operate. Population level data should be comprehensive, equity driven and outcomes focused to understand community needs and to monitor progress. This includes an explicit focus on improving equity and working with people who are most adversely impacted, with the understanding that doing so would improve overall population health. It would also require genuine community partnerships, working alongside local communities to understand their unique needs and to find appropriate context relevant solutions.

Health NZ would have a major role in leading and supporting this shift in the health and disability system. There would need to be determined effort to build a workforce with the skills to support this and mechanisms in place to share evidence of what works and good practice exemplars.

Screening programmes make an important contribution to improving population health

There are currently five national population-based screening programmes in New Zealand and one quality improvement programme.

Three cancer screening programmes:

- ▶ BreastScreen Aotearoa
- ▶ National Cervical Screening Programme
- ▶ National Bowel Screening Programme.

Two newborn screening programmes:

- ▶ National Metabolic Screening Programme
- ▶ Universal Newborn Hearing Screening and Early Intervention Programme.

Screening for Down syndrome and Other Conditions (DSOC) is provided as a quality improvement programme.

The National Screening Unit, within the Ministry of Health, is responsible for the development, quality, monitoring and oversight of all the screening programmes in New Zealand. Specialist providers are contracted by the National Screening Unit to screen for specific conditions within clearly defined population groups. Providers include DHBs, private radiology providers, public and private laboratories, and community-based providers.

Looking to the future there is a need for screening services to be better integrated into the services that are provided via Tier 1 locality networks.

Technological advances will present options for new and existing population screening programmes. Genomic testing, for example, may provide greater insight into identifying high-risk groups for screening in the future. New understanding of the aetiology of some health problems could require existing screening programmes to be modified.

The National Cervical Screening Programme illustrates these developments. Over time it is estimated that 90% of cervical cancers could be prevented by human papilloma virus (HPV) immunisation alone. Additionally, with the introduction of primary HPV testing (to replace cytology tests), including self-sampling, there is potential to eliminate cervical cancer altogether.⁹⁶ New Zealand has lagged behind other countries in introducing primary HPV testing, partly due to the inadequacies of the National Screening Unit's current IT system.

There remains, however, significant and unacceptable inequity within the coverage of the current screening programmes, particularly for Māori, Pacific and Asian populations and those living in high deprivation neighbourhoods. There is also significant variation in coverage across DHBs for some programmes. The cost of cervical screening is an obvious barrier. Cost is an anomaly in the current suite of cancer screening programmes, which are otherwise free. Other barriers are access, feasibility and acceptability.

Deliberately ensuring equity is at the forefront of all screening programmes is essential if the health and disability system is to improve overall population health outcomes.

He Tapu Te Whare Tangata (the sacred house of humankind): Removing barriers to cervical screening for Māori women⁹⁷

Māori women are more than twice as likely as NZ European women to be diagnosed with, and three times more likely to die from, cervical cancer. This disease is the second leading cause of cancer death for Māori women aged 25–44 years.

- ▶ Thirty-four percent of Māori women do not attend regular screening compared to 21% of New Zealand European women. The cost of attending a clinic and perceived invasiveness of a pelvic examination are barriers to screening. These barriers can be compounded for Māori women by services that lack cultural safety.
- ▶ A kaupapa Māori research project led by a team at Te Tātai Hauora o Hine, the Centre for Women’s Health Research at Victoria University of Wellington, has shown that with culturally competent HPV self-testing many Māori women who have previously never been, or have been under-screened would be willing to use the self-administered HPV test.

Protecting the population

- ▶ A continued focus on the basics, such as clean water, immunisation, and the provision of robust emergency preparedness capacity able to react immediately at the local level, will become more, not less, important as issues such as climate change and antimicrobial resistance, have an increasing impact. | [Interim Report](#)

Increasing pressure on health protection services

Health protection is one of the core population health functions. It involves ensuring the safety of food, water, air and the general environment, preventing the transmission of communicable diseases, and managing outbreaks and other incidents which threaten population health. Population health specialists lead the delivery of these functions and fulfil statutory obligations under a number of Acts. Many of these roles are undertaken by designated officers, such as medical officers of health, health protection officers, drinking water assessors, and hazardous substance and new organism (HSNO) enforcement officers.

New Zealand will almost certainly be increasingly impacted by new global and domestic threats to health, which will place immense pressure on the health system. The COVID-19 pandemic is testing health system emergency preparedness across the globe, including our own. It has highlighted the importance of having a critical mass of population health expertise at the centre of the response with strong networks to draw on at regional and district levels and investing in preparedness planning and simulation exercises.

This is not an isolated event. Other recent events that have put the health and disability system under pressure and demonstrated vulnerabilities in the system’s capacity to respond include:

- ▶ the 2016 Havelock North campylobacteriosis outbreak, which resulted in approximately 5,500 people becoming seriously ill, several deaths and was estimated to cost the country \$21 million⁹⁸
- ▶ the 2019/20 measles outbreak affecting more than 2,000 New Zealanders and resulting in serious outbreaks across the Pacific, particularly in Samoa.

Emergency preparedness assessment

As a member of the international community, New Zealand has a shared responsibility to prevent, detect and respond to disease outbreaks and other health security threats. These obligations are explicitly set out in the International Health Regulations and include developing and maintaining the capacities to detect, investigate, manage and report all potentially serious population health events and emergencies. These capacities must be in place locally/regionally, nationally and at borders, such as ports and international airports.

Assessing New Zealand's health security capability

Two recent assessments of New Zealand's health security capacities identified gaps and highlighted some vulnerabilities.^{99 100}

- ▶ The WHO Joint External Evaluation (JEE) identified that New Zealand needed to further work to address antimicrobial resistance, enhancing surveillance and risk assessment, addressing critical workforce resource needs, and building risk communication capacity. The JEE also noted the importance of maintaining strong preparedness systems to deal with prolonged, multiple concurrent and cascading hazards. This is particularly important for long duration events such as a pandemic, when it is likely that other events will occur, such as an earthquake, infectious disease outbreak or extreme weather event, which would place immense demands on our population health infrastructure.¹⁰¹
- ▶ The Global Health Security Index, which assessed the readiness of 195 countries (including New Zealand) to prevent and respond to a significant infectious disease outbreak concluded that collectively, international preparedness is weak and no country is fully prepared for epidemics or pandemics.¹⁰²

These assessments highlighted the importance of building and maintaining a critical mass of population health expertise. Specifically, core population health expertise (such as epidemiology, public health medicine and emergency response), to lead, inform and sustain responses to health threats and incidents, particularly at a national level.

Building resilience in the system is essential to ensure that the significant human resources required to manage a crisis response for an extended period of time does not adversely impact other important work.

Regional and local capacity and capability should also be strengthened with mechanisms in place to ensure that the system works effectively to quickly deploy additional resources where needed.

Reducing fragmentation

Concerns have also been raised that some population health functions, particularly health protection functions, have become increasingly fragmented across multiple agencies resulting in confused roles, weakened accountabilities and a depletion of critical mass and population health expertise at the centre.

Leadership for food safety, for example, now sits with the Ministry of Primary Industries, and over the next year, responsibility for managing drinking-water safety and regulation is proposed to move from the Ministry and DHBs to the new standalone water services regulator – Taumata Arowai.¹⁰³

The Review is not suggesting that these decisions are revisited, but does caution against further fragmentation of core population health functions. Where population health functions are delivered outside the health and disability system, there should be mechanisms in place to ensure decisions that impact on human health are informed by population health evidence and expertise.

Robust surveillance systems to inform action

A strong infrastructure for health protection requires comprehensive population health surveillance systems in place for both communicable and non-communicable diseases. This involves the ongoing systematic collection, analysis, interpretation and dissemination of data to assess health trends, threats, risk factors and influences.

Currently, New Zealand's public health surveillance services are distributed across several providers under contract to the Ministry of Health, including the Institute for Environmental Science and Research Ltd (ESR), Massey University and the University of Otago and private laboratories. There are also numerous other information and surveillance systems that inform the health system.¹⁰⁴

Now and into the future it would be increasingly important to ensure our surveillance systems are sufficiently robust and well-integrated and that there is capability in the system to interpret and respond to this information in a timely way.

Strengthening the system

Population health is an integral part of the system

For population health to drive the system, all key population health functions need to be embedded in the system. There are very real concerns about building critical mass to ensure New Zealand is well positioned to both protect the population and deliver improved and equitable health outcomes.

The Review has considered these issues closely and is convinced that achieving the transformational shift needed to address the population health challenges of the future cannot be achieved by carving population health off to the side.

Rather, a population health approach needs to be fully integrated into the system. This requires strengthened national capacity and capability – Ministry, Office of the Director of Public Health, Health NZ, Māori Health Authority - and competent population health leadership at regional and local decision-making levels.

The need for all aspects of health promotion to be strongly led and driven by the agencies that are at the centre of the system's architecture has led the Review to the conclusion that the functions undertaken by the Health Promotion Agency should be established within the Ministry, Health NZ and the Māori Health Authority. This would consolidate population health capability at the centre and provide more coherence to the system. It would enable stronger leadership of the health promotion activities and increase responsiveness to emerging population health, issues. The independence,¹⁰⁵ currently afforded to the Health Promotion Agency, in relation to the provision of advice on the sale, supply, consumption, misuse and harm of alcohol, would need to be protected in future system arrangements.

Independent, authoritative advice

Sustaining a shift to a population approach would require determination and ambition and the public to better understand the significant issues. The Review has therefore considered the need to build additional elements into the system architecture to provide:

- ▶ Public facing, independent, authoritative thought leadership on population health that is unconstrained by commercial interests, employment provisions or political constraints
- ▶ Scrutiny on government policy and action to hold the system to account to maintain a focus on population health

Within the system there needs to be the ability to provide independent advice to the Minister of Health. The statutory role of Director of Public Health should have the authority and independence to do this when necessary, without prior discussion with the Director-General of Health as is currently required. Similarly, the Medical Officers of Health in DHBs should have the authority to provide advice directly to their Board and to the Director of Public Health on any matter relating to population health that is considered urgent or significant.

In addition, the requirement to have a Public Health Advisory Committee should be reinstated to provide both independent advice to the Minister and a public voice on important population health issues.

The existence of the Public Health Advisory Committee should not however reduce the need for a strong network of population health expertise. Such a network should include the Public Health Clinical Network, academics and non-government organisations that provide important public facing thought leadership, expert advice and advocacy roles, which are fundamental for a healthy democracy and a smart system. Using their independence and credibility would help ensure debate on key population health issues is informed by evidence and can build public support that in turn can influence decision makers for durable effective action. It is also important that, in our rapidly changing information and social media environment, credible, authoritative information can breakthrough misinformation and myth.

Roles and responsibilities, resourced to deliver population health functions

To achieve a strengthened health and disability system where population health is embedded throughout the system, a coherent map of roles, functions and accountabilities is needed.

Further work would be required to set out expectations for roles as part of the transition process, but a starting proposal is set out below regarding core national, regional and local population health functions. This builds on the work done by the Public Health Clinical Network¹⁰⁶ over the past few years and which is the subject of ongoing work being led by the Ministry.

National functions

Proposed national functions are set out in Table 6.2 below.

Table 6.2: Proposed national functions

Level	Function or service
National	These are functions that, for reasons of authority, leadership, statutory obligation, consistency, effectiveness or efficiency, should be delivered once and not duplicated.
Ministry	<p>The Ministry would have a strengthened role in setting the overall strategy and direction for the publicly funded health and disability system. It would maintain its key role working closely with other government agencies to ensure issues around population health receive sufficient attention and have influence on policies and actions.</p> <p>There should be strengthened capacity and mechanisms to enable the Director of Public Health to have a more effective line of sight with local and other statutory office holders. For example, ensuring there is a clear avenue for local statutory officers such as medical officers of health to report directly to the Director of Public Health without permission from their DHB board.</p> <p>The Ministry would also need to reach critical mass and have effective systems in place to draw on to lead effective emergency responses and population health thinking.</p>
Māori Health Authority	<p>The Māori Health Authority would also need population health expertise to focus on improving the health and wellbeing of Māori. It would be the source of Māori population health intelligence for the health and disability system and would play a key role in ensuring population prevention programmes have a strong equity focus.</p> <p>The Māori Health Authority would also:</p> <ul style="list-style-type: none"> ▶ monitor and report to the Minister on the performance of the health and disability system with respect to Māori health outcomes and equity. ▶ describe and report on Māori health and disability data and provide advice on Māori population health priorities, informed by population data. ▶ ensure and evaluate the use of kaupapa Māori methodologies and whānau rangatiratanga (whānau participation and voice) in Māori health needs assessment.
Health NZ	<p>Health NZ would ensure the delivery arm of the sector prioritises the achievement of population objectives. To do this Health NZ would need to develop a core population health capability to support DHBs to integrate population health throughout their services.</p> <p>It would have a key role in drawing together best evidence to guide prioritisation and use systems to share examples of good practice and facilitate best practice. It would commission key national population health services, such as health promotion campaigns and lead the delivery of national programmes, such as screening.</p> <p>Regional and district population health services should principally be funded through Health NZ and provided by DHBs local NGOs, Māori and Pacific providers and other providers.</p> <p>Health NZ would monitor DHBs to ensure that district plans and expenditure sufficiently prioritise population health and prevention approaches.</p>

Regional and local functions

Greater regional collaboration and networking will be required to ensure that core population health functions are delivered consistently across DHBs. There is an expectation that there would be more consistency around the country with regard to which services are managed regionally and which by individual DHBs.

Table 6.3: Proposed regional and local functions

Level	Function or service
DHBs	<ul style="list-style-type: none"> ▶ DHBs' statutory functions in protecting and promoting the health of their populations would remain largely unchanged. A stronger line of sight is proposed between medical officers of health to the Director of Public Health to enable more coherent responses to emerging issues. ▶ DHBs will have the funding and accountability to deliver services to protect and promote the health of their populations. District and regional DHB strategic plans will set out in a more integrated manner how health outcomes and equity will be improved, including an increased focus on prevention, maintenance of wellbeing, and influencing the broader determinants of health. ▶ The functions currently undertaken by public health units will continue to be the responsibility of DHBs.

Decisions relating to which services are best delivered regionally or locally should build on the work done by the Public Health Clinical Network and the Ministry in regard to this, using the principles summarised below.

Principles

- ▶ **Regional:** These are functions that for reasons of consistency, effectiveness or efficiency should be delivered across several DHB districts, through either a lead provider or through a regional network of DHBs. This should include functions that are more specialised, or for issues where particular skills or expertise are scarce.
- ▶ **Local:** These are functions that for reasons of responsiveness, relationships and flexibility should be delivered locally. It recognises that most population health programmes are provided in partnership with a range of other health and non-health providers. Effective programmes depend on strong local relationships and a deep understanding of local communities and their needs. It also recognises that many functions require a local presence, such as managing communicable disease outbreaks, contact tracing, and investigating and managing environmental hazards.

There is an expectation of greater regional collaboration and networking to ensure that these duties are effectively discharged. DHBs would be expected to develop a plan setting out what services they intend to deliver regionally and locally for approval.

Building the future

The Review proposes the following changes

Population health drives the system

- ▶ Population health would drive all strategies and outcome measures and targets are predominantly population rather than treatment based.
- ▶ The Ministry should have a strengthened leadership role and capacity for population health.
- ▶ The Ministry should increase work with other government agencies on policy that impacts the social and commercial determinants of health
- ▶ The Māori Health Authority should have population health expertise to focus on improving the health and wellbeing of Māori. It would be the key source of Māori population health intelligence for the system. The Māori Health Authority should be proactive in reporting on Māori health and disability issues and providing advice on Māori population health priorities.
- ▶ Health NZ should build a strong population health intelligence function to support population health being embedded into service planning, delivery and performance.
- ▶ The functions currently performed by the Health Promotion Agency should be transferred to the Ministry, Health NZ and the Māori Health Authority.
- ▶ DHBs should provide greater focus on population health through allocating resources, strategic and locality planning, service delivery and population health management functions.
- ▶ The funding for population health would be devolved to DHBs rather than being managed through a central appropriation and separate contracts.

The system is prepared and resilient

- ▶ Core health protection competence and capacity will need to be strengthened as will connections between the Ministry and other agencies with responsibilities for public health functions.
- ▶ The system's emergency preparedness needs to be better connected, use data and be capable of rapid deployment. The system needs to have sufficient resilience to cope with the increasing frequency of emergencies and outbreaks.

There is an authoritative voice on population health

- ▶ The Director of Public Health and medical officers of health should have the authority and independence to advise the Minister and DHB boards directly about urgent or significant population health matters.
- ▶ A Public Health Advisory Committee should be mandatory. It should provide independent advice to the Minister and be a public voice on important population health issues.

7 Tier 1 / Taumata 1

To make a difference, particularly for individuals and communities who are currently missing out, Tier 1 needs to become more useful to consumers and their whānau, simple to access and easy to navigate. Services need to be commissioned in a way that enables them to be designed for the wellbeing of the people they serve. More services should be planned locally and be available in places and at times of the day that reflect the needs of local communities.

Services also need to be available on a fair basis, with the system taking a greater hand in ensuring that resources are spent in the communities and on the people with the greatest needs. This is not about making more services free for all, but a targeted expansion in public funding of particular services, and improving how services reach out to consumers, to each other, and to the wider social system.

Introduction

For most New Zealanders, Tier 1 is the entry point into the health and disability system. Regardless of income, location, ethnicity, gender, or age, all New Zealanders interact with Tier 1 services at some point in their lives.

The importance of Tier 1 for reducing the burden of disease, improving equity and health outcomes for Māori and other groups has been espoused for over 20 years. Yet little progress has been made at a system level in strengthening the role that these services play. In many instances, service delivery arrangements have not considered the burden of chronic disease, comorbidities and mental health issues that now exist in communities. Culturally safe services are not yet the norm, disability is treated as an exception and technologies have not kept pace with how New Zealanders expect to access services or health information for themselves.¹⁰⁷

Tier 1 encompasses a broad range of services and other activities that take place in homes and communities, in marae and in schools, delivering most of the health services that most people need, most of the time. Tier 1 includes, but is not limited to self-care, mental health services, general practice, maternity services, Well Child / Tamariki Ora, outreach services, oral health, community pharmacy services, health coaching, medicines optimisation, district nursing, aged residential care, hauora Māori services, community paramedic services, school based services, home-based care and support, rehabilitation and palliative care. It also includes laboratory and radiology services and other allied health care that takes place outside of hospital, such as podiatry, physiotherapy and dietetics. Most kaupapa Māori services are in Tier 1.

Tier 1 is important for Māori

Tier 1 has particular significance for Māori. While health strategies of the last two decades, particularly the Primary Health Care Strategy,¹⁰⁸ intended to improve equity and Māori health and wellbeing, it is clear that significant inequities remain.

In its recent kaupapa inquiry (Wai 2575), the Waitangi Tribunal found that although the Primary Health Care Strategy provided a strong foundation towards pursuing equity in health outcomes for Māori, it had not been adequately implemented to achieve this goal.¹⁰⁹ While it is not the Review's responsibility to respond to the Tribunal's *Hauora* report,¹¹⁰ its findings were valuable for our analysis.

The Review considers that the major improvements in Māori health outcomes will come from better primary and community services that are culturally safe and accessible for Māori communities. This would require a much greater focus on understanding the health needs of Māori whānau, addressing these needs in a more connected way, and ensuring an expansion of outreach and home-based services in particular.

Many of the changes to the health and disability system recommended in this chapter seek to address issues that were also raised in the Waitangi Tribunal's *Hauora* report, such as:

- ▶ the need to tackle the wider social determinants of health
- ▶ investing in kaupapa Māori services to provide cultural options and choice for Māori whānau
- ▶ ensuring funding arrangements recognise higher-needs populations are often being served by Māori Health Providers.

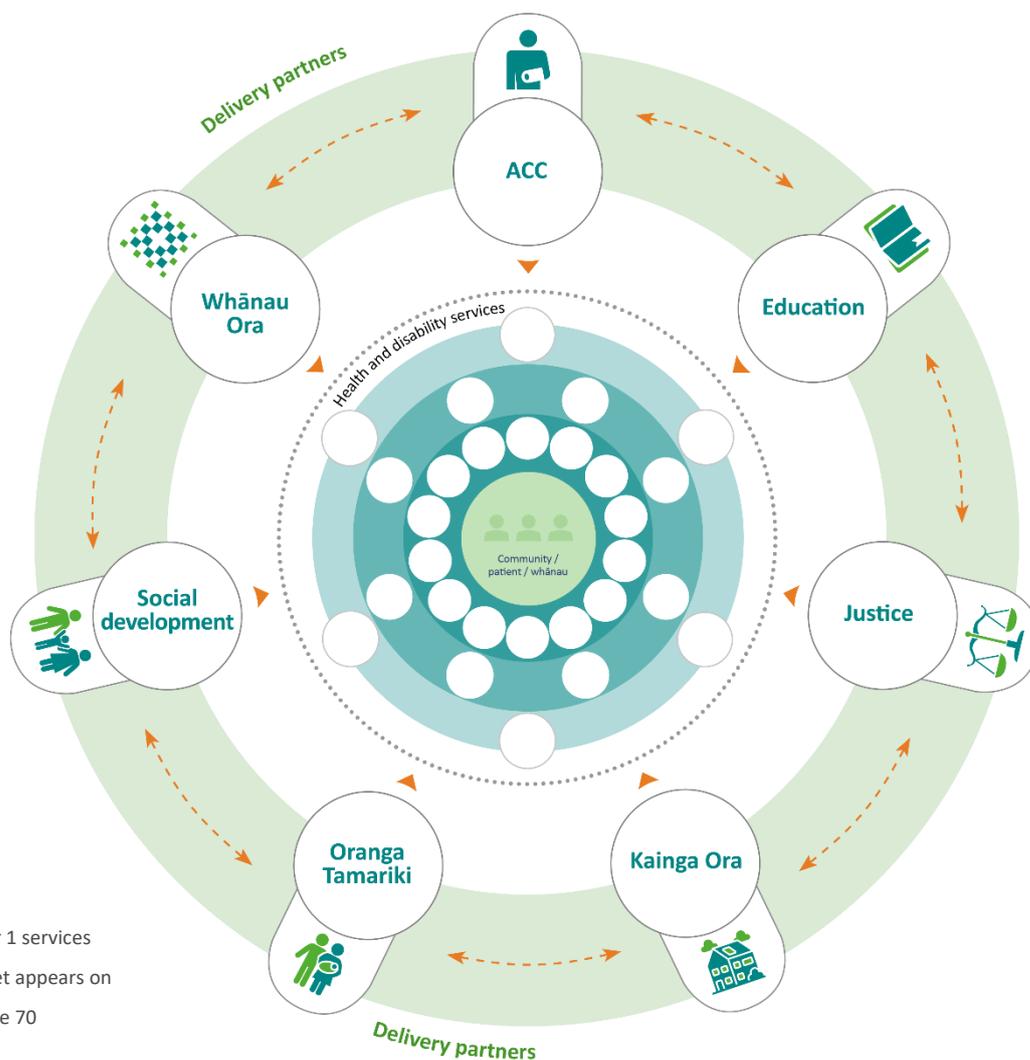
The *Hauora Māori* and *Settings* sections of this report give more detail on kaupapa Māori services, equity, Māori Health Providers, and the role of the Māori Health Authority in supporting and monitoring the changes to the system.

Refocusing the system on people

The health and disability system is not the main factor in determining health outcomes. If New Zealand does not significantly reduce intergenerational poverty and act on the social determinants of health, little that happens in the health and disability system would have a lasting impact.

Improving the health and wellbeing of the population would not come from the efforts of any single organisation nor should it be driven primarily from within traditional health services. The health and disability system and its institutions would need to partner across government and with other sectors to address inequity and improve outcomes, particularly for those for whom the current system is not working – Māori, Pacific peoples, disabled people, people living in rural communities or with socioeconomic disadvantage and other vulnerable groups.

Figure 7.1: Delivery partners



Tier 1 services
inset appears on
page 70

Population health in the driver's seat

However, there is also much that the health and disability system *can* do to give all New Zealanders the opportunities to start and live life in the best possible health.

For many years, the health sector has talked about the need for a population health approach. A population health approach considers the interrelated factors and interrelated conditions that influence health over the life course, identifies systemic variations, and applies this knowledge to improve the health and wellbeing of the population.¹¹¹ In terms of services, a population health approach emphasises prevention, the multiple determinants of health, health equity, intersectoral partnerships, and understanding needs and solutions through community outreach.¹¹²

It is now almost 20 years since the Primary Health Care Strategy was launched, and there have been many developments that can assist a population health approach to be integrated into service design, eg behavioural insights, changing consumer expectations and significant advances in access and use of data and digital technology.

The Review saw examples of a population health approach applied successfully in combination with place-based strategies that organise services around the needs of defined communities.¹¹³

Organising services around smaller populations in localities (see definition below) makes it easier to recognise what really matters to people, to build relationships across professions and organisations, and work with other sectors to address the wider determinants of health.

The Review has concluded that there is merit in applying a locality model to Tier 1 services in New Zealand.

Services planned by localities and needs

The term locality has been adopted to mean a geographically defined area with a population of between 20,000 and 100,000 people, with footprints that make sense for the community being served. Localities could be aligned to council boundaries, iwi, or natural borders. A district health board (DHB) region could include more than one locality, but localities would not generally span multiple DHBs.

Rohe and localities

Within a DHB or region, an iwi rohe may be a defined locality. Responsibility for locality planning and monitoring outcomes could therefore be the shared responsibility of the DHB and the Rūnanga.

District health boards responsible for Tier 1 services

The Review considered ways that a locality approach could be achieved in New Zealand and concluded that governance would sit most appropriately with DHBs, as they have statutory responsibility for the health and wellbeing of their populations. Although still called district health boards, they would be expected to look and behave very differently to how they do now.

For each locality, DHBs would be responsible for ensuring that the mix of Tier 1 services reflects the characteristics of the community, are culturally safe, and improve access for consumers and whānau. Each locality would have a mix of services and business models, with NGOs and Māori providers playing an integral role. A core group of services, strongly focused on prevention, wellbeing and outreach, would be common across all localities in New Zealand, with a varied delivery model to respond to differences in local needs. Other services in the locality would be determined as part of planning, and may be specific to the health and wellbeing needs of its population.

Having reviewed the lessons of previous health sector reforms, it is clear that for this approach to be successful, these next generation DHBs should not just have accountability, but the authority, funding, purchasing and contracting powers to bring a locality approach to life.

Locality plans and funding

As described in the System Settings section, DHBs would be required to develop five-year strategic plans for their regions, approved by Health NZ and the Minister of Health, and supported by intelligence and analytics from Health NZ and the Māori Health Authority. Each locality would have an indicative budget based on age, ethnicity and deprivation of its population. This would be transparent to the public (see funding in this chapter).

A locality approach to services in the Ngāti Porou East Coast

Ngāti Porou is a dynamic, future focused iwi with a proud history of mana motuhake.¹¹⁴ With around 71,000 people across the country, it is Aotearoa's second largest iwi,¹¹⁵ of which 11,000 people live in the Ngāti Porou rohe that includes 48 marae and 58 hapū.

Within the rohe, whānau living in Ngati Porou East Coast (from Tolaga Bay northwards to East Cape) face the combined challenges of distance and deprivation. More than 90% of the population live in the highest quintile of deprivation in Aotearoa, and household incomes are a third lower than the national average.¹¹⁶ A third of the population live in rural areas, and infrastructure such as roading, electricity and water supplies are frequently damaged by severe weather events.

The resident population of Ngāti Porou East Coast currently experiences very high morbidity and mortality rates. Amenable mortality rates for the resident population are over twice the national average.¹¹⁷ Together, geographic isolation and the socioeconomic determinants of ill health are contributing to a high need for health services.

Enabling every Ngāti Porou person to reach their full potential and be socially and culturally empowered is an important aspiration for the Runanganui.¹¹⁸ Te Runanganui o Ngāti Porou, Tairāwhiti DHB, Ngāti Porou Hauora and other service providers are working together to lift health outcomes and reduce inequities by strengthening the configuration of health services in Ngāti Porou East Coast. The Review believes this area would benefit greatly from a locality-based approach and pro-equity funding for Tier 1 services, as described in this chapter.

Commissioning the right mix and design of services for the population would require effective community engagement to understand the aspirations, capabilities and expectations of the people using the local health system. Understanding and responding to the needs of those who do not access the system, including both Māori whānau and Pacific communities, would be just as important for planning as understanding the needs of those who do access the system. Clinical engagement would also be important for safe and high-quality service design.

Locality plans would show:

- ▶ the locality health needs assessment results, including unmet need for different services
- ▶ indicative budgets for the locality, based on age, ethnicity and deprivation
- ▶ what Tier 1 services would be available to meet these needs, in what settings
- ▶ how networks of services would be organised and provided and by whom
- ▶ how access would be enabled to suit the community and value the time of consumers and whānau, for example, locations, extended hours, digital services, outreach services and transport options
- ▶ how specific populations would be served, for example, kaupapa Māori services to provide choice for Māori whānau, services designed for Pacific fanau, people with disabilities, and rural communities
- ▶ the outcomes these activities are expected to achieve for defined populations.

Locality plans would also set out a programme for investment that is transparent to the public, the workforce, Health NZ and the Māori Health Authority about how the service delivery model would be developed over time.

The role of primary health organisations and Alliances

District health board responsibilities for Tier 1 would have particular implications for primary health organisations (PHOs). The Review considered the potential role of PHOs in a locality framework and concluded that split accountabilities between DHBs and PHOs for population health outcomes do not serve the objectives of the future system. While some developments by PHOs, such as the Health Care Home model, are improving service delivery in some places when compared with a traditional general practice model of care,¹¹⁹ at a system level, they still do little to change the paradigm.

It is recommended that DHBs no longer be required to contract PHOs for primary health care services, and that within five years there is a deliberate move away from the National PHO Services Agreement. Alliance arrangements required by the PHO Services Agreement and DHB Operating Policy Framework should also no longer be mandatory.

While a DHB could choose to continue to fund services via a PHO in the interim using the current PHO Services Agreement, DHBs would be expected to take on the responsibility for population data analysis and the management functions currently contracted out to PHOs. Funding for Tier 1 services would also increasingly be managed by DHBs and paid directly to providers through new commissioning arrangements. Health NZ would monitor this transition.

A local network of services to keep people well

For the most part, historic models of service delivery have prevailed with little adjustment to recognise the differentiated needs of the local community. A largely monocultural approach based on a western biomedical model has consistently failed to achieve equity for Māori.¹²⁰ Service delivery needs to evolve to be more holistic and directed to the needs of both Māori and Pacific communities.

If the health and disability system is to be genuinely culturally safe, connected and designed for prevention and wellbeing, the breadth of Tier 1 services that consumers have a right to expect in their community should be actively expanded and commissioning done differently than in the past.

Guaranteed and locally specific services

To ensure fair access to services that are equity focused and tailored to local needs, the system should play a more active role in shaping the mix of services available in each locality. As Tier 1 is usually the first point of contact with the health and disability system, the mix of services should consider the cultural, clinical and social determinants of need, recognising that these are mutual determinants of health status.

It is proposed that each locality be served by a network of publicly funded Tier 1 services. Some services would be common across the country and others tailored to meet the health and wellbeing needs of a particular population. The service mix would be developed through the locality planning process, as described earlier. Some workforces or providers would serve more than one locality.

Table 7.1 sets out the proposed list of services that DHBs should guarantee are available and accessible to the population of each locality (although coverage may be differentiated to respond to local priorities). These services have a strong focus on promoting wellness throughout the life course as much as treating sickness. As with other parts of the health and disability system, services would be culturally safe. A mix of service models, including kaupapa Māori services, would be available.

Table 7.1: Services guaranteed for localities

Service	General description
Care coordination	▶ Team-based activity designed to facilitate the successful navigation of consumers through the health care system, based on their individual needs, preferences, capabilities and support. Intensity of care coordination depends on complexity of need.
Child and adolescent oral health	▶ Basic dental care, including check-ups, cleaning, preventative treatments, and fillings or extractions, for people up to their 18th birthday
Community pharmacy services	▶ Pharmacist-led services in community settings, including dispensing, treatment of minor ailments, acute demand triage and referral and relevant population health services.
General practice services	▶ Services to prevent, diagnose, educate and provide care for patients, and access to other appropriate services in the health system to benefit the patient.
Maternity services	▶ Services related to the care of women and babies from conception to six weeks after birth.
Medicines optimisation services	▶ A person-centred approach to safe and effective medicines used to ensure people obtain the best possible outcomes from their medicines. ¹²¹ Services are led by clinical pharmacists and take place at home, or other places that meet consumer and whānau needs.
Mental health services and behavioural support	▶ Support to help people achieve their best possible mental and emotional wellbeing which could include health coaches, health improvement practitioners, counsellors, social workers, youth workers and whānau ora kaimahi.
Needs assessment for disability and aged-care support	▶ Assessing a person's level of need and eligibility for health and disability support services.
Nursing services	▶ The health care and assistance provided to individuals by any qualified nurse across a range of health settings, including in institutions, homes and communities.
Older people's services	▶ Health and wellbeing services for older people, including aged residential care and home-based support services, so they can live well, age well and have a respectful end of life.
Outreach services	▶ Health services provided to people in their homes or convenient locations, often by community health workers, kaiāwhina or social workers.
Palliative care	▶ Services for people and whānau living with progressive, advanced illness, where the primary goal is to optimise quality of life.
Population health services	▶ Preventive interventions delivered to individuals aimed at promoting wellbeing and avoiding the development of disease or disability, eg, screening, immunisation, health promotion.
Well Child/ Tamariki Ora	▶ A package of health and support services for children and their whānau from birth to five years to ensure healthy growth and development.

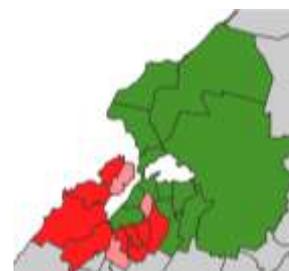
Coverage of these services is currently variable across New Zealand. The immediate priority should be to achieve coverage within localities with the highest needs. Specific investment would also be required to support the growth of kaupapa Māori services.

Equally, networks would be expected to calibrate their delivery model to the level of need (eg, more frequent dental therapist visits to lower decile schools, more outreach services in areas with higher unmet need), and a shift to localised commissioning would ensure DHBs have the contract levers to achieve this (enabling, for example, more employed lead maternity carers in some locations).

Case study: Tier 1 Services in South Porirua

South Porirua, located in Capital and Coast DHB area and the Ngāti Toa rohe, is a vibrant, young and diverse community of over 30,000 and one of the largest Pacific communities outside of Auckland. It celebrates its culture, the strength of whānau and aiga, and its strong Māori and Pacific identity with most households being multilingual. Unfortunately, the community experiences low incomes, overcrowded housing and intergenerational poverty, resulting in poor health outcomes.

- ▶ Over 100 health and social service providers serve the South Porirua community. Some providers, such as Ora Toa and Porirua Union Health Clinic, provide a range of whānau-centred services. However, complex funding arrangements, multiple commissioners, and inflexible national contracts make serving the South Porirua community unnecessarily difficult.
- ▶ Taking a population health approach to serving the South Porirua locality would allow services to be designed for the unique needs of the community. For example, one priority for South Porirua is to support whānau and pēpē to have the best start in life.
- ▶ DHB-commissioning, rather than national commissioning of services, would enable a whānau wellbeing outreach service, including a mix of midwives, nurses, social workers and kaiāwhina, to support whānau to meet their health and social aspirations.



Socioeconomic deprivation across Porirua City

Note: Quintile 5 (high) deprivation shown in red, quintile 4 in pink, quintile 1 (low) in green.
Source: University of Otago¹²²

Culturally safe services, including investment in kaupapa Māori services

Locality plans would include providing culturally safe services. Investment in kaupapa Māori services and embedding mātauranga Māori (see the Hauora Māori section for definitions and further information) into service delivery are central to developing these models of care and pursuing Māori health equity. Planning for localities should engage Māori-centred design thinking so that tangata and whānau needs and delivery models are considered and prioritised in models of care.

The Māori Health Authority would partner with the Ministry, Health NZ and DHBs to develop Māori Health Provider Development strategies and Māori workforce strategies to ensure that there is a Māori workforce (including clinical and non-clinical roles) and range of services to meet the health and wellbeing needs of Māori whānau and communities.

See the Hauora Māori section for further information, including the proposed central role of kaupapa Māori services in the future health and disability system.

Commissioning services that are not currently funded

A feature of localities would be the mandate to commission quality services that are not currently publicly funded or that have eligibility restrictions, where there is a clear benefit to equity and the wellbeing of the population. Examples could include rongoa Māori, podiatry, physiotherapy and adult oral health care. These could be funded by prioritising spending across localities within a region, discretionary funds within the DHB, or with the agreement of Health NZ through the health and disability system's collective responsibilities for outcomes (see System Settings). Joint commissioning with ACC may also be appropriate and should be enabled (see the Services Introduction chapter in this section).

Tier 1 services connected as a network

A key objective of the locality approach is for services to be easy to access and simple to navigate by the people who live and work there. Consumers and whānau should experience all Tier 1 services in their locality as though they were a single service. Services would be expected to operate as a single network, enabled by data sharing and digital platforms, referral pathways, shared protocols and commonalities in terms and conditions. There is no expectation that services would be co-located.

The DHB would be responsible for managing the network, with a dynamic mix of partners to support service delivery that addresses the clinical, cultural and socioeconomic determinants of health, ensures responsiveness to different needs and promote innovation in service design.

NGOs, Māori Health Providers and private businesses would be integral, alongside DHB-owned or operated services. In some localities, Tier 2 services, Whānau Ora services or other social services may be included as part of the network.

The network may be Taha Māori or consist of kaupapa Māori services (see the Hauora Māori chapter for definitions). It is expected that networks and localities would share learning to help achieve Māori equity and wellbeing.

Joint accountability for population health outcomes

Services within a network would be jointly accountable to the DHB for agreed locality outcomes through new contracting arrangements. Regular analysis and reporting on population health outcomes would ensure that services are meeting the needs of the population. The network's performance would be managed by the DHB. The DHB should also ensure clinical governance for services delivered in the community.

Contract terms and funding arrangements for services within the network would enable the workforce to collaborate and practice across their full scope to keep people well. To support this and reduce dependence on throughput for revenue, a deliberate change in how Tier 1 services are funded would be integral for services currently paid on a piece-rate basis. This would be particularly important for services that predominantly serve high-needs populations, particularly Māori Health Providers, who have been disadvantaged by current funding arrangements (see the section on funding in this chapter).

In the first instance, these expectations would apply to the group of services guaranteed in each locality and new contracts. Over time, however, public funding for all Tier 1 services would become dependent on being part of a network and meeting data sharing, access and accountability requirements.

Addressing access

Despite many of the services listed in the previous section already having zero or low co-payment for many New Zealanders, this does not mean they are free of charge. Costs of interacting with health services often have not been addressed and include transport, parking, time off work or away from dependents.

For both Māori and Pacific peoples, there is evidence that additional barriers include location and access to services, lack of childcare support,¹²³ health care characteristics such as racism and poor relationships with practitioners and providers, and health care structures and practices.¹²⁴

For people living in rural areas, distance, travel and poorly coordinated appointment times are significant barriers to accessing both Tier 1 and Tier 2 services.

For disabled people there is evidence that proactive approaches such as annual health check can make a difference to health outcomes. Poorly coordinated needs assessment processes, care coordination and service delivery also need to be addressed as access issues are particularly challenging for many disabled people.

For services to address inequities, they must be accessible. Better use of technology, clearer obligations on services for availability, for example, location and hours, and using outreach services are three strategies that would improve access.

Locations and hours of services

Services need to be located where they best suit the community and more services need to be open longer.

As part of the planning and contracting process, operating hours for services within the network would be agreed with the DHB. This could mean, for example, some or all services being open earlier or later in the day, providing clinics at the weekend, or participating in outreach. It could mean aligning services' opening hours and workforce in similar locations and times, so a person or whānau can conveniently meet all their needs at the same time.

New providers wishing to enter the locality, or services intending to expand, would be funded only where it is consistent with the locality plan.

DHBs would be responsible for ensuring access

Where existing providers are not available or able to operate in ways, times or arrangements that meet the above, DHBs would be responsible for sourcing or developing new services that address these gaps. This could involve influencing the location of new providers entering the locality, or by providing the service directly. Analysis of gaps in services and feedback from the community, would also inform the next cycle of strategic planning and investment.

Digital platforms and data sharing

Consumers and whānau should experience services within their locality as though it were a single service. This includes having the digital tools to access advice, book appointments, communicate with services, receive a referral, order a prescription, access and contribute to their health information and choose who they share it with.¹²⁵

New contract terms for Tier 1 services would have a much stronger emphasis on enablers of connected, whānau-centred service delivery. For example, requiring that a digital portal provide consumers the option to access their personal health information from any service within the network, and to carry out activities such as bookings, needs assessment forms and service registration online. Services within a network would be required to facilitate the exchange of health information so that, with consumer and whānau consent, their health information could be readily shared between providers to support, for example, wrap-around service delivery.

Outreach services in every locality

The term 'outreach services' can be used to describe any or all of the following:

- ▶ Services that might otherwise be provided in a health care setting but that are delivered at home (eg, nursing services, medicines optimisation) or at places that are convenient for consumers (eg, marae, church).
- ▶ Home-based care and personal support (eg, older people or disabled people).
- ▶ Community services that deliberately seek out unmet need within a population, and (with permission) connect people with services that would help keep them and their whānau well.

This section discusses the third type. However, all three are important and should be available in each locality.

A new model of outreach services

The purpose of population outreach services is to improve health outcomes for those with unmet and/or complex health needs or risks from multiple socioeconomic determinants of health, by ensuring people are well supported by health and disability services in their community.

DHBs should be required to introduce or embed outreach services that respond to the needs of their localities. Services would be provided by community health workers, such as kaiāwhina, with a deep understanding of the population they serve and the skills to build trusted relationships with individuals and whānau. The exact model of delivery would reflect the unique local population, service network and community needs.

Case study: Outreach services for Pacific households

Auckland DHB's Integrated Services Agreement (ISA) funds three Pacific primary health care providers to deliver a holistic health service combined with elements of social support to Pacific households.

An ISA team recently worked with a Samoan household of six who were facing multiple health and social challenges. Mum and Dad were both unemployed; Dad was unable to drive due to sleep apnoea, was considered morbidly obese, and both parents had diabetes. One daughter had a heart condition having contracted rheumatic fever a few years earlier, while another suffered from depression and had diabetes. The family's house was damp and leaking. The household was also struggling to manage its finances and two older brothers (adolescents) were the sole breadwinners for the family.

The ISA team began working with the household and over a 12-month period:

- ▶ A CPAP machine was secured for Dad which he began using to successfully combat his sleep apnoea. He lost 20 kgs as a result of increased understanding of nutrition/healthy eating and the importance of exercise, and the influence of the CPAP machine. He was no longer obese. Dad also secured his driving license, significantly improving the number of GP and hospital appointments that Mum and daughters could attend.
- ▶ The daughters were connected with their GP, with one receiving support for depression and the other received increased support for her heart condition. Mum, Dad and the younger daughter all had significant reductions in their HbA1c, with their blood pressure moving into their respective ideal ranges, and their diabetes was better managed.
- ▶ The household was connected with a healthy housing provider to reduce the dampness and increase the warmth of their home, while the ISA team worked with the family to secure improved long-term accommodation.
- ▶ The family was connected to budgeting services to help them better understand and manage their household costs and reduce credit card payments.

(Source: Adapted from Alliance Health Plus)

In localities, outreach services would work closely with the DHB's population analysis and management functions to understand the health profile of the community and to identify and connect with people who may have unmet need. For individuals and whānau, outreach services could serve as health educators, help with completing documentation and assessments and assist with health promoting activities.

Outreach workers who observe social situations, living conditions and resilience issues could, with permission, arrange health services for others in the household. Similarly, recognising the socioeconomic determinants of health, outreach services are likely to work closely with other services in the community, and (again, with permission) connect consumers and whānau with these resources.

Funding for the locality would support employment of outreach workers at a ratio appropriate to the needs of the community. This is to ensure there is sufficient workforce to recognise the time needed to build trusted relationships with people, and carry out a mix of tasks including identifying those with unmet need, spending time with individuals and whānau and following up on actions.

Investing in services that promote health and address inequity

Investing in services that promote health and wellbeing and address inequity should be the priority for the system. The Review considered the merits of investing to expand service coverage relative to addressing other barriers to access (eg, reducing co-payments on pharmaceuticals or other primary health care services) and concluded that to achieve equity, the first priority should be to improve quality and uptake of preventive services in the network, such as screening and Well Child / Tamariki Ora, for those that the current system does not serve well, and extend outreach services.

Beyond this, discretionary funding should be targeted towards improving the quality and range of publicly funded services for those with the greatest needs.

Maternal and child health

Getting it right for future generations, ensuring more equitable outcomes for Māori and Pacific children

Child and maternal wellbeing is critical. The first 1,000 days of a child's life is a crucial time for development that sets the stage for physical and mental wellbeing throughout life. A child who is exposed to negative experiences very early in life is more at risk of physical and mental health problems later in life.¹²⁶ Globally, one in three children do not achieve their full developmental potential due to the absence of health and wellbeing in their early years.¹²⁷

As a child grows, there are milestones and behaviours that are instrumental to their future wellbeing. Child wellbeing improves when children are happy and healthy. It starts at the point of conception. A happy, healthy and nurturing environment means children can develop and flourish. It is estimated that children who get the right nutrition and support in their first 1,000 days are 10 times more likely to overcome a life-threatening childhood disease and will go on to earn an average of 21% more in wages as adults.¹²⁸

For these reasons, successive governments have invested in services and programmes aimed at ensuring children have the best start to life. This includes access to:

- ▶ free, universal maternity care
- ▶ maternal mental health services
- ▶ newborn hearing and metabolic screening
- ▶ Well Child / Tamariki Ora
- ▶ B4 School Checks
- ▶ the national immunisation schedule
- ▶ oral health care from 0–18 years
- ▶ school-based health services
- ▶ free access to general practice and funded prescriptions, from 0–14 years.

Services for children are free, yet inequities remain

Maternal and child health care is fragmented and inconsistent. There is no one single agency responsible, at a system level, for maternal and child health or wellbeing. Fragmentation in where and how services are commissioned, who funds them, and where accountability lies for outcomes is a challenge as is ensuring that services are accessible, easy to navigate and make sense to people who need them.

While all the services identified above are technically free of charge, hidden costs exist and inequities remain, particularly for Māori and Pacific children.

The Review is aware that Well Child / Tamariki Ora and the funding model for maternity services are being reviewed. Discussions have also been held with workforce representatives, the Ministry, DHBs and service providers to understand their ideas for how the system could work better for those currently missing out. It is clear that attempting to address these issues would achieve little if done in a piecemeal, programme-by-programme or service-by-service way.

Maternal and child health services would be organised by locality

Maternal and child health must be at the heart of a connected, whānau-centred system, with Tier 1 services guaranteed within localities.

To achieve this requires DHBs to have the contracting and funding mechanisms to commission the models of care and workforce that are most effective locally, particularly for Māori whānau and Pacific families. Barriers between services caused by business or contracting models (eg, between maternity and Well Child / Tamariki Ora) should be removed so that the lead practitioner reflects the needs and preferences of consumers and whānau, not solely providers.

This requires a move away from national level purchasing of Well Child / Tamariki Ora services, and that the funding and decision rights for these services should be vested with DHBs. Service providers would still be able to serve multiple localities and contract to multiple DHBs, but they would need to meet the unique needs of each locality (see the Services Introduction for discussion of commissioning) Further, providers would need to meet contracting requirements for services within the network (eg, data provision and reporting).

DHBs should have the flexibility of funding and authority to source extended services for children or pregnant women where these meet an identified health need, for example, child optometry or oral health.

In the interim, the above expectations would not prevent continued contracting for services and with providers where arrangements are best meeting the needs of populations.

Oral health services

Poor oral health is one of the most common chronic health problems experienced by New Zealanders. Poor oral health effects, and is affected by, poor general health including health conditions such as diabetes and cardiovascular diseases. Yet most oral health conditions are preventable, through for example, water fluoridation, reducing sugary drinks and food consumption and improving oral health literacy. Children's oral health is particularly important as oral health status early in life predicts later adult oral health status.¹²⁹ Protecting the oral health of children can help them maintain good oral health later in life.

Publicly funded oral health services are planned and organised differently from other Tier 1 services, and coverage depends on age.

- ▶ Children from 0 to year 8 are served by the Community Oral Health Service (COHS). These are services provided by DHBs and are based in schools or mobile units.
- ▶ Adolescents from 13 to their 18th birthday access free, DHB-funded oral health services, primarily from private dental practices.
- ▶ Adult services are largely privately funded, with limited government funding for emergency dental care of low income adults, hospital dental services and, in some DHBs, free or low cost care provided directly or through Māori Oral Health Service providers. Work and Income grants can contribute to the costs of urgent dental treatment, but these are difficult to access and restricted to \$300 per annum which is generally less than the cost of required treatment.

Inequities remain in child and adolescent oral health

Despite being free of charge, significant inequities in oral health outcomes and access remain for children and adolescents. Māori and Pacific children are more likely to have cavities than non-Māori and non-Pacific children¹³⁰ and Māori adults are more likely to have teeth removed due to decay.¹³¹

The table below illustrates the inequities in access to oral health services. It shows Māori and NZ European populations accessing oral health services over the last 12 months, broken down by ethnicity and age.

Table 7.2: Percent population accessing oral health services

	Five-year olds	Year 8	Adolescent services	Adults
Māori	58%	69%	44%	38%
NZ European	74%	86%	78%	52%
Difference	-16%	-17%	-33%	-14%

Source: Ministry of Health, NZ Health Survey, Stats NZ

- 1 Utilisation data for the 5 year old and Year 8 checks are from on Ministry of Health published data.
- 2 Utilisation data for adolescents are based on Ministry of Health payments data, and excludes around 4% of served adolescents.
- 3 Population data for 5 year olds and Year 8 and adolescents are from Stats NZ population estimates. Utilisation rates for adults are from the NZ Health Survey.
- 4 Rates for Pacific peoples have quality issues due to inconsistency between utilisation and population data, and are therefore not shown.

The considerable difference between Māori and NZ European children and adolescents in utilisation of free services suggests that non-financial factors also play a role in uptake of oral health care. For example, there is evidence that there are fewer dental clinics in high-needs areas¹³² and a lack of culturally safe services reduces service use by Pacific adolescents.¹³³

Localities should include child and adolescent oral health services

The Community Oral Health Service should be included within local networks. This would allow for better tracking of children enrolled or accessing services, more seamless referrals from maternity and child health services and inclusion of oral health promotion as part of population health services within the locality.

Joint accountability between services within the network may also encourage greater multidisciplinary approaches to improve equity of oral health for children.

Adolescent oral health services should also be incorporated into service networks, with a focus on reducing inequitable access, including ensuring that the model of provision is culturally safe and provides options for Māori rangatahi. The Combined Dental Agreement should remain an option for DHBs where this is working effectively, but there should be no constraints for commissioning adolescent dental services using other means.

Adult oral health services

The Review has heard calls for universal coverage of oral health services for adults. However, estimates suggest that the cost of broad population coverage could be very significant (assuming the current model of provision), and needs to be weighed against other opportunities to improve equity. Further policy work would be required. The Review considers that to improve the equity of oral health outcomes for the next generation, the immediate priority needs to be on oral health outcomes for children and adolescents.

There has also been calls to expand coverage into early adulthood. However, with less than half of Māori adolescents accessing services in the current model, extending eligibility without considering the delivery model risks further embedding significant inequities, and would likely benefit, for example, non-Māori young adults more than Māori young adults. The priority should be ensuring that adolescent oral health services are accessible and responsive to populations not well served by current arrangements.

As networks develop, there should be no impediment for DHBs to increase coverage to groups such as young adults, pregnant women, whānau or low-income adults. Whether increasing oral health services is a priority to improve health equity would differ between localities and DHBs would need to consider this when planning and engaging with their communities.

Medicines optimisation services and clinical pharmacists

Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in health care. As the population ages and life expectancy increases, more people are living with more conditions that are being managed with an increasing number of medicines.

Issues in prescribing, dispensing, administration or use of medicines can prevent the desired outcomes being achieved and cause harm to the consumer. As few as 16% of patients who are prescribed a new medicine take it as intended, experience no problems, and receive as much information as they need.¹³⁴ One study found that a third of people admitted to hospital suffered medicine-related harm, of which around 30% originated in the community.¹³⁵ People are at greater risk of harm when they are taking multiple medicines (polypharmacy), such as when they have multiple chronic conditions. Due to a range of barriers, Māori are also not able to benefit from medicines in the same way as non-Māori.

Medicines optimisation services

Pharmacists are medicines experts and can work collaboratively with consumers and their whānau, prescribers, and other members of a person's health care team to assess and monitor medicines use. They can recommend changes to achieve the best possible outcomes.¹³⁶

Medicines optimisation is a person-centred approach to safe and effective medicines use, to ensure people get the best possible outcomes from their medicines.¹³⁷

Medicine optimisation helps people taking medicines, and their whānau and carers, to:

- ▶ get the best health outcome from their medicine
- ▶ have access to an evidence-based choice of medicine
- ▶ improve adherence and take medicines correctly
- ▶ avoid taking unnecessary medicines
- ▶ reduce wastage of medicines
- ▶ improve medicines safety.

All of the health workforce is responsible for medicines optimisation, but clinical pharmacists play a key role as medicines experts. Clinical pharmacists have completed additional postgraduate training and can lead medicines optimisation activities across settings, advising and collaborating with consumers, whānau, carers and others in the health care team.

Clinical pharmacists should be in localities

Clinical pharmacists have been employed in a small number of primary and community care locations in New Zealand with positive results for consumers' experience and health outcomes.

The Review considers that medicines optimisation services should become more widely available to support high-need populations (eg, people with complex medical regimens due to mental illness or addiction, comorbid chronic conditions, children with complex medical needs, frail older people, or people transferring from hospital to community-based care) in every locality.

Case study: Medwise Clinical Pharmacy Service, Bay of Plenty

Auckland DHB's Integrated Services Agreement (ISA) funds three Pacific primary health care providers to deliver a holistic health service combined with elements of social support to Pacific households.

- ▶ “Mrs P was referred following an accidental overdose. She was taking 14+ oral medicines, three inhalers and three lots of eye drops. Her own medicines management plan was to put her oral medicines into old medication bottles to take during the day. One day she selected a container thinking it was one of these doses and accidentally swallowed all her sleeping tablets.
- ▶ Mrs P was seen by a Medwise pharmacist and her medication was organised to reduce the workload associated with her medicines. She found her pain and sleep improved with the change in dosing time and regular administration of her pain medication. Large amounts of excess medication, which had accumulated over the years, was removed which gave her lots of storage space but, more importantly, made her home safer when grandchildren came to visit.”

Source: Medwise.¹³⁸ Medwise is a DHB funded service. Pharmacists visit patients in their home to assess and review medication to ensure it is safe, appropriate and effective.¹³⁹

System-wide actions

Embedding medicines optimisation within the community would require a growth in the pharmacist workforce trained in these speciality functions, and developing skills across all health workers. At a policy level, work would be needed to understand models of care for medicines optimisation that best support health equity and to support commissioning of these services.

Mental health and addiction services

Mental illness and addiction touch many people in New Zealand, with nearly half of the population meeting the criteria for a mental illness diagnosis at some stage during their lives.¹⁴⁰ Each year around one in five people experience mental illness or significant mental distress, and there are increasing numbers of children and young people showing signs of behavioural distress and deliberately self-harming.¹⁴¹

Anyone can be affected by mental illness but some people are more at risk. Socioeconomic determinants, such as poverty, lack of affordable housing, unemployment and unpaid work, family violence and social isolation (especially for older and rural populations) and, for Māori, deprivation and cultural alienation, are risk factors for poor mental health.¹⁴²

Alcohol and drug use can make a person more susceptible to mental distress and discrimination and stigma can exacerbate the impacts. There is disparity among populations and Māori and Pacific peoples have disproportionately poorer mental health outcomes.¹⁴³

Demand for mental health services is increasing

The number of prescriptions for mental health-related medications increased 50% in the decade to 2018 and continues to grow about 5% each year.¹⁴⁴ The number of people accessing mental health and addiction services has grown 73% over the past 10 years.¹⁴⁵ The majority of those most severely affected by mental illness are reportedly well served, but the much larger number of people with moderate mental health needs are not.¹⁴⁶ The Government Inquiry into Mental and Addiction, *He Ara Oranga*, found that there are unmet mental health needs for Māori, Pacific peoples, disabled people, LGBTQI+ and other vulnerable populations, such as refugees.¹⁴⁷

Significant activity is underway to improve access

A significant programme of work is currently underway to transform New Zealand's approach to mental health and wellbeing, including investing in Tier 1 services such as:

- ▶ virtual health and digital support for mental wellbeing
- ▶ support for people experiencing a mental health crisis
- ▶ school-based health services (a key access point for children and youth with mental health issues)
- ▶ wellbeing support for primary and intermediate children
- ▶ support for parents and whānau.

The Review strongly supports this effort and its long overdue recognition of the importance of mental health in wellbeing.

New behavioural support roles are being introduced

The Ministry of Health is leading work to introduce new service models for mental health and wellbeing, including behavioural support roles in the community.

- ▶ Peer and cultural health coaches are an unregistered workforce from a range of backgrounds who are usually a member of the local community. Their role is to provide regular support to whānau.
- ▶ Health improvement practitioners are health professionals who are trained and have experience in mental health support. They work with individuals and groups to access evidenced-based interventions and actively help people make changes to their health and wellbeing.
- ▶ Cultural and social supports vary by population, but it is envisaged that these would include health coaches, NGO community support workers and Whānau Ora services.

(Source: Ministry of Health)

Expanding access and choice in primary mental health and addiction services

Expanding access to and choice of primary mental health and addiction services for people with mild to moderate need is a priority within the above programme of work, so that people can get skilled help in their local communities for free, when they need it.

The first tranche of work has focused on developing a model of integrated primary mental health and addiction services accessed via general practice to ensure peer and cultural health coaches, health improvement practitioners and a competent general practice team is available for anyone whose thoughts, feelings or actions are impacting on their health and wellbeing. These services would also provide access to cultural and social supports and ensure effective links and coordination between primary health care and secondary services. Designing and sourcing kaupapa Māori, Pacific and youth focused services is the focus for the second tranche of activity.

Ensuring access is equity focused and responsive

Improving access to and choice of primary mental health services is much needed and essential for population wellbeing. The programmes and services must be given the time to develop and evolve.

To ensure services are equity focused and responsive to those most at risk of mental distress, primary mental health services and behavioural support (peer and cultural coaches) should be included as guaranteed Tier 1 services within a locality, work closely with outreach services and be accessible from any entry point in the network.

The starting point of access via general practice is well intended, but care is needed to ensure this model does not crowd out the potential for other service designs and access that meet local needs and are culturally safe, or that it embeds existing barriers to access. There is considerable potential for innovation in how these services are developed, led for example, by kaupapa Māori services and other NGOs.

Health NZ should be responsible for further implementation, working closely with the Māori Health Authority and Mental Health and Wellbeing Commission. Over the longer term, funding for primary mental health should become part of the Tier 1 allocation for localities so that services are reflective of what matters to local populations. Developing the skillset for commissioning these services locally would be essential for this transition and, again, Health NZ, the Māori Health Authority and Mental Health and Wellbeing Commission would work together and with people with lived experience to ensure DHBs have the capabilities for this.

Ngāti Hine Health Trust – Te Hononga Hou Mental Health and Addictions Service

Steve* was sceptical that the alcohol and other drug rehabilitation programme would work for him. He had been in many rehabilitation facilities before, ticking the court-ordered boxes, but nothing had changed. Steve’s life began to turn around when he was given the opportunity offered by the NHHT Residential Programme to reconnect with his Māori roots. ‘It was like he was hungry for his whakapapa,’ says one of the staff.

Vital to the success of the programme is the ahua and knowledge of the staff who lead from a kaupapa Māori perspective. Readily absorbing all the ahua and teachings of the programme leaders, he in turn earned the respect of his colleagues as he awhi’d them on their own journeys. The most rewarding indication to staff of his success was when he took charge of organising graduation day, fully engaging in Māori protocol and getting his fellow graduates on board.

The turnaround for Steve was amazing. Two years later Steve is drug free, he is a partner in a successful local business, is a consumer advisor to Northland DHB and has earned a diploma in mental health and addictions.

* not his real name

(Source: Ngāti Hine Health Trust¹⁴⁸)

Older people’s services

New Zealand’s population is ageing and different service approaches are needed

It is predicted that by 2050 around 27% of the population in New Zealand will be over 65, an increase from 15% in 2016.¹⁴⁹ Over the same period, within the 65+ age group it is expected that the percentage of 85+ year olds will grow from 12.5% to 25%.¹⁵⁰ The ethnic mix is also expected to diversify, as the populations of Māori, Pacific and Asian peoples are proportionately younger.

Even though people are living longer, they are not experiencing better health in their later years.¹⁵¹

Multimorbidity is now seen in almost half of those aged 65–69 and 75% of those over 85 years. Māori and Pacific peoples also have higher rates of chronic disease from an earlier age, leading to disproportionately greater health needs in older age.¹⁵²

As more people live longer with functional limitation or disability, different approaches and more accessible services are needed so that older people and their whānau can continue living as independently and actively as possible.

Connecting Tier 1 services for older people

Most people would prefer to continue living in their own home as they age, with support from whānau and carers, and accessing services as needed. Whānau and carers also need support, information and training to enable caregiving while maintaining their own health and wellbeing.

The proposed changes to Tier 1 should support older people to live independently for as long as possible eg by connecting older people and their whānau more easily to a wider range of health and disability services within a locality network, and these services being more accessible - provided in locations that are comfortable for older people, such as at home, marae and community facilities.

Figure 7.2: Tier 1 services with greater outreach would support older people to live well



Home-based care and support services

Home-based care and support services (HCSS) provide clinical and support services, including patient assessment, goal setting and plans, personal care, household management and equipment to support people to live at home. Each year more than 100,000 people receive support from these services. More than 70% are over 65 and just over 40% are aged 85 plus.

The range of support available varies by provider size, funding model and geographic location. Services are funded by DHBs, the Ministry of Health for disability support and by ACC for injury. Older people can be receiving services funded by more than one of these agencies (sometimes delivered by the same provider).

The Review considers that HCSS has an important role to play as part of enabling older people to live well and independently in their own homes, and it has been included in the guaranteed minimum services recommended for each locality. However, there are a wide range of issues associated with the current model that go beyond the scope of this report. Defining models of care for older people and addressing issues of sector sustainability and service consistency in HCSS needs specific attention, looking across disability support services, aged residential care, and services funded through ACC (see further below).

Aged residential care services and caring for whānau

When older people can no longer live safely in their own or whānau home, aged residential care in a rest home or hospital can provide 24-hour supervision.¹⁵³ Aged residential care is available to anyone over 65 assessed as needing it on a means tested, user pays basis subsidised by public funding. These services are also used by some people aged 50–64 with disability or illness who need 24-hour long-term care (see the Disability chapter for more information). While the growth rate trajectory is slowing, the total number of people using aged residential care is still growing, particularly hospital and dementia-level care. Aged residential care residents are among the most vulnerable and frail older New Zealanders.

In recent years there has been a particular focus on aged residential care pricing to determine whether it is accessible and keeping up with New Zealand's health care needs. It is questionable whether the funding model is sustainable, as there is already a narrowing of choice in the range of service providers. As with HCSS, resolving these issues poses a considerable task in itself, with many different views within and between stakeholder groups.

While the Review considers that aged residential care plays an important role as an option when people need a higher level of care, the inevitability of residential care seems at odds with the aspirations of many older people to live in their own home or with whānau.

Focus groups with kaumātua, for example, have highlighted a preference to live at home with whānau caring for them.¹⁵⁴ However, barriers exist within the current system – from a lack of training and information for whānau carers, to assessment processes, to a lack of options for home-based support for the very frail or for people needing end-of-life care.

The Review concluded that a different approach to older people's services is needed, and that services for older people should be thought of together, rather than continuing to review individual service types. This is to ensure a continuum of care is designed to best meet the needs of older people as they become frailer and develop models of care that provide options for kaumātua and others wishing to be cared for by whānau at home.

A priority for the Māori Health Authority should be to lead the development of Māori models of care for kaumātua and to work with the Ministry of Health on the shape of older people's services.

Funding consumer and whānau-centred Tier 1 services

For the system to truly tackle inequities in health outcomes, it must be funded on an equitable basis. Funding needs to encourage providers and workforces to deliver services that best meets consumer and whānau need, rather than what attracts a co-payment.

Locality funding distributed according to health need

The Interim Report noted major concerns in the health and disability system that funding was not being allocated and spent equitably, particularly for Māori populations. The Waitangi Tribunal's *Hauora* report strongly echoed these concerns.

Analysis during Phase 1 supported these concerns. Though DHB Tier 1 funding is adjusted for ethnicity and deprivation, it is based on historic primary health care service use as a proxy for need. Historic use often understates the need of some populations because it does not account for financial and non-financial barriers to access services. This results in little additional funding for Māori and Pacific populations and an overall distribution of funding that does not match the needs of communities.

Funding needs to be distributed more towards localities with higher Māori, Pacific, high deprivation and older populations to reflect the higher needs of these communities. Ideally, a sophisticated measure of need would be used as the basis for this distribution. Unfortunately, the system currently lacks the centralised data necessary to produce these measures.

In the interim, Tier 1 funding should be weighted towards high-need populations on the basis of hospital measures of need. This would apply, on average, a 20% higher weighting to Māori and Pacific populations and an even higher weighting for Māori and Pacific peoples in high deprivation areas. While imperfect, these measures do result in a more equitable distribution of funding. This is in line with the findings and recommendations of the Waitangi Tribunal and can be improved over time with new data. This would be used to allocate Tier 1 funding to DHBs and set indicative budgets for localities.

Better data necessary to measure health need

During Phase 2, many examples were found of need measures being developed and tracked based on detailed locally held data. Other countries with more developed data systems can develop more sophisticated measures at individual level.¹⁵⁵ However, these measures cannot be developed in New Zealand because either the health and disability system does not collect the necessary data, or because the data is not centrally collated.

The Review believes that Health NZ, working with the Ministry, needs to invest in the research, data collection and analysis necessary to develop more sophisticated measures of health need. These measures are important not just for informing funding allocations, but essential for identifying populations with the greatest needs, understanding how the system can best meet these needs, and demonstrating whether the system is actually improving health outcomes.

This recommendation is not new. For example, the 2015 review of the population-based funding formula noted the need to improve the quality of data collected and research alternative funding models. Developing, analysing and improving these measures would be a core and ongoing function in Health NZ.

The following would be core to this process.

- ▶ Developing a nationally consistent collection of Tier 1 data including measures of utilisation, quality, outcomes, diagnosis and health status.
- ▶ Analysis comparing health status and service utilisation to understand the level of unmet need across different populations and in different communities.
- ▶ Ensuring all DHBs have costing systems in place and comply with costing standards.
- ▶ Improving financial accounts and reporting to more accurately and consistently measure how much is spent on what and for whom.
- ▶ Analysing other social sector data (eg, the Integrated Data Infrastructure) to better understand the social determinants of health and potential unmet need.
- ▶ Researching differences in access, outcomes and cost of services in rural areas.

Protecting Tier 1 funding

The changes envisioned for Tier 1 are ambitious and would require sustained, growing investment over time. This investment would be supported by the more consistent and predictable growth in Vote Health funding as described in the System Settings section, and by the longer-term contracting arrangements described in the Services Overview chapter.

To further support and grow investment in Tier 1, the Review believes ringfencing around Tier 1 funding is required for the medium term. The level of this ringfence should be set to grow faster than overall funding to provide certainty to planners and providers, and set a clear expectation for all that the system needs to do more to support people in the community.

More flexible arrangements for funding general practice

Contracting arrangements

General practice and general practitioners are a critical part of Tier 1 and would continue to be in the future envisioned by the Review. General practice works on the frontline of the health system and has shouldered a significant burden during a period of low funding increases.

The Review has heard that primary health care funding needs to be reviewed to:

- ▶ account for the higher needs and of people aged over 75
- ▶ ensure equitable funding for Māori and Pacific peoples
- ▶ account for the concentration of complexity in certain areas.

These factors have been considered in the proposed Tier 1 funding allocation to DHBs and localities, and future funding models of general practice should also consider these factors.

However, the persistence of these funding problems reveals a more fundamental problem: the current national process for contracting primary health care services is slow, inflexible and not fit for purpose. The current capitation rates are based, in part, on utilisation rates that are nearly two decades old.¹⁵⁶ Ad-hoc funding streams have been added over time to partially address these issues, but this has created a more confusing funding model.

The Review believes that one nationally negotiated contract with one set of capitation rates and one service specification is not appropriate to cover all general practice services. General practice has a diverse range of different providers (including Māori Health Providers and Pacific providers and nurse-led models) and the role of different providers and workforce would need to be tailored to the needs of the local population.

Across Tier 1, Health NZ should develop minimum requirements for services provided in localities and set commissioning rules and guidance for DHBs. As part of this, Health NZ should develop options for contracting for general practice services. These could include:

- ▶ a capitation-based contract with updated weighting for different populations
- ▶ modular contracts to allow funding to support expanded primary health care teams
- ▶ a contracting framework for working with larger groups of connected providers
- ▶ salaried arrangements to support services in high need and rural areas.

Regardless of the option used, all contracts should be informed by nationally agreed salary scales. This would ensure that:

- ▶ general practitioners are paid proportionate to their capabilities as medical specialists
- ▶ practice nurses are paid equitably relative to their colleagues working in hospitals
- ▶ all workforces are paid fairly regardless of where they work in the country.

With an equitable distribution of funding to localities, funding would target need regardless of the contracting option used.

Co-payment arrangements

In an ideal world, the system should work towards reducing and removing co-payments for publicly funded services. However, service fees are just one of many barriers to access and removing co-payments would not guarantee equitable access to services, let alone equitable health outcomes. Furthermore, given that children and low income households already qualify for free or significantly reduced fees, extending the reduction of co-payments would disproportionately benefit higher-income households.

Consideration has been given to the fiscal cost of reducing co-payments and alternative uses of this funding. The Review believes the top priority for improving the equity of health outcomes is to invest in prevention, population health management, more outreach services and better care coordination.

The Review believes the health and disability system needs to develop improved contracting arrangements to support new models of care. New technologies and embracing a wider Tier 1 workforce bring great opportunities to better meet the need of consumers and whānau, reduce workforce burnout and improve the efficiency of the system.

The Review recognises that different arrangements would work better in different circumstances. Different approaches have been considered, including:

- ▶ subscription models where consumers pay to be enrolled but can access services free of charge
- ▶ employed workforce models with national salary bands and residual risk held by the public system
- ▶ higher, guaranteed capitation payments in exchange for co-payment revenue being collected by the public system.

The Review believes that Health NZ should lead the development of a range of approaches in consultation with the health and disability sector, and DHBs can decide which of these best meets the needs of their community. A mixture of these and other approaches could be used in different parts of the country. Combined with a secure and growing ringfence of Tier 1 funding, this would better support the adoption of new models of care.

Building the future

The Review proposes the following changes

DHBs have the resources and authority for Tier 1

- ▶ DHBs should be fully accountable for planning and organising Tier 1 services on a locality basis for their population.
- ▶ Where a rohe is a defined locality, the plan could be the shared responsibility of the DHB and rūnanga.

Tier 1 services are connected as a network and jointly accountable for outcomes

- ▶ Tier 1 services receiving public funds should be connected as local networks, managed by the DHB. Services within the network should be jointly accountable to the DHB for health and wellbeing outcomes of the locality's population.
- ▶ A mix of service types and business models should be a part of the network, with NGOs and kaupapa Māori services playing a vital role.
- ▶ Contracts for Tier 1 services should, over time, have common requirements that facilitate working in a connected way. These include digital connectivity and data provision for measuring performance and outcomes.
- ▶ The default timeframe for contracts should be longer-term to provide greater financial certainty and stability for service providers, encourage investment and a sense of shared ownership of the network and the population served.

Tier 1 services reflect local populations and needs

- ▶ Each network should be made up of a mix of publicly funded Tier 1 services that address local needs and include guaranteed services with a strong focus on prevention and wellbeing. This should include outreach services, behavioural support, population health services, care coordination, home-based support and medicines optimisation.
- ▶ DHBs should be responsible for ensuring the mix of services is accessible to the population. This would include more services being delivered at home, marae, or schools, at times and locations that reflect the community's needs, and with transport options that ensure reasonable access.
- ▶ If accessibility and availability of services cannot be achieved by existing providers, DHBs should bring in new providers or provide them directly.

A commitment to culturally safe services, including options for Māori whānau to access kaupapa Māori services

- ▶ DHBs should engage with Māori in locality planning to ensure that tangata and whānau needs are considered and prioritised in models of care.
- ▶ DHBs should include provision for kaupapa Māori services in locality planning.
- ▶ DHBs should ensure mātauranga Māori is embedded in all services with the Māori Health Authority providing support and guidance.

▶ *Continued*

Building the future – continued

The Review proposes the following changes – continued

A locality approach drives commissioning of Tier 1 services

- ▶ DHBs should have the flexibility to commission Tier 1 service delivery models that reflect their population’s aspirations and needs.
- ▶ There should be no requirement to contract primary care through the national PHO services agreement. Similarly, Well Child / Tamariki Ora and maternity services should be planned and organised at the DHB level.
- ▶ Health NZ should develop detailed commissioning guidance for a range of Tier 1 services, including a range of contracting options for general practice.
- ▶ Health NZ should have responsibility to ensure consistency in commissioning and contracting protocols.

Equity and prevention is the priority for future funding

- ▶ Tier 1 investment should prioritise prevention and addressing inequities by initially expanding service coverage in areas of highest need.
- ▶ The first priority should be preventive services and services that ensure children, Māori and Pacific peoples achieve optimal outcomes. Investing in a wider range of mental health services must also continue to increase
- ▶ Priority should also be given to introducing medicines optimisation services (eg, for people living with chronic conditions) and new models of care for frail older people and older people with complex health needs.

Equity and ringfenced funding for Tier 1

- ▶ Tier 1 funding should be ringfenced, at least in the medium term, to ensure funding is not diverted to other services.
- ▶ Each locality should have an indicative budget based on the age, ethnicity, and socioeconomic deprivation of its population, which is transparent to the public. This would ensure services address local needs.

8 Disability / Te Huātanga

Increasing numbers of people are living with impairments, and more disabilities are being recognised. The principles of Enabling Good Lives (EGL) should drive service design so that the fact that any individual has an impairment is not what defines their life chances. The system needs to respond to disability becoming more of a norm and must be focused on a nondisabling approach to service design and delivery.

Better health, inclusion, and participation of disabled people must be a priority for action across the whole health and disability system. Disability support system should move away from relying on diagnosis for initiating eligibility for assistance, towards providing assistance to live well, according to an individual's need. Assessment and reassessment processes should be streamlined so that those who require more service coordination support receive this in a timely manner, the need for regular reassessment is reduced, and people gain more freedom to manage their own support. Over time, needs assessment and service coordination services should be integrated into Tier 1 service networks.

Commissioning rules should encourage providers to use more salaried staff with the aim of building a better trained and more secure disability support services workforce and Health NZ should lead a programme of work to engage and support the system to become a leading employer of disabled people in New Zealand.

Disability in New Zealand

An increasing number of New Zealanders are living with a disability. The range of disabilities is diverse and the impacts for people vary substantially. Half of disabled children have had impairments since birth.¹⁵⁷ Throughout life, more people become disabled through illness or injury and many disabled people have more than one impairment or health condition.

The Government has committed to reducing disadvantages faced by disabled people and aspires for New Zealand to be 'a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen'.¹⁵⁸ The health and disability system has a major role in achieving this ambition.

Disability support and funding

Responsibilities for providing disability supports are divided across the system.

- ▶ The Ministry funded \$1.4 billion¹⁵⁹ in 2018/19 for:
 - disability support services for 38,000¹⁶⁰ disabled people, aged under 65 years when they entered the system
 - equipment and modifications (such as to homes and vehicles) - 82,500¹⁶¹ requests from people of all ages, many of whom also accessed other disability supports funded either by the Ministry or DHBs
- ▶ DHBs funded more than \$1.4 billion of support services for:
 - people aged over 65 years: 75,000 received home and community-based support and 33,000 received aged residential care^{162 163}
 - people disabled by mental health conditions and associated social and attitudinal consequences.

These groups are a subset of the total population living with disabilities. The 2013 New Zealand Disability Survey¹⁶⁴ asked participants about their ability to carry out everyday activities that were associated with specific impairment types. The survey identified one-quarter of the population as having difficulty doing everyday things, even with equipment that helps.

The survey showed that disability rates vary markedly across the population:

- ▶ Higher rates of disability are found in families living in high deprivation communities
- ▶ Māori have significantly higher rates of disability across all age bands
- ▶ People aged 65 or over are much more likely to have disabilities (59%) than adults under 65 years (21 %) or children under 15 years (11%).

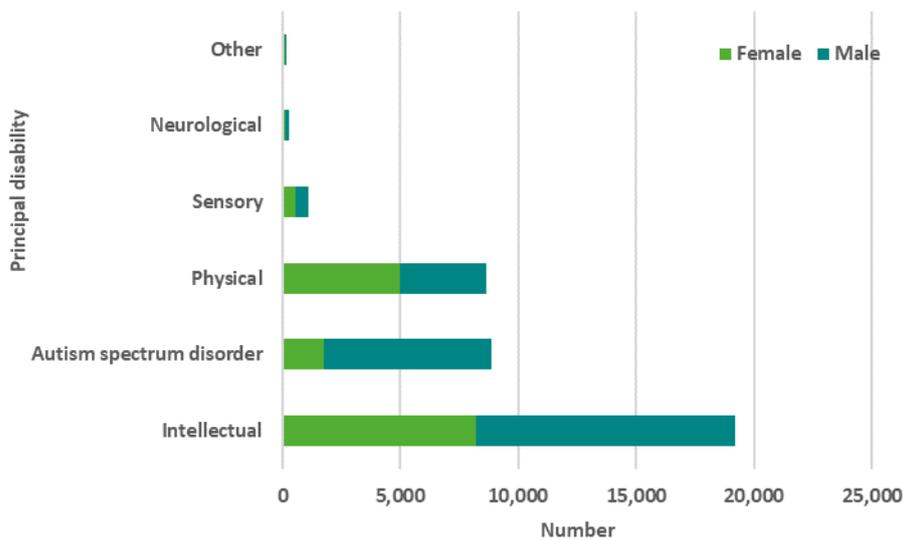
The proportion of people living with disabilities in 2013 was higher than in previous surveys,¹⁶⁵ with the growth driven largely by an ageing population. This trend is expected to continue as the number of people living with comorbidity and complications associated with age increases. The future system will need to recognise this and ensure that supports are in place to address changing needs as living with disability becomes the norm. The system will need to move away from reliance on a diagnosis, to providing assistance to live well according to the need for support.

Understanding the population

Of the people currently receiving Ministry funded disability support services:

- ▶ more than half have an intellectual disability as their principal disability. Many may also have a physical disability.
- ▶ Just under one-quarter (23%) have Autism Spectrum Disorder (ASD) as their principal disability.
- ▶ Just under one-quarter (23%) have a physical disability as their principal disability.¹⁶⁶

Figure 8.1: Number of Disability Support Services clients, by principal disability and sex, 2018¹⁶⁷



European/Other and Māori are over-represented among people receiving disability support services. Asian people are significantly under-represented but have had the highest recent increase with numbers of people who receive disability support increasing by 60% over the last four years.¹⁶⁸ Māori and Pacific peoples are under-represented when compared to Disability Survey aged adjusted prevalence rates. Māori also have higher rates of impairment and comorbidity.¹⁶⁹

There are considerable differences in the types of services accessed across different age groups, ethnicities and disability types, as shown in Figure 8.2.

Figure 8.2: Typical services by age group



The population receiving Disability Support Services and their service mix is changing. The median age of people receiving disability support services has decreased from 31 years in 2014 to 26 years in 2018 due to the large growth in children (driven by the inclusion of ASD in 2014). The adult population has stayed relatively stable with 8% growth from 2016 to 2018, compared to a 20% increase in the number of children aged 5 to 14 years.^{170 171}

In addition, the total mix of people is shifting towards those with higher needs. Between 2016 and 2018, the number of people receiving:

- ▶ low and very low packages decreased by 24.7%
- ▶ medium packages of care increased minimally by 0.4%
- ▶ high and very high packages of support increased by 9.6% and 11.0% respectively.¹⁷²

Challenges that need to be addressed

Challenges identified in the Interim Report include:

- ▶ greater visibility of disability is needed at a system level so that the health outcomes of disabled people are properly focused on and equity is improved
- ▶ more joined-up information, advice, and service delivery within health and across the wider government system
- ▶ a focus on wellbeing and an increase in preventative strategies that make this possible
- ▶ improved services and workforce development, designed around Enabling Good Lives (EGL) principles
- ▶ ensuring whānau and carer needs are an integral part of all aspects of disability service assessment and provision
- ▶ the health and disability system leading by example by employing disabled people.

These challenges are discussed below.

More visibility and integration of disability in planning

The Review faced many of the same challenges sourcing data that those working in the system encounter when trying to develop policies and improve the performance of the system.

Improved data collection and use

Much of the current information on disability is sourced from survey data or contracting and payment systems. Survey information on disability is improving. The Washington Group Short Set questions¹⁷³ that were developed to create robust measures of disability status and promote international comparability in disability data are being used more widely. While useful for understanding disability at a macro level, surveys generally do not provide person-level information.

Data from contract and payment systems can support analysis of disability support services use and expenditure. This data can be linked with health service data through the National Health Index and with wider government datasets through Stats NZ's IDI data collection. There is potential to use this data better for planning services but only a comparatively small number of people can access and effectively analyse all these datasets.

Currently New Zealand does not have readily available patient-level data to identify if a person has an impairment. If available, it could be used by those involved with service delivery or to inform analysis of health outcomes. Some jurisdictions have introduced a disability flag across all health data collections to help improve service delivery and inform analysis of health outcomes. The Review considers it a high priority to improve data collection and sharing of disability data across the health and disability system and with other government agencies. Technological advancements already exist to facilitate this but the lack of investment in data analytics and digital systems has been a barrier to progress. Building an improved national dataset and analytics capability is an essential next step, with consideration being given to whether this should include a disability flag.

Australia developed a 'standardised disability flag', which is intended to be used in all mainstream services data collections (eg, health care, housing, education) to identify people with disabilities or long-term health conditions. The flag is determined through a set of questions that are based on the International Classification of Functioning, Disability and Health.

The flag is designed to provide consistent and comparable information on the interactions of disabled people with mainstream services to understand the gap in health and social outcomes between disabled people compared to the wider population. This is essential for measuring the effectiveness of services in improving outcomes for disabled people, to ensure visibility of disability issues and improve the performance of mainstream services in addressing the needs of people with disability.¹⁷⁴

Engaging with disabled people (both as a consumer and community)

Data is important to inform planning but, equally important, is the lived experience and views of disabled people and their whānau. As emphasised in the Interim Report, the Review considers that:

- ▶ 'greater inclusion and participation of disabled people through all levels and parts of the system [...] are fundamental'.

Consistent with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006), engaging disabled people and their whānau is a valuable way to inform and improve long-term planning, policies, service design and delivery.

Disabled Person's Organisations (DPOs) currently work with government to promote and protect the rights and interests of disabled people. District health boards engage with disabled people through disability reference or advisory groups. At a national level, the Ministry has established a disability sector strategic reference group and Māori advisory group Te Ao Mārama. The cross-government Enabling Good Lives governance and leadership groups are further examples of national and community partnerships.

Some of these engagement approaches are working well, while others have limited influence on planning, decision making and service design. Enabling disabled people to be partners in service design and delivery requires expertise in a wide range of inclusive practices.¹⁷⁵ For example, engaging with tāngata whaikaha and their whānau must come from a Māori world view and there needs to be a commitment to establish and maintain good partnerships with tāngata whaikaha and their whānau, hapū, iwi and Māori communities.¹⁷⁶

A continued shift in culture is needed to give disability communities a real say in the system so they have formal ways to influence, see the changes made because of their input and the results of those changes.

Creating more ways for disabled people, their whānau and carers to get involved would be an important element of DHB strategic and locality service planning.

Improving equity and health outcomes for disabled people

The Interim Report signalled a strong commitment to improving health outcomes for disabled people.

- ▶ 'A focus on living well and preventing the exacerbation of disability should be a priority. This will require more integration both within the system and across other parts of government. Promoting living well for everyone, with and without disability, and preventing different abilities and health conditions from becoming disabling, need to be a focus.'

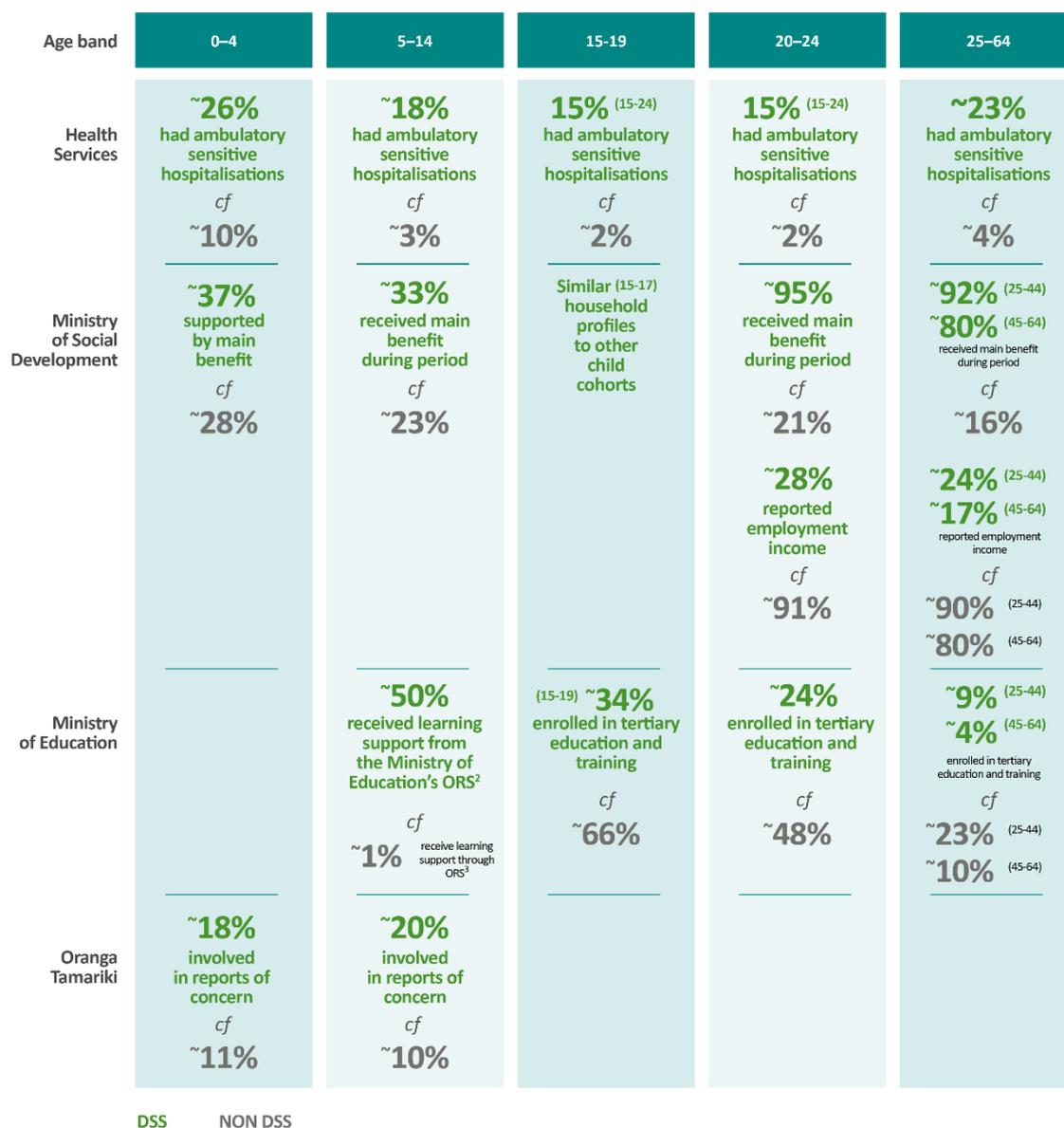
Disabled people, regardless of their age or disability, are high users of the health system. Data suggests that their use of health services is generally at least double that of the non-disabled population.¹⁷⁷ In addition, people receiving disability support services are high users of other government services. For example, disabled people are more likely to receive benefit and employment support from the Ministry of Social Development and use learning support services from the Ministry of Education.¹⁷⁸ (refer Figure 8.3.)

Evidence shows that disabled people have more frequent contact with the health and disability system but do not achieve equity of health outcomes when compared with the rest of the population. They report poorer health than their non-disabled peers and may experience multiple barriers in accessing health services.¹⁷⁹

Research has found that 'physically disabled adults experience a higher prevalence of chronic diseases including arthritis, asthma, cardiovascular disease, diabetes, high blood pressure, high cholesterol and stroke'.¹⁸⁰ National and international research identifies higher rates of chronic illness and early death for people with learning and intellectual disabilities.^{181 182 183} Tāngata whaikaha and Pacific peoples also report higher levels of unmet health need.^{184 185}

Most DHBs have developed disability responsiveness plans with recommendations for change, following in-depth engagement with disabled people and their whānau in their local communities. These plans do have similarities but lack coherency between DHBs.¹⁸⁶

Figure 8.3: Interface with health services and other agencies¹



NOTES:

- 1 The statistics are based on incidence rates over three years to June 2018, except for health indicators which are for the 3 year period to 30 June 2017 due to limited data availability at the time of analysis.
- 2 It is important to note that actual learning support is higher than this once MOE funded services linked to schools (but not individual children) are included, eg funding for teacher's aides. Schools may also provide support not funded by MOE.
- 3 <https://www.educationcounts.gov.nz/statistics/learning-support/ongoing-resourcing-scheme>

Reference: Draft Ministry of Health. 2020. Mana Whaikaha program evaluation – Baseline outcomes analysis results from administrative and population survey data.

In some instances, the plans are high level with limited evidence of measurable, evidence-based improvements. Other initiatives under way in New Zealand, such as health passports, annual health checks and specialist disability coordinators are showing signs of success and should be considered further across the system. ^{187 188}

Health NZ should use its national role to improve health outcomes and track progress in reducing the disparity in health outcomes for disabled people. DHB strategic planning processes should have a specific focus on what is required for disabled people and include tāngata whaikaha in their planning processes. Progress should be tracked against strategic and locality plans from the point of disability identification through to population health outcome assessments.

Delivering services that address inequity and better meet people's needs

If the system is to meet the needs of disabled people, it needs to ensure disability support services fulfil the principles of Enabling Good Lives (EGL): that the fact that a person has an impairment is not what defines their life chances.

Enabling Good Lives

The EGL principles are as set out below:¹⁸⁹

- ▶ **Self-determination** – disabled people are in control of their lives.
- ▶ **Beginning early** – invest early in families and whānau to support them; to be aspirational for their disabled child; to build community and natural supports; and to support disabled children to become independent, rather than waiting for a crisis before support is available
- ▶ **Person-centred** – disabled people have supports that are tailored to their individual needs and goals, and that take a whole life approach rather than being split across programmes.
- ▶ **Ordinary life outcomes** – disabled people are supported to live an everyday life in everyday places; and are regarded as citizens with opportunities for learning, employment, having a home and family, and social participation – like others at similar stages of life.
- ▶ **Mainstream first** – Disabled people are supported to access mainstream services before specialist disability services.
- ▶ **Mana enhancing** – The abilities and contributions of disabled people and their whānau are recognised and respected.
- ▶ **Easy to use** – Disabled people have supports that are simple to use and flexible.
- ▶ **Relationship building** – Supports build and strengthen relationships between disabled people, their whānau and community.

The three Enabling Good Lives initiatives in Waikato, Christchurch and, most recently, MidCentral (Mana Whaikaha) are demonstrating a new approach that has been positively received by the disability sector.

Disabled people and their whānau are making decisions (with assistance as needed) about what supports would work best for them. People who had not previously accessed the system are now accessing services and, with more information about services, some are choosing options that they previously did not think were possible; for example, a group of families pooling funding so their young disabled family members can flat together with support. Some are holding and managing budgets, but the option of individualised funding packages is being used by more participants of the EGL Waikato initiative. In MidCentral, the majority are continuing to access services through traditional approaches.

The role of the tūhono/connector has been particularly valued by disabled people and their whānau.

- ▶ ‘Some successes are that whānau identified that they felt safe and supported, particularly in comparison with previous systems they had engaged with. In addition, whānau reported having positive relationships with Tūhono/Connectors and were appreciative there were Tūhono Māori, noting that they “love that they are Māori, it makes a big difference”. It was also clear in the interviews that open and ongoing communication is critical and strengthens relationships between Tūhono/Connectors and participants.”¹⁹⁰

The Review identified some changes within the health and disability system that have the potential to make a real difference for disabled people. Some of these relate to disability support services and some to health services.

Better access to disability information and advice

Given the varied nature of disability it is not surprising that people, particularly those new to the system, often find it challenging to know where to find information.

While the health and disability system currently spends \$9 million¹⁹¹ to fund more than 100 organisations to provide disability information advisory services (DIAS), there is no central point to access information about disability and wider community supports.¹⁹² Instead, multiple sources exist with the potential for disjointed and confusing information and advice. Significant numbers of people, particularly Māori and Pacific peoples, struggle to find out about or access disability supports and entitlements.^{193 194} While some variation in information sources and channels is helpful in meeting people’s needs, greater consistency and coordination would ensure quality and reliability of the range of information available.

The following changes are proposed to improve access to information:

- ▶ Health NZ should take overall accountability for ensuring that nationally-consistent information and advice about impairments and disability-related supports and services is available and easily accessible through a variety of channels for disabled people, family and whānau. The recommendations in a recent report for ‘national branding of disability in New Zealand’ should be considered further.¹⁹⁵
- ▶ DHBs and, particularly, Tier 1 service networks should play a greater role in providing advice. The proposed integration of needs assessment and coordination services into these networks would facilitate this.
- ▶ All information and digital and data standards should meet accessibility requirements.

Accessing information – what the future could look like

- ▶ A fully accessible website, app and helpline provides consistent information and advice to disabled people and whānau. The website and app are linked to information from other government agencies, as well as to local and specialist information.

Diagnosis and early intervention

Families and carers often experience lengthy delays in obtaining a diagnosis and accessing supports. While this cannot always be avoided, there is considerable scope to improve outcomes by investing in early intervention.

For example, research has demonstrated the benefits of early intervention for children with autism spectrum disorder (ASD). 'Evidence-based practices in early intervention for autism spectrum disorder has the potential to improve children's developmental trajectories and address family needs. [...] Early intervention is a critical component to any ASD service design.'¹⁹⁶

Early intervention in ASD can improve outcomes

- ▶ Children who are part of an early intervention programme before they are three years old experience significantly improved outcomes. When children and young people with ASD receive coordinated support and interventions at home, early childhood education and school there is a greater likelihood of them completing their education,¹⁹⁷ gaining employment and/or having meaningful life outcomes.¹⁹⁸
- ▶ Currently, however, many children are not diagnosed early enough, resulting in critical learning and development time being lost. Access to early intervention programmes for young children is also not readily available.

A lack of data and research, limited long-term planning and the current purchasing model for disability support services has contributed to limited focus and investment in early diagnosis and intervention. Changes that are required include:

- ▶ identifying opportunities to extend the focus of current health checks to support early diagnosis (eg, extending Well Child/ Tamariki Ora checks to include behavioural checks that may assist with early diagnosis of conditions such as ASD)
- ▶ improving information sharing and care planning across the health and disability system to better support early identification and diagnosis
- ▶ increasing the capacity and capability of the workforce and services that undertake the diagnostic and intervention processes.

These changes cannot happen overnight. However, the case for investment should be developed with a view to having improved early diagnostic and intervention pathways in place within five years.

Needs assessment and service coordination

Needs assessment and service coordination services are delivered by 12 needs assessment and service coordination providers (NASCs). Five NASCs cover 13 DHBs (and about 70% of the population) although their coverage is not always contiguous. Also, the scale of coverage varies significantly, from 44,000 to 1.6 million people.

The Ministry of Health's 2013 and 2018 demographic reports show a 19% increase in the numbers of people accessing NASCs over this time period, or around 5% growth per annum.^{199 200} However, funding for NASCs has been largely unchanged. This is one of the factors making it increasingly hard for NASCs to fulfil their role.

Issues with the current NASC system include:

- ▶ the one-size-fits-all NASC system is inefficient, too invasive for many, and slows down outcomes for people
- ▶ people find it difficult to navigate the disability system and wider system(s)
- ▶ some people require service coordination that is more intensive to ensure their needs are met.²⁰¹

A recent review found that scheduled NASC reassessments accounted for 92% of service coordination events and may be putting pressure on the system, potentially for little purpose. An analysis of annual client reviews indicated that for 68% of people, this did not lead to any change in the number, type, or volume of services allocated. Similarly, there was no change for 63% of people at their full three-yearly assessment.²⁰²

This suggests there is considerable scope to reduce multiple reassessments when impairments and support needs are stable. Resources could be better directed towards providing a greater level of support for those who need more assistance to navigate the system.

Disabled people also raised significant concerns about inconsistencies between NASC assessments and the challenges associated with leaving one NASC and enrolling with another if they move.

Significant improvements in the NASC processes are proposed. They include the following.

- ▶ Ensuring that:
 - a nationally consistent needs assessment and funding allocation framework is in place and is used consistently across all NASCs
 - information is shared (with appropriate consents) between NASCs and the requirement to re-enrol is removed when a person moves between NASCs
 - evidence of impairment only needs to be provided once and then updated if it changes.
- ▶ Assessment and reassessment processes should be streamlined so that those:
 - with stable impairment and support needs engage with the system on an as-required basis, rather than having regular assessments
 - who want to, can essentially self-manage by accessing an online portal, where people could decide the supports they require and request these through the portal
 - who need or request more hands-on service coordination can access this in a timely manner. In time this service would be integrated into Tier 1 localities as many of these people may also have high health needs. In Motueka, a similar approach is being trialled where people with complex health needs are connected to services using planned and integrated locality-oriented models of coordinated care.

Streamlining access to supports – what the future could look like

Casey is a graphic designer and has a physical impairment, which is stable. When he first registered on the portal, he uploaded a photo of a letter from his GP as evidence of his impairment and completed a self-assessment.

The portal offered options including speaking with a coordinator online or meeting a local coordinator face to face. Casey didn't need this level of assistance and was pleased he could do everything online. His assessment was processed quickly and he received exactly what he requested – funding for three hours' housework and gardening a week. Casey's funding is paid to him directly and rolls over each year. He understands the process for initiating another assessment if things were to change in his life.

System improvements need to be designed in a way that works for Māori. This includes the growth of kaupapa Māori services and mātauranga Māori models of care.

Current barriers to kaupapa Māori services include inflexible funding models that do not recognise different levels of need and a focus on the individual without acknowledging the needs of whānau.²⁰³ Historical provider arrangements and a lack of system-wide knowledge and capability may be prohibiting the development of services that Māori and Māori communities want.

Disability support services

Around \$1,358 million is spent annually on disability support services.

Figure 8.4: Disability support services - cost and client numbers

Community care

 <p>Personal care 8,300 people \$159m</p>	 <p>Supported Living 4,000 people \$66m</p>	 <p>Home support 7,400 people \$48m</p>
 <p>Respite 4,100 people \$40m</p>	 <p>Caregiver support 15,600 people \$35m</p>	 <p>Community Day services 900 people \$30m</p>

Residential care

 <p>Community Residential 6,900 people \$571m</p>	 <p>Hospitals 600 people \$36m</p>	 <p>Rest homes 200 people \$8m</p>
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Other services

 <p>Child Development Services n/a \$24m</p>	 <p>Behaviour Support 2,800 people \$22m</p>	 <p>Rehabilitation n/a \$11m</p>
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The trend towards using home-based services is expected to continue. However, there is likely to be an ongoing requirement for residential services for many people already in residential care and for some people with complex health needs,

The changes required to better meet current needs are not so much about the range of services available, but more about the design and delivery of them. The EGL pilots have demonstrated that a comparatively small number of people want to budget and manage services themselves. For some, individualised funding packages have provided an opportunity to manage or part manage services in a way that better meets their needs. Access to a coordinator also helps people to plan and change supports as they need to.

Getting more assistance when things are difficult – what the future could look like

Afa and Langi are Tongan and live in Wellington. They have two teenagers living at home and three adult children living nearby. Because Langi has multiple health and disability needs, she works with a coordinator to ensure her wellbeing and that of her kāinga is maintained. Langi was given the choice of having a Tongan coordinator who liaises with the hospital and all services on their behalf.

The coordinator is currently working on getting an accessible bathroom and van with hoist funded for them. The coordinator keeps in close contact with Afa and Langi to plan ahead and ensure any issues are quickly resolved.

More focus needs to be placed on achieving consistent national service coverage, recognising that services may be delivered differently in rural and urban settings. It is also essential that services are culturally responsive (eg, kaupapa Māori services) and focus on improving outcomes for disabled people and whānau.

In addition to the disability support services set out above, around 82,500 requests, from around 58,000 people, are received annually for access to environmental support services.

Figure 8.5: Environmental supports - cost and client numbers

Environmental supports



Around 90% of referrals are for equipment, with the balance being for housing or vehicle modifications. Expenditure on this service is growing rapidly, with a 31% increase over the last five years.²⁰⁴ The option to streamline requests for equipment so that straightforward requests are processed in a more automated way should be considered, particularly where this supports people to live independently. For example, investing in environmental supports can improve outcomes for the individual, family and whānau. It may also result in lower downstream costs for government: if a person can live a more independent life and complete tasks that they previously needed support workers for.

ACC interface with the health and disability system

As discussed in the Interim Report, submitters raised concerns about the inequities between people whose impairments result from injury compared to those whose impairments result from other causes.

ACC provides income compensation and a wide range of services and support, including up to 24-hour home-based support, childcare, and any aids or assistive technology that supports increased independence, including housing and vehicle modifications. Services can be accessed irrespective of income.

In contrast, Ministry-funded disability support services tend to be more restricted and complex to access, particularly for housing and vehicle modifications. Disability support services also provide home-based support services, but anyone requiring 24-hour care will likely be referred to residential services. Some supports are means-tested, such as household management.

The Review acknowledges that some differences in the levels of assistance provided will continue to exist, as ACC is an entitlement-based scheme that compensates people for their injury and loss of earnings.

Calls for all disability supports to be included in the ACC scheme fall outside the scope of this Review and the recent move to a Disability Insurance Scheme in Australia has illustrated the complexity and risks of making such changes.

There are, however, opportunities to learn from ACC's approaches.

- ▶ **Long-term planning and early intervention:** ACC projects lifetime costs for all injury claims which assists with long-term planning. While an actuarial type approach is not suggested for health, the case for early intervention for long-term benefit needs to be given more prominence in future planning and decision-making.
- ▶ **Case management:** ACC is launching a new case management model that gives clients greater control, with much of it being managed online. A dedicated case manager supports those with more intensive support needs. The case management approach is holistic and client directed. It aims to be an agile system that ensures people receive support according to their level of need, with no one being under- or over-served. 'Serious injury' clients can also opt for the 'Living My Life Service' where ACC provides a case manager but a community-based service provides the day-to-day service and can coordinate services from a variety of providers to provide seamless support for the client.

Other actions could include more collaboration between ACC and the health and disability system to develop best practice guidelines for service providers. Joint purchasing with shared service specifications for disability support services could also be considered to ensure that services are delivered with the same standards and quality, whether purchased by ACC or the health and disability system.

To that end, provisions under the Commerce Act 1986 should not be a barrier to joint purchasing between DHBs (or Health NZ) and ACC where this is in the interests of improving health outcomes and equity. At present, legislation prohibits joint purchasing with the health system in all but very few circumstances, as set out in the Accident Compensation Act (2001) (eg, emergency services).

Funding and contracting to provide services

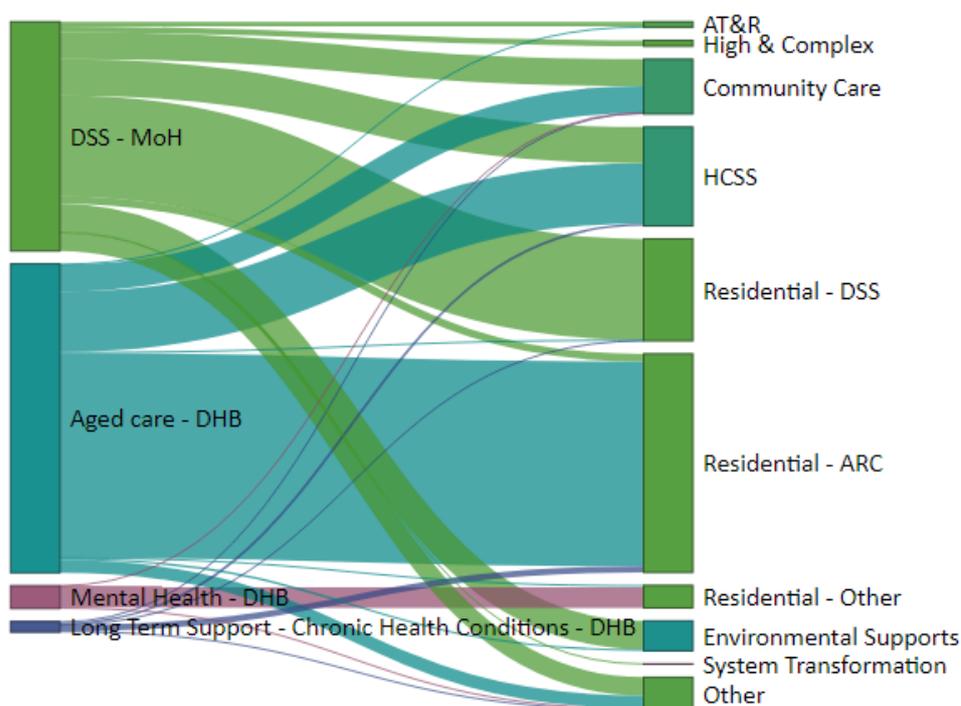
Funding flows

Funding arrangements in the disability system are complex. Government agencies, including the Ministry, ACC, Ministry of Social Development and Ministry of Education, fund disability supports using varied assessment criteria, processes and delivery methods.

Disability support services for people under 65 years are funded mostly by the Ministry. This is inconsistent with other health and disability services, which are largely devolved to DHBs. For example, aged care, long-term support for chronic health conditions and mental health-related disability supports are funded and purchased by DHBs.

The diagram below illustrates the funding flows from the Ministry and DHBs to different service types in 2018/19.

Figure 8.6: Funding flows to different service areas, 2018/19



*DSS = Disability Support Services, ARC = Aged Residential Care [formatting TBC]
 Note that some of the mental health service types are excluded from the flow diagram.

Source: Ministry of Health, Oracle Payments System, FY 18/19

While similar services (eg, home and community support services (HCSS), community care and residential care) are purchased by the Ministry and DHBs, there are often variations of service specifications and pricing. In addition, the high number of providers delivering services, contributes to the complexity of the provider landscape.

Funding for disability support services has not kept up with need. There has been an increase in overspend each year, but no serious attempt to forecast future demand and service requirements, or assess the funding required to deliver these services. Rather, the funding path has been informed largely by spend in the previous year with some adjustment for inflation.

The Review considers that data analytics and better planning is a critical first step to assessing what level of investment is likely required to better meet future requirements for disability support services. This work should be completed before disability support services are rolled into the DHB baseline and funded via the population-based funding formula.

Sustainability of services

The health and disability system should be accountable for ensuring that services are available to people right across the country to meet their support needs. This requires an ecosystem of providers who are paid a fair price for delivering services to the quality and service specification standard set out in contracts. For providers of residential services with five or more beds, certification standards also need to be met.

The current model of service delivery relies on non-governmental organisations (NGOs) to provide many of these services. The disability sector has had regulatory changes in recent years, including settlements for sleepovers, in-between-travel, and pay equity for care and support workers. While funding from the Ministry and Ministry of Social Development has increased over the past 10 years to account for the increasing number of people accessing supports, it has not kept up with cost pressures.

Overall, analysis shows that provider sustainability is becoming increasingly fragile.²⁰⁵ There has been a consolidation of the provider market, generally resulting in larger providers taking over small, often unsustainable providers.²⁰⁶

The Review considers that a sustainable, consistent and transparent funding and pricing model should be developed to ensure sufficient services are available and enable providers to deliver high quality and innovative services.

Purchasing and contract terms

The current contracting and pricing model for disability support services is based on historic arrangements which have been largely unchanged in the past 25 years. An example of this is Ministry-funded residential care, which has different funding models around the country.

Providers that operate around the country may receive different rates for the same service as funding arrangements vary depending on the geographic location and funders (eg, Ministry, ACC and DHBs). This results in a significant administrative burden for both funders and providers.

In addition, a large proportion of disability support services are funded on a fee-for-service basis. While this is easy to administer, it lacks flexibility to address changing needs and provides no incentive to discharge or reduce services for people that no longer need them. It also makes it difficult for providers to introduce new ways of meeting people's needs.²⁰⁷

Various attempts have been made to move towards outcomes-based contracting and reporting for NGO-led services, most recently the introduction of a streamlined contracting framework and outcome agreements for contracted providers. Current analysis suggests there is still a way to go to deliver outcomes through contracting, as the quality of what is requested, data inputs and how it is used for planning purposes has room for improvement.

The Review considers that funding for disability support services should be devolved to DHBs so that it can be managed with primary and community services. It is expected that there would be only a small number of contracts managed nationally for highly specialised services (eg, secure facilities for those under the Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003).

Health NZ should develop a consistent commissioning framework for disability support contracts that aligns with the Tier 1 framework. This should specify core components that must be nationally consistent, while allowing DHBs the flexibility to contract for services that would best meet their population's needs.

Leading by example in employment

Employing disabled people

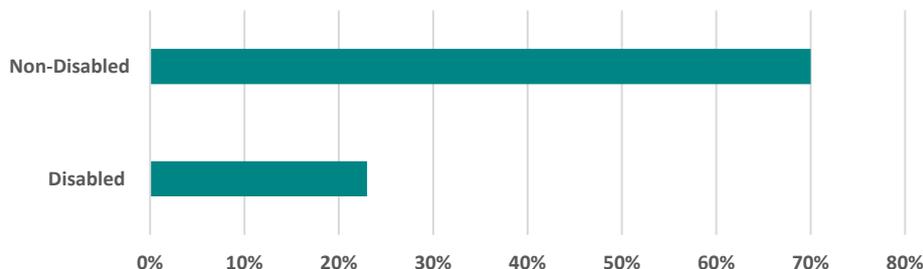
Many disabled people want to work, and some methods that support disabled people into work have demonstrated success.^{208 209} Good work has many benefits – income, social connections, achievement and purpose all enhance wellbeing and lead to better health outcomes. Despite this, employment rates for disabled people are low in New Zealand, at 23% compared with 70% for non-disabled people.²¹⁰ The number of disabled people employed within the health and disability sector is also low. Analysis of DHB and Ministry select committee answers suggests the proportion of disabled people working in the health sector is between 1% and 3%.²¹¹ However, this data is weak, with most DHBs not having this information.

Meeting people's desired outcomes within the current contracting regime.

Marama's daughter Kyra, who has a learning disability, is finishing school at the end of the year. Marama wants to find a service provider who can support Kyra find a job and participate in things she enjoys, such as kapa haka and weaving kete harakeke and rourou.

Marama and her whānau want Kyra to be based at a marae where she can take part in marae-based wānanga and learn work skills, but the local disability providers are unable to offer this. Marama tries an iwi-based social service but they are unable to assist as they have no funding to support disabled people.

After months of further frustration dealing with the system Marama and her whānau decide to provide Kyra's support themselves and not use disability services at all.

Figure 8.7: Employment rate by disability status

Source: Statistics New Zealand. 2019. Employment Gap for disabled people remains high.

As set out in the Interim Report, the Review considers that:

‘as the largest employer in many regions, the system should lead in employing people with disabilities. Boosting employment of disabled people overall may be the single biggest contributor to improving wellbeing of disabled people. Bringing their skills to the workforce in health will also make the sector more responsive, adaptive, inclusive, and reflective of the community’.

The Draft Disability Employment Action Plan is a call to action and states: ‘The Government’s Employment Strategy aims to make sure all New Zealanders can reach their potential to learn skills and find a good job’.²¹² Health NZ should lead a programme of work to engage and support the health and disability system to become a leading employer of disabled people in New Zealand. This work needs to draw on the expertise of disabled people in the design, implementation and review phases, as it would require improvements in flexibility and inclusiveness for both education and workplace environments and cultures.

Factors that increase employment of disabled people include:²¹³

- ▶ leadership – a senior executive who is a disabled person or an ally of disabled people, and disabled people in senior roles
- ▶ employment practices – recruitment, induction, career development, tailored support, and retention practices that are inclusive and accessible
- ▶ accessibility – requirement that all buildings and facilities are accessible to and usable by all people and that employees’ requirements for access are met
- ▶ engaging with disabled people – having formal programmes in place to learn from and address the needs of the disability community and for disabled employees.

Health NZ should learn from international successes. The DXC Dandelion programme,²¹⁴ designed to build valuable information technology skills and careers for people on the autism spectrum, and Project SEARCH in Ireland²¹⁵ are two examples that could be adapted for New Zealand. Developing a career path for disabled people from school into employment in the health and disability sector would be particularly beneficial and start these young people on a positive life trajectory.

There are opportunities to increase the number of disabled Māori in the health and disability system workforce by extending DHB Māori health workforce programmes, which don't currently have a disability focus.

Developing a valued workforce

In the disability support system, the demand for a skilled and caring workforce is expected to increase significantly, due to an ageing population with increasingly complex needs. Retaining and upskilling staff will be critical, as well as attracting new workers with appropriate skills and ensuring that the workforce is delivering culturally responsive services.

This is particularly relevant for home and community support services (HCSS). These services have been delivered by a semi-trained workforce with low wages, low qualification levels and poor working conditions.²¹⁶ Despite recent regulatory changes that include in-between-travel, pay equity for care and support workers and provisions for guaranteed hours, workers are still faced with irregular hours and a lack of job security. In addition, the current system is complex and bureaucratic, as different top-up rates exist for travel times, guaranteed hours and pay equity.

Addressing casualisation – an example of home-based support services

This issue is not restricted solely to those providing home-based support services. To promote the overall growth of a better trained and fairly paid workforce, Health NZ's commissioning rules throughout the health and disability system should specify that the workforce should be predominantly on secure salaried contracts. This would also simplify the current payment system for both providers and the workforce. Simulating this scenario for home and community support services shows that costs and expected gains from moving to secure salaried contracts may be offset, and therefore may not substantially increase costs for the sector.

Project SEARCH's primary objective is to secure competitive employment for disabled people. It was first developed at Cincinnati Children's Hospital Medical Center, which began training people with learning disabilities to fill entry-level posts at the hospital.

Since its inception, Project SEARCH has grown from a single programme to a large and continuously expanding international network. In Ireland, a programme at Naas General Hospital offers young people with learning disabilities an internship programme. Participants rotate through various departments to learn about administration, patient care, customer interaction, catering, housekeeping and general communication skills. The programme has a high success rate in securing paid employment for the interns.

Having secure salaried contracts is expected to help grow a skilled workforce by improving staff retention and attracting new people to the sector. This would help meet future demand. A skilled workforce can better support disabled people using an Enabling Good Lives approach, as well as whānau and wider society. It is expected to improve wellbeing for workers, including the Kaiāwhina workforce, which has a high representation of Māori and Pacific peoples, by providing more job security.

Supporting independence

The workforce should be trained in how to maximise opportunities for people to do things for themselves. The traditional model of care has focused on providing hands-on care with a limited focus on maintaining or building skills. While some providers do promote self-determination and work in a mana-enhancing way, others create dependency that results in a reliance on workers and an ineffective use of the workforce. For example, cooking for someone rather than teaching them how to cook and promoting their independence. There are also opportunities to adopt digital skills and use mobile devices, which has the potential to be transformative in how they enable people to be in control of their daily lives.

Delivering these skill improvements would require more flexible models. Modular training modules that are accessible online and provide group learning support can fit with earn-as-you-learn models and improve health literacy, inclusion and promote independence for all staff.

Building the future

The Review proposes the following changes

Strong focus on improving equity and health outcomes for disabled people

- ▶ Health NZ and DHBs should engage with disabled people including tāngata whaikaha and their whānau as part of the planning and design processes, nationally and locally using a range of inclusive practices.
- ▶ The disability support system should move away from relying on diagnosis for initiating eligibility for assistance, towards providing assistance to live well, according to an individual's need

Better data collection, analytics and meaningful engagement of disabled people

- ▶ Increased capability and use of data analytics to ensure better disability data collection and sharing that would underpin planning and services delivery.

Improved information, advice and early intervention

- ▶ Health NZ should have overall accountability for ensuring that nationally consistent information and advice about disabilities, and disability-related supports and services is available and accessible through different channels; this should be linked into the Tier 1 networks.
- ▶ Well Child / Tamariki Ora or other health checks could be extended to support early diagnosis and early intervention with improved information sharing and care planning across the health and disability system.

Accessing disability support services is an easy process for disabled people and whānau

- ▶ Health NZ should ensure there is a consistent needs assessment framework in place and used across the country.
- ▶ Assessment and reassessment processes should be streamlined so that those who require more service coordination support receive this in a timely manner, the need for regular reassessment is reduced, and people gain more freedom to manage their own support.
- ▶ Service coordination support should work more closely with other agencies to ensure disabled people receive more joined-up services.
- ▶ Over time, needs assessment and service coordination services should be integrated into Tier 1 service networks.

▶ *Continued*

Building the future – continued

The Review proposes the following changes – continued

Disability support commissioning and funding transitions to Health NZ and DHBs

- ▶ Health NZ should develop a consistent commissioning framework for disability support contracts that aligns with the Tier 1 framework and supports the integration of purchasing of these services. The framework should specify core components that should be nationally consistent, while allowing DHBs the flexibility to contract for services that best meet their population's needs.
- ▶ Funding for disability support services should, over time, be devolved to DHBs so that it can be managed with Tier 1 services.
- ▶ Health NZ commissioning rules should aim at building a better trained and more secure disability support services workforce.
- ▶ Health NZ commissioning rules should specify that the majority of services should be supplied by workforces on a secured salary basis and that salary rates should be consistent.

The system is a leading employer of disabled people

- ▶ Health NZ should lead a programme of work to engage and support the system to become a leading employer of disabled people in New Zealand.

9 Tier 2 / Taumata 2

While changes to models of care should support more care being delivered in the community, hospitals will always be needed to treat complex conditions and acutely unwell patients. It is expected that for the foreseeable future, growth in demand will continue to outstrip population growth.

Tier 2 services in the future should be supported by technology and focus on caring for more patients with complex conditions and providing virtual and outreach specialist advice.

They should be organised as a cohesive network of providers, working across settings and closely with Tier 1 to deliver care for all New Zealanders. Streamlined planning, design and funding arrangements should enable a cohesive service delivery system, and rural communities should be specifically planned for.

The challenge for the health and disability system is to make the changes required to ensure that hospital demand is stemmed to the greatest extent possible, while investment planning addresses the state of current assets, capacity pressures and workforce needs.

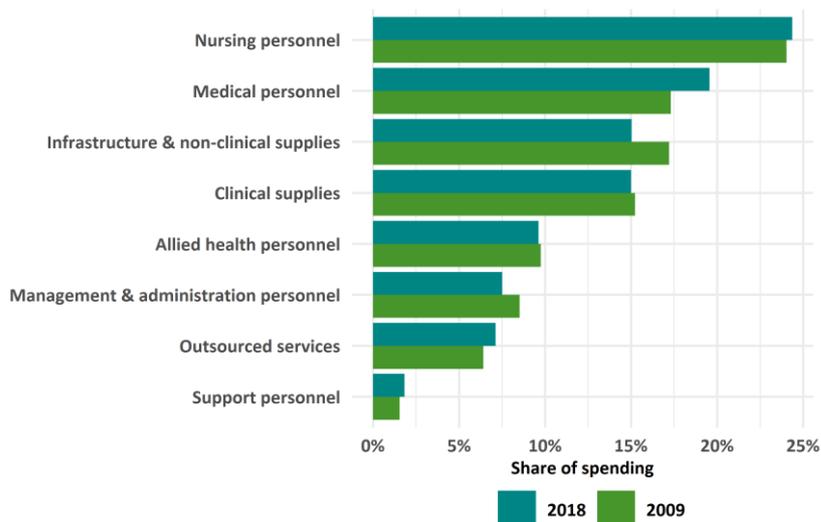
Delivering Tier 2 services

Tier 2 services play a significant role in health and disability service delivery and make up a significant proportion of health spending. Tier 2 encompasses public and private hospital (excluding aged residential care) and specialist treatment and diagnostic services. Services are provided for local populations, as well as regional and sometimes national catchments. Tier 2 boundaries are blurred as specialist services are also delivered in the community and Tier 1 services can be located in hospital facilities, particularly in rural communities.

DHB expenditure on Tier 2 services

In 2018/19 around \$8.8 billion of DHB expenditure was for Tier 2 services. The majority (63%) of spending was on personnel, as shown in Figure 9.1 below.

Figure 9.1: Share of DHB spending by category, 2009 and 2018²¹⁷



Source: Ministry of Health, DHB financial accounts

Between 2009 and 2018, the proportion of DHB expenditure on:

- ▶ medical personnel increased more than other personnel categories
- ▶ management and administrative personnel, infrastructure and non-clinical supplies decreased.

Almost all DHBs are spending more than they receive, leading to financial deficits. Much of this is attributed to demand and wage pressure growth in DHB provider arms that largely deliver Tier 2 services. Deficits as a percentage of revenue are now at the highest level since the mid-2000s, the forecast deficit for 2019/20 is \$559 million.²¹⁸

Current Tier 2 service delivery arrangements

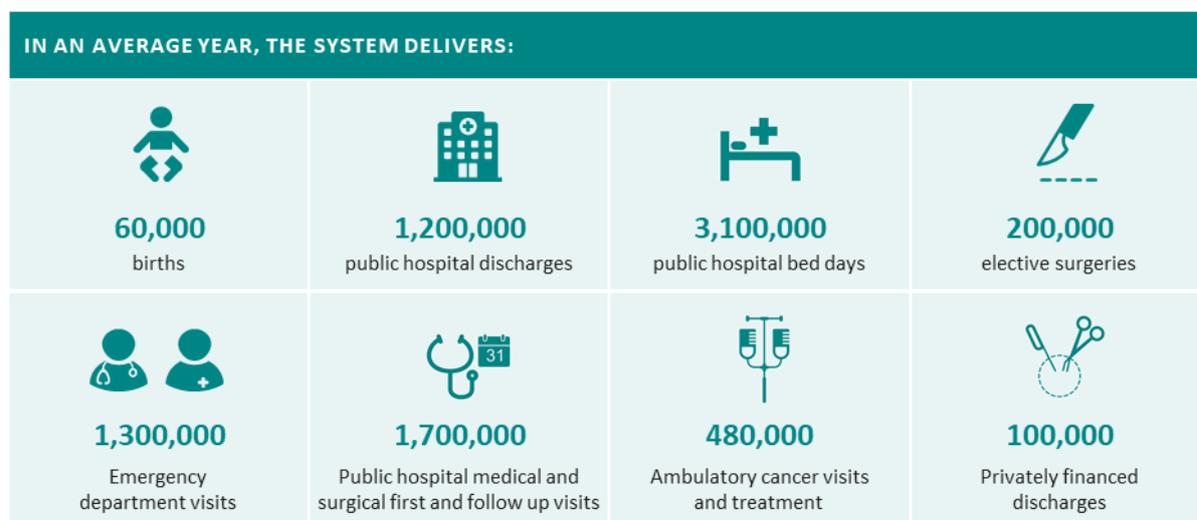
Most Tier 2 services are delivered by DHBs. All have at least one hospital that provides a core set of local services, including an emergency department. In larger urban centres DHBs may have more than one campus.

In total, there are around 90 public or community-owned hospitals that vary considerably.

- ▶ **Size and complexity:** large urban hospitals have from 650 beds to more than 1,000 (Auckland City Hospital), mid-sized provincial hospitals have 200 to 400 beds and smaller community hospitals have fewer than 100 beds. The complexity of services able to be provided tends to increase with hospital size.
- ▶ **Service range:** Some hospitals provide a full range of services while others provide only one service; for example, only maternity services, mental health services or elective services.

Private hospital providers also have an important role in the health care system. They provide extra capacity to the public system for planned care and provide around 100,000 privately funded hospital discharges each year. There are about 75 private surgical hospitals and a wide range of specialists working in private practices.

Figure 9.2: Snapshot of Tier 2 services 2016/17 and 2017/18

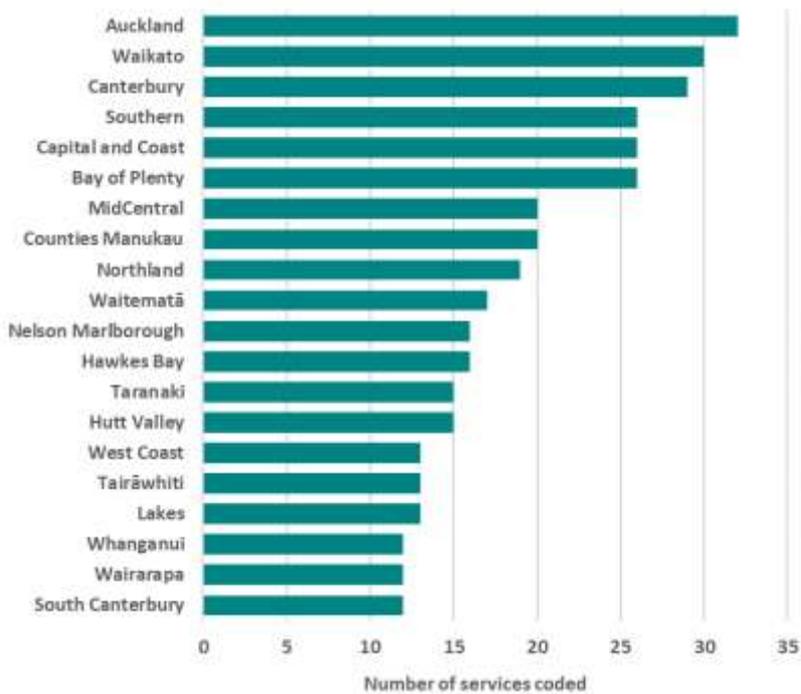


Source: Interim report, Ministry of Health private hospital discharges, NNPAC, NMDS

Current patient flows

There are a core of around 12 to 13 personal health hospital services including general medicine, general surgery, emergency departments, paediatrics and maternity services offered by all DHBs. As DHB populations grow, the range of services offered by the DHB increases (refer to Figure 9.3), but all Boards rely on another board to provide some services for their domicile population.

Figure 9.3: Personal health admitted events: number of services by DHB²¹⁹

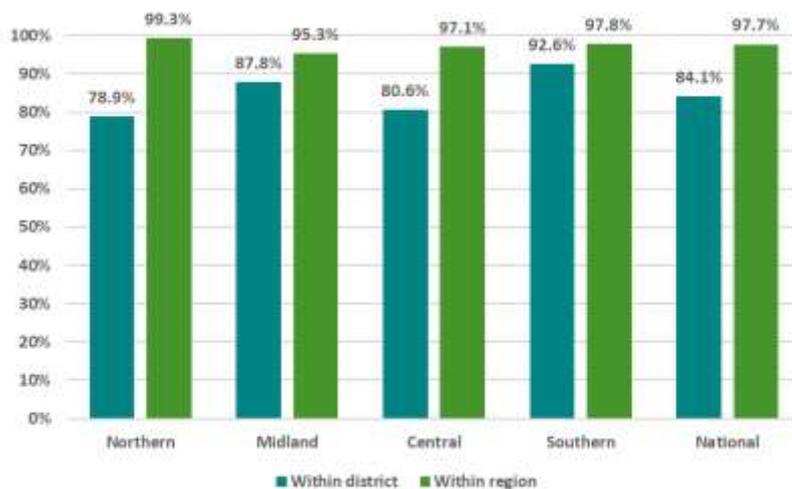


Source: Ministry of Health inter district flows analysed by HDSR review team

Further analysis of current patient flows, using inter-district flow (IDF) data, (refer Figure 9.4) shows that on average:

- ▶ DHBs provide 84% of inpatient services for the population in their district
- ▶ Less than 2% of patients are required to travel outside their region for treatment.

Figure 9.4: Regional comparison of IDFs by value year 2017/18²²⁰



Source: Ministry of Health inter district flows

The need for small volumes of patients to travel for high complexity inpatient services is likely to always be necessary given New Zealand’s comparatively small population, but there are many examples of services that were initially provided in one or two hospitals now being routinely provided in most DHBs. There has also been a steady stream of new, highly complex services being offered at a restricted number of hospitals. This is expected to continue.

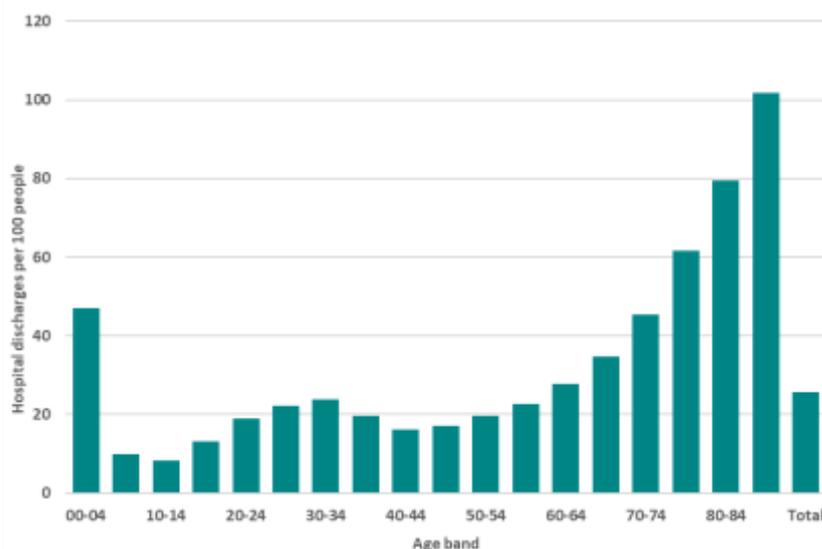
Demand for Tier 2 services

New Zealand’s population is changing

Population growth and changing demographics will have a significant impact on hospital services. People are living longer, and they are living longer in poor health. An increasing number of people are living with long-term health conditions and multi-morbidities. This is particularly so for Māori, Pacific peoples, refugees, disabled people, and people living with a mental illness.

As the proportion of the population aged over 65 increases, so too will the demand on services. People aged 65 and older are more likely than younger people to be diagnosed with cancer or have a stroke, diabetes, heart disease, chronic pain or arthritis. This, coupled with frailty and multi-morbidities, contributes to greater complexity and longer lengths of stay when older people are admitted to hospital (refer to Figure 9.5).

Figure 9.5: Hospital discharges per capita by age 2016/17²²¹

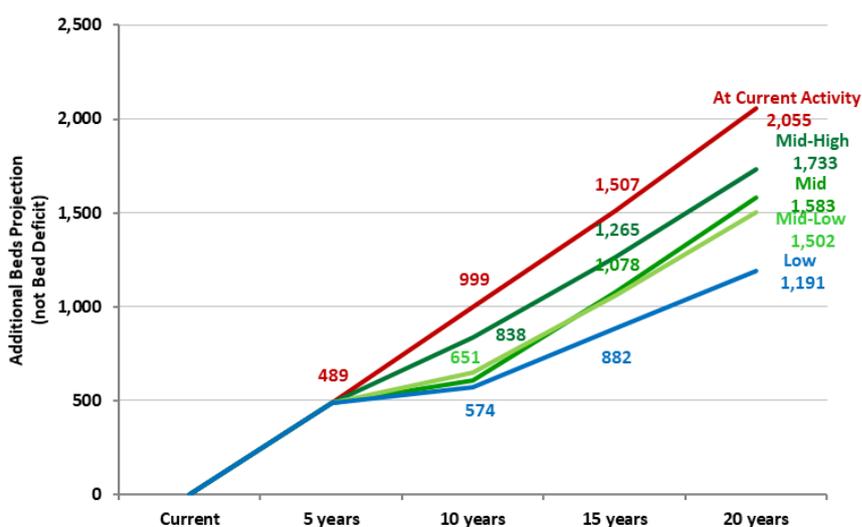


Sources: Discharges from Ministry of Health publicly funded discharges 2016/17, Population data from Statistics New Zealand

In 2018, people aged over 65 accounted for 15.8% of the total population, 34.5% of all hospital discharges and 53.0% of acute bed days. If this trend continues over time with nothing done to ameliorate demand growth, around 38% more capacity (around 4,000 more beds) would be required in 20 years.

The Northern region has completed detailed modelling of bed requirements as part of the development of their long-term investment plan. Figure 9.6 below shows the growth trajectory of beds in the Northern region assuming a range of growth paths and demonstrates that even with the highly ambitious lower growth rate, a significant increase in capacity is required. Adding 1,000 beds is the equivalent to a very large new hospital.

Figure 9.6: Bed demand forecasts in Northern region²²²



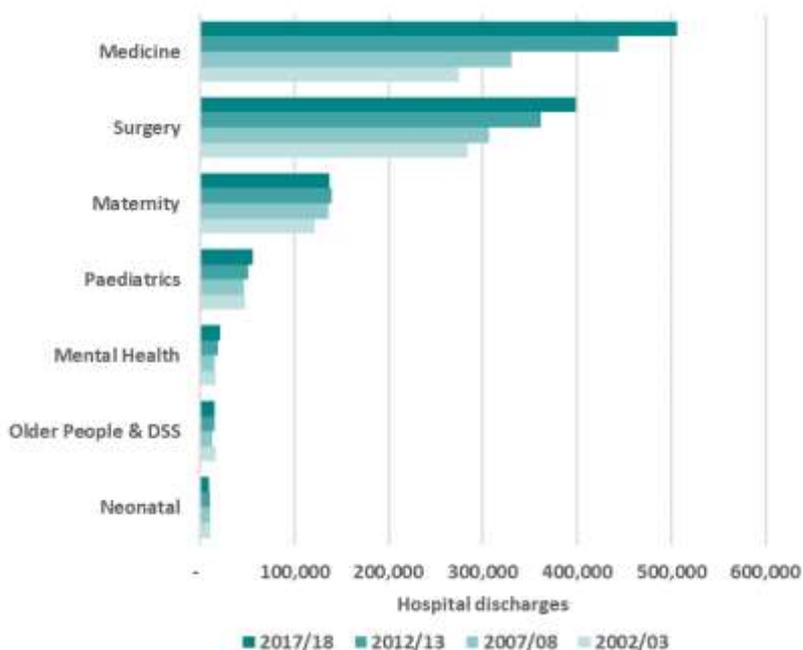
Source: Reproduced from Northern Regional Alliance. 2018. Northern Region Long Term Investment Plan, Figure 14, p71.

The Northern region’s analysis considered how adopting more preventive and community models of care might slow the demand for hospital services. It also assumed that it would take time for changes in models of care to flow through to hospital volumes, with the potential for activity to increase as current unmet demand flows through the system.

Hospital discharges and bed days

Over the last 15 years, hospital discharges have increased by 49% compared with 20% population growth. The growth rates have varied by specialty group (refer to Figure 9.7), with the highest growth rates happening in surgery and medicine.

Figure 9.7: Growth in public hospital discharge by major service group 2002 to 2018²²³



Source Ministry of Health NMDS

While there has been a steep increase in hospital discharges over the last 15 years, there has been much slower growth in bed days. Changes in technology, clinical practice and models of care have resulted in more care being delivered on a day case basis and in community settings and reduced lengths of stay in some services.

At the same time, there has been limited investment in additional acute hospital capacity, so hospital bed numbers have not increased in line with population growth.

This growth has been accommodated by:

- ▶ operating hospitals at higher than optimal occupancy rates
- ▶ using capacity that was intended primarily for surges in demand (eg, winter peaks, disease outbreaks)
- ▶ continuing to use facilities that are no longer fit for purpose.

This has resulted in many hospitals being stretched to a point where emergency escalation plans for managing excess demand are routinely being used. This is especially the case for major acute hospitals where there is very little surplus capacity to provide the buffer that is required for unplanned short- or medium- to long-term demand pressures.

The future role and delivery of Tier 2 services

While demand for hospital services will grow due to population changes, this is only part of the picture. The future role of hospitals and delivery of Tier 2 services will also be heavily influenced by changes in technology. They include:

- ▶ virtual specialist, telemedicine and other virtual health support that will reduce the need for patients to travel and support rural communities to deliver more local services
- ▶ greater use of robotics in a range of activities, from ancillary services such as linen delivery through to surgical procedures²²⁴
- ▶ improvements in productivity through increased use of digital processes such as patient scheduling, workforce rostering
- ▶ greater use of artificial intelligence and deep learning-based algorithms to improve clinical decision-making processes^{225 226}
- ▶ increasing the quality and efficiency of patient care through the improved sharing of data within hospitals, between providers and with patients²²⁷
- ▶ advances in medical care including precision medicine based on patient genomics and personalised medicine based on the combination of pharmaceuticals paired with a diagnostic test²²⁸
- ▶ using real world data to assess and improve service models, treatment and technology.

The hospital of the future should be better supported by technology, be focused on caring for more complex patients, and provide virtual and outreach specialist advice.²²⁹ The expectation is that it would also be better integrated into the community so that people could access specialist expertise without needing to visit hospital. As some services move out of the hospital the services that remain are likely to be more highly technical and cater for increasingly complex and frail older populations.

Addressing current demand, while shifting to future models of care

While changing models of care should support more care being delivered in the community, hospitals would still play a key role for patients with complex conditions and those who are acutely unwell. To continue to provide high quality specialist health services, the workforce would also continue to grow, and increased investment would be required.

It is unrealistic to expect all growth for tier 2 services to be addressed solely through efficiency gains, technology changes or by devolving services to the community.

The challenge for the health and disability system is to make the changes required to ensure that hospital demand is stemmed to the greatest extent possible, along with planning that recognises significant investment in hospital facilities would be required to address capacity issues. Investment would also be required to replace facilities that are either in poor or very poor condition or are not fit for purpose, as discussed in Chapter 13: Facilities and equipment.

Planning and designing a cohesive system

New Zealand Health Plan would set the direction

There was a consistent view from those working in the current health and disability system that the short-term and fragmented nature of planning and the requirement for DHBs to meet zero or low deficits every year negatively affects how the sector works.

There has been very little work done recently on national Tier 2 services planning and there is limited guidance available to support any systematic analysis and decision-making about what services should be provided where or with what other services. The health and disability system does not have a coherent services planning framework or a national overview of the configuration of publicly funded services.

New Zealand needs a highly functioning hospital network to continue to deliver world-class health care and to deal with a growing and ageing population. The hospital network would need to manage current delivery, respond to growth, have the resilience to manage crises and work to reduce inequalities in health outcomes and treatment. The Interim Report outlined concerns over access and fragmentation of services that impact on health outcomes and on the sustainability of the system.

Responding to these pressures would require a smart network able to plan and deliver high-quality services and make good prioritisation decisions. The New Zealand Health Plan (described in the Governance and funding chapter) would set out what Tier 2 services are required to meet the future needs of New Zealanders. It would also set out how these are best delivered across the Tier 2 network, balancing considerations of access, clinical viability and financial sustainability. It would establish what services should be delivered where in the country, with equity being paramount to the decision-making about access to services.

The NZ Health Plan would provide a blueprint for service delivery arrangements over the next 10 to 20 years, rather than making wholesale changes in where services are delivered in the short term. The NZ Health Plan would, in turn, inform the regional and DHB strategic plans that include more detailed Tier 2 service planning for the short and medium term. It is expected that all plans would map out a cohesive service delivery system. By setting the direction for Tier 2 service delivery, the NZ Health Plan would also provide the information required to develop national facility, equipment, workforce and digital plans.

A clinical services capability framework should guide Tier 2 services planning

To develop the Tier 2 components of the NZ Health Plan, internationally developed clinical services capability frameworks (also called role delineation models) should be used as the starting point for analysis.

Australian Role Delineation Models (RDM) are examples that could be considered. They have been adapted previously in New Zealand when long-term planning work was last done.

Prior planning work and role delineation models

The Long-term Systems Framework (LTSF) was an extensive piece of work done between 2007 and 2009 that developed thinking around a longer-term, more joined up health and disability system. While the LTSF contributed to new thinking and tools, a full services plan was not completed. Disagreement on what services should be provided where has since led to many delays in planning new hospitals.

The LTSF developed a New Zealand Role Delineation Model. This categorises services along a six-level continuum from community services (level 1) to supra-complex services (level 6). General acute and elective hospital services are level 3. Complex services at level 4 and above are generally grouped together because of the complex infrastructure needed to support them.

DHB	Facility name	Emergency Medicine	Medical service	Oncology & Haematology	Surgical services	Maternity & Neonatal	Paediatric services
Tairāwhiti	Gisborne Hospital	3	3		3	3	3
Whanganui	Whanganui Hospital	3	3		3	3	3
Wairarapa	Wairarapa Hospital	3	3		3	3	3
West Coast	Grey Base Hospital	3	3		3	3	3
South Canterbury	Timaru Hospital	3	3		3	3	3
Lakes	Rotorua Hospital	4	3		3	3	4
Northland	Whangarei Hospital	4	3	4	3	4	3
Taranaki	Taranaki Base Hospital	4	4		3	4	4
Bay of Plenty	Tauranga Hospital	4	4	4	3	4	4
Nelson Marlborough	Nelson Hospital	4	4	4	3	4	4
Hutt Valley	Hutt Valley Hospital	4	4		4	4	4
Hawkes Bay	Hawke's Bay Hospital	4	4		4	4	4
Waitemata	North Shore Hospital	5	4		4	4	2
Counties Manukau	Middlemore Hospital	5	4		4	5	4
MidCentral	Palmerston North Hospital	5	4	5	4	4	4
Southern	Dunedin Hospital	5	5	5	5	5	4
Waikato	Waikato Hospital	6	6	6	5	5	4
Capital and Coast	Wellington Hospital	6	6	6	5	5	5
Canterbury	Christchurch Hospital	6	6	6	6	5	5
Auckland	Auckland City Hospital	6	6	6	5	6	6

- ▶ For each level of service, the model describes the minimum support services, workforce, the hours of access and other requirements for clinical services to be delivered safely. A full assessment of DHBs against an RDM framework was last done in 2009.
- ▶ This assessment showed that the smallest five DHBs provided local services from a level 3 facility, supported by several rural facilities operating mainly at level 2 (discussed in more detail later in this chapter). Regional lead hospitals provided a wider range of services at a mix of level 5 and 6. Individual DHB assessments will have changed since the last assessment, for example, increased local provision of oncology services, but level 5 and 6 services being concentrated in 6 to 8 hospital is expected to be largely the same.
- ▶ Although the New Zealand RDM has not been updated, Australian models have continued to develop into more comprehensive expectation setting frameworks (also called clinical services capability frameworks)

Adopting a framework such as the RDM would help develop a blueprint for what services would be best delivered, nationally, regionally or in all DHBs, and in how many locations within a DHB.

National services planning

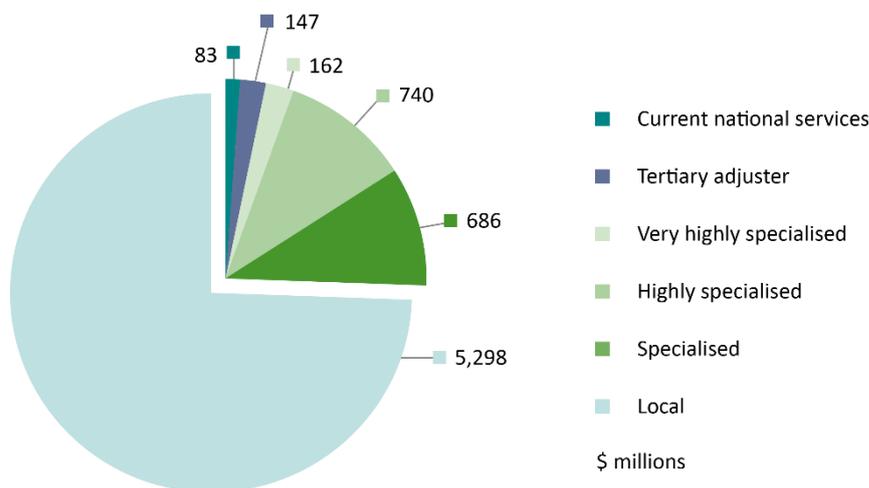
Very highly specialised services are offered by a few DHBs. From the analysis of service flows described in previous sections these represent a relatively small proportion of all services. Currently, planning and funding for these services is spread among DHBs and the Ministry.

Planning for these services should be led by Health NZ and aim to:

- ▶ ensure equity of access for everyone to highly specialised services
- ▶ ensure the best possible clinical outcomes within the funding available
- ▶ provide more certainty about the total funding that would be provided for current highly specialised services and to develop new national services
- ▶ reduce unnecessary duplication, thus promoting clinical quality and cost effectiveness
- ▶ share the costs where incidence is sporadic, and treatment involves specialist skills or expensive equipment.

The sorts of services that are likely to be the focus of national services planning work in the near term are set out below in Figure 9.8.

Figure 9.8: Analysis of DHB personal health services funding (\$ millions) specialist services²³⁰



Some service examples for each level of specialist services

Current national services		
RDM level 6	<ul style="list-style-type: none"> • Paediatric Cardiac • Paediatric Metabolic • Paediatric Rheumatology • High Cost Burns(adjuster only) 	<ul style="list-style-type: none"> • Clinical Genetics • Heart Lung Transplants • Hyperbaric Services
Very highly specialised services		
\$162m RDM level 6	<ul style="list-style-type: none"> • All services where there are out of region transfers to lead DHBs for high level care. For example renal transplants, ECMO (extracorporeal membrane oxygenation), all national burns 	
Highly specialised services		
\$740m RDM levels 5 and 6	<ul style="list-style-type: none"> • Services provided by a regional lead not available from a mid-sized hospital. For example cardiac surgery, some cancers services 	
Other specialist		
\$686m RDM levels 4, 5 and 6	<ul style="list-style-type: none"> • Services provided by a regional lead or mid-sized DHB but not available from the smaller 7 DHB hospitals. For example cardiology, lower complexity cancer services, renal 	

Source: Ministry of Health inter district flows analysed by HDSR review team, data mix of 2017/18 and 2018/19 information

The intention of national service planning is not to see services centralised to one location but, rather, to ensure equity of access and the clinical and financial sustainability of these services. Specialist services planning should not only set expectations about the inpatient service requirements but should also set expectations about how outreach services would be provided and the respective roles of the referring and treating DHBs.

Funding for national services

As discussed in the Governance and funding chapter, Health NZ would fund the majority of secondary Tier 2 services using a population-based funding formula. However, for highly specialised services where a small number of providers would deliver these on behalf of multiple DHB populations, funding should be from a Health NZ service agreement, with clear service expectations set. Such agreements would be negotiated on a three- to five-year basis and would include a transparent analysis of costs of service provision.

Some high-need and high-cost patients access multiple services and drugs and, in these cases, a risk pool for a patient group could be more effective than national service planning and funding.

Regional services planning

Regional services planning would provide an opportunity for DHBs to consider what service configuration would best meet needs of their collective populations. Regional plans would include the mix of services that the region considered would be best delivered in different hospital settings including major hospitals, specialist hospitals (eg, mental health, elective surgical hospitals), levels 3 and 4 hospitals, and local community and rural hospitals.

DHBs should engage with iwi, communities, local government, social sector agencies, NGOs, private providers and communities when developing these plans.

Over time, this planning process would likely lead to agreed shifts in service delivery arrangements as decisions are made to:

- ▶ deliver services in more settings where the technology or clinical practice changes mean this can be done safely and cost effectively, and where this is important for patient access
- ▶ consolidate services where there is an opportunity to improve quality, safety and outcomes of care and to deliver services more cost effectively.

Contracting for regional services

Improved regional planning would also support improved regional services contracting and should reduce volatility with longer-term contracts. Where regions agree that a lead DHB would provide services for other DHBs, they may agree to do this via a 'regional top slice' rather than an inter-district flow (IDF) model. In the medium term, the volume of unplanned IDFs would decrease substantially as the combination of national services funding, regional longer-term contracts and DHB mergers happen. These changes should reduce volatility and support longer-term operational planning. However, IDFs would still continue for patients treated outside their own DHB where no national or regional agreements are in place.

Operating as a cohesive system

It is expected that hospital and specialist services would operate as a cohesive network working across all care settings and locations, and work collaboratively with Tier 1. The focus would be on providing care in the most appropriate setting with the right team of people engaged in delivering that care, to improve access and deliver more equitable health outcomes for New Zealanders.

For Tier 2, this would mean making services local where increased access would improve equity and population health (eg, chemotherapy). It would mean consolidating or continuing to provide services from a small number of hospitals for quality, clinical sustainability or cost effectiveness reasons (eg, paediatric surgery, major burns, acute spinal cord impairment, clot retrieval).

Working across settings and geographic boundaries

Geographic boundaries between DHBs are meaningless for patients and should become less important in the day-to-day delivery of care. So too should the boundaries created by the terminology used between service settings. The workforce needs to be able to work across these boundaries in a more collaborative way, supported by technology that enables them to share information and engage with patients and clinicians located in different parts of the health and disability system.

The proposed changes to Tier 1 are an opportunity for DHBs to rethink patterns of care for local services. This should build on and encourage quicker adoption of initiatives that many DHBs are already trialling.

Case study: Kāpiti see-and-treat service

Unnecessary emergency visits and inappropriate admissions to hospital are stressful for older people and their whānau and can pose a risk of rapid deterioration in health or further harm (eg, acquiring an infection).

- ▶ Capital & Coast DHB has collaborated with local general practices, the Kāpiti Health Advisory Group and Wellington Free Ambulance to provide emergency and after-hours care closer to home for Kāpiti residents.
- ▶ Following clinical assessment by Wellington Free Ambulance paramedics, patients can receive free urgent care from their GP at their local centre from 8am until 10pm. Prior to this initiative, more than 6,200 Kāpiti residents travelled to Wellington Hospital emergency department every year seeking after-hours treatment. More than half travelled by ambulance and fewer than 50% ended up requiring hospital admission.
- ▶ Reducing the number of patients who travel from Kāpiti to Wellington Hospital alleviates the strain on available resources, benefiting the hospital and ambulance system, and patients and their whānau.²³¹

The Interim Report noted the potential use of pathways to reduce variations in service and ensure greater coordination between care settings. Pathways are a tool that DHBs can use to improve integration and coordinate care across the network. Care pathways aim to link evidence to practice for specific health conditions and can be used within a DHB to connect hospital and Tier 1 services or connect local and regional hospital services. All providers should operate collectively to ensure that effective care pathways improve access, equity and patient experience.

Service development should be clinically led and use local and international evidence to more systematically determine investment (including health technology assessments) and disinvestment decisions. Clinical networks that operate across the health and disability system should play an important role in developing pathways that ensure there are:

- ▶ strong connections between Tier 1 and Tier 2
- ▶ transparent processes in place for standardising access across the health and disability system
- ▶ protocols in place for providers to access facilities where they are not directly employed
- ▶ pathways extended to services that have not always been included, such as palliative care.

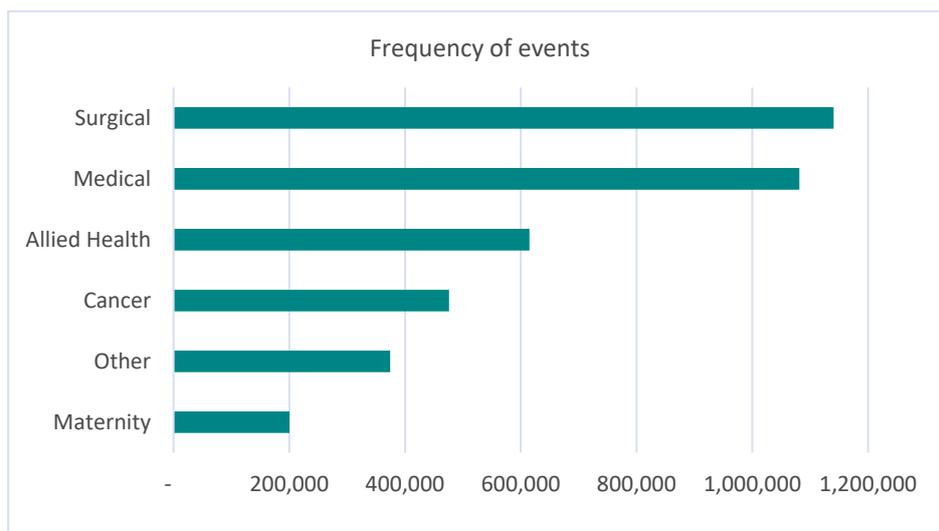
In the same way as a significant change is proposed in how Tier 1 engages with consumers and whānau, so too must change occur in Tier 2. This should include engaging patients more in their care plans, ensuring that transfers of care are more seamless and coordinated, and ensuring that planned care is delivered at times and in ways that are more accessible for the population using them.

Improving access to Tier 2 services

Improving access to hospital services would improve patient care and address equity issues. Hospital services are free but there are costs involved in attending care: time off work, child care, parking and travel. Problems with access are higher for high-needs populations: rates of ‘did not attend’ are significantly higher for Pacific peoples and Māori.

Analysis of patient flows shows that about 80% of out-of-district treatment is for ambulatory care that does not require an overnight stay. Many patients also have to travel long distances to get to their local hospital. Most of this activity is for outpatient attendances and treatments or procedures associated with this.

Figure 9.9: Non-admitted activity, 2017/18²³²



Source: Ministry of Health inter district flows analysed by HDSR review team

The quality of data captured in the non-admitted datasets is not as complete as the inpatient datasets and there are inconsistencies between how DHBs record activity. This makes it hard to develop an accurate picture of service utilisation patterns or trends. Nonetheless it is reasonably clear that the time and travel costs associated with these attendances falls most heavily on people living in rural areas. Even when services are within a local DHB, there can still be considerable patient time and travel costs involved.

Analysis suggests that on a weekday, every hour, there are around 2,000 people waiting for an appointment somewhere in our health and disability system. Assuming there is three hours of time per visit (which is conservative), this amounts to 11 million hours of time per year that patients are just travelling or waiting.

The magnitude of this time cost alone demonstrates why future service planning should prioritise reducing travel and time costs by offering virtual options where possible and by ensuring that coordinated appointments or 'one-stop clinics' become the norm when face-to-face visits are required.

There are a number of strategies to reduce travel for ambulatory care:

- ▶ using telemedicine for advice and appointments
- ▶ coordinating appointments across different specialties
- ▶ specialists visiting smaller DHBs, localities and rural facilities
- ▶ using paramedics to perform health care interventions on site, reducing the need for the patient to travel to hospital.

Virtual care delivery

Many of the strategies to reduce travel for ambulatory care are beginning to be adopted but need to be more widely delivered. The requirement for national and regional services plans to set out how access would be equitable would require consideration of how to reduce the burden for patients and their whānau. Service design processes will need to ensure the needs of their communities are best met.

This would likely include specialist advice and support being provided via telemedicine. The barrier is no longer technology; what is now required is to recognise that clinical rosters should routinely include virtual sessions as well as face-to-face sessions. It is unrealistic to expect the increased level of virtual access to specialists to happen unless it is built into rosters.

Transport costs

The transport and accommodation costs to attend specialist services are a barrier for many people. The national travel and accommodation policy supports access by recompensing patients and whānau for some of the costs associated with travelling for treatment.

The Review supports further analysis that considers travel and accommodation within the goal of improving access.

A 2018 review of the national travel and accommodation scheme was constrained by the lack of information on the impact of the current policy on access.

'At this stage, we would not understand the degree of investment required to make a real impact on improving population outcomes and equity.'²³³

Scheduling appointments

Access can also be improved by allowing patients to book their own appointments and there being extended clinic hours. This would minimise the need for time off work or the need to find child care. Longer opening hours could also use costly resources such as diagnostic equipment and outpatient clinics better.

The following case study demonstrates how Auckland DHB tackled did not attend/was not brought cases using a combination of patient-focused bookings, referrals to Tier 1 and outreach services. The outcomes were improved access for Māori and Pacific children.

Case study: Reducing Starship Did Not Attend (DNA)/Was Not Brought (WNB) – A whānau-centred approach boosts successful child outpatient care

Starship Hospital has implemented changes to reduce the number of outpatient appointments that Māori and Pacific children were missing. Analysis had identified that on average around 12% of total outpatient appointments were being missed and that rates for Māori and Pacific children were double this.

Starship talked with parents and caregivers to find out what the issues were from their points of view. Many had children with multiple medical problems and coordinating appointments with different Starship departments was a big issue for them. Inefficiencies such as data and address errors, and missed follow-up were also identified, all contributing to difficulties.

Starship has adopted a new patient and whānau-focused scheduling service that works with those who have not attended, talking directly and scheduling appointments to work better for caregivers: where possible at community locations that are easier to get to, with transport assistance provided and multiple appointments grouped together.

A Pacific social worker supports aiga whose children need to attend the club foot clinic, so they can understand the value of the care and have help with practical issues that can get in the way of coming. Extra support may be coordinated with schools, community health teams or NGO cultural and social workers.

The new whānau-friendly approach is being phased in across Starship's departments. The diabetes, endocrine and respiratory clinics where it first started have seen significant improvements. There has been a marked decrease in missed appointments rates, with:

- ▶ rates for missed appointments in the diabetes service dropping from:
 - ▶ 23% to 7% for Māori children
 - ▶ 27% to 10% for Pacific children
- ▶ rates for missed appointments in patient focused booking services dropping from:
 - ▶ 26% to 18% for Māori children
 - ▶ 31% to 14% for Pacific children.

These are early results as the programme continues to roll out across all services.

Services designed for rural communities

There are approximately 45 rural facilities that are either DHB owned or owned by the local community. They are part of a local network of services and meet three broad functions.

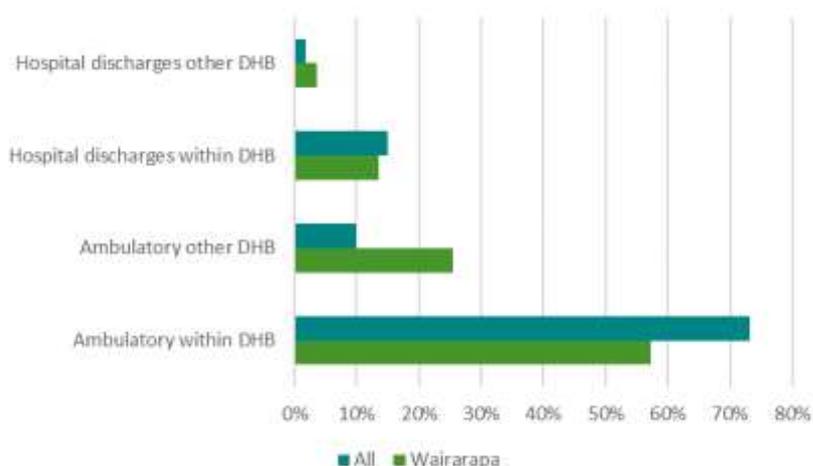
- ▶ They minimise the need to travel to a main hospital by providing some local hospital-level services.
- ▶ They provide a local base for DHB-provided community services.
- ▶ They fill gaps in the network, for example, GP services, palliative care, aged care.

Larger rural facilities provide 24/7 emergency and acute medical services, elective general surgery, specialist medical and surgical consultations, primary maternity, maternity consultations, allied health services, community care and nurse-led clinics. Other facilities provide aged care and palliative care. Smaller facilities offer limited emergency cover and GP managed beds. About a quarter of facilities have no overnight services but provide community and nursing services. The arrangements that are in place have in many instances not been deliberately planned but rather have evolved. Some are serving their communities well, others not so well. The Review considers that a more deliberate approach should be taken to planning for rural services

Rural practitioners have different roles, often with broader scopes of practice compared to their urban counterparts. To acknowledge this the clinical services framework should have a separate section for rural facilities that would describe their specialist roles. This would provide an opportunity to develop a best practice rural hospital model based on examples already in place in New Zealand and overseas.

As noted previously, a major concern for rural communities is distance and travelling costs and time. For example, as shown in Figure 9.10, the Wairarapa population travels out of their DHB more often than the average, with most for short outpatient visits and treatments.

Figure 9.10: Wairarapa population's travel out of DHB area compared to the national population 2017/18²³⁴



Source: Ministry of Health inter district flows analysed by HDSR review team

The Review noted many instances where rural services provide good examples of local adaptation, with models of care using different workforces to ensure local requirements are met and initiatives in place to reduce patient travel. However, there is also acknowledgement that more should be done to prioritise initiatives (such as telemedicine and coordinated outpatient visits) that would improve access for rural communities.

Most DHBs either own or contract with one or more facilities to provide local services to support their rural communities. Some rural facilities may be at the heart of a community's rural Tier 1 network while providing some Tier 2 services.

The challenges faced by each rural community are determined by local population characteristics and geography, so the solutions would need to be local. However, there are opportunities to learn from each other and from overseas. The Review recommends that Health NZ works alongside existing rural health groups to support nationwide collaboration to share local and international innovations in rural health care delivery.

Emergency transport

Emergency transport services are a core part of service delivery and a well performing ambulance service is a prerequisite for ensuring patients are transferred to care as quickly as possible.

Ambulance services in New Zealand

Table 9.1 provides an overview of ambulance services in New Zealand. The majority of funding for these services comes from the Ministry and ACC, with the remainder from DHBs, co-payments, sponsorships and donations.

Road ambulance is provided by Wellington Free Ambulance (WFA) and St John, who also manage the three communications centres and provide staff, including for telephone triage (outside of Healthline), call and dispatch, the air desk and clinical desk.

Air ambulance is currently organised in three regions, with one contracted provider in each region, and nine local providers. Aeromedical staff for most emergency missions are primarily St John and WFA trained paramedics, with DHB staff deployed for inter-hospital transfer.²³⁵

The National Ambulance Sector Office (NASO), currently operated from within the Ministry, manages funding and service agreements for ambulance communications centres, emergency road ambulance services and air ambulance services, on behalf of both the Ministry and ACC. Over the last few years NASO has been working with its parent agencies and the ambulance sector to develop more consistent and sustainable joint funding approaches.

NASO also has a broader, strategic role, in progressing the Ambulance Services Strategy and providing a 'single voice for the Crown on strategic and operational matters regarding the Emergency Ambulance Services'.²³⁶

Table 9.1: New Zealand ambulance services²³⁷

Service	Details
Road ambulance	<ul style="list-style-type: none"> ▶ Emergency response: Ranges from immediately life-threatening or time critical (eg, serious injuries, cardiac arrests) to potentially serious but not immediately life-threatening incidents. Ambulances with at least two crew members bring clinical care to the scene. Patients are transported to emergency departments or other facility (eg, GP, A&M clinic) if needed, based on patient condition and available options. ▶ Low acuity/non-urgent response: Patients who do not require transport (eg, gastrointestinal illness, influenza) are attended by an ambulance crew or other specialist staff and are provided with care at the scene. They may then be referred to their GP or another clinical pathway. ▶ Patient Transfer Service (PTS): Transports patients (planned and urgent) between facilities for higher level care or interventions and returns patients back to their communities. ▶ Primary Response in Medical Emergencies (PRIME): Uses specially trained GPs and nurses to support ambulance services in rural areas. Fills need where response times may be longer than usual, or where more specialised medical skills are needed.
Air ambulance	<ul style="list-style-type: none"> ▶ Pre-hospital (emergency) service: Used when patients cannot be accessed by road, timeliness of care or transport is critical, or when there is a large number of patients. Mostly uses helicopters. ▶ Inter-Hospital Transfer (IHT): Transports patients from a less specialised hospital to more specialised care. Mostly uses planes.
Telephone triage	<ul style="list-style-type: none"> ▶ Over-the-phone triage: by a registered nurse or paramedic, or the caller is connected with Healthline. Responses include advice on self-care, referral to a GP or private A&M centre, or sending an ambulance or other vehicle to treat on site or transport.

The future role of ambulance services

While the predominant role of ambulance remains transfers to hospital, this is changing. There are a number of programmes already underway where ambulance staff provide a broader role such as providing treatment at home, treating at the accident location, and following up low acuity patients at home. The Kāpiti 'see-and-treat' service, described earlier in this chapter, is an example of a community based model of care, using the paramedic workforce differently to avoid unnecessary hospital admissions.

Within rural areas, ambulance services play a particularly important role, and new roles and ways of working that are being led by ambulance services should be encouraged.

In the future, DHBs would be expected to have transport plans in place to better support patient and whānau transfers where required. Where capacity allows, new models of care involving ambulance services and the paramedic workforce should continue to be developed in the community.

The Review was made aware of issues and challenges in the current arrangements for air ambulance. These included challenges associated with appropriately planning for the two types of air ambulance services, differing specifications between providers making it challenging for the fleet to be optimised nationally and the impacts of sharing workforce between road and air ambulance. These issues were exacerbated during the roll out of new contracting arrangements.

The planning for ambulance services is complex as it is an integral part of many areas of service delivery, ranging from low acuity non urgent responses, to Tier 1 emergency responses, through to inter hospital transfers for paediatric intensive care patients and multi trauma patients. Ensuring access to the appropriate fleet and the effective deployment of this fleet and the workforce delivering care, requires vast clinical and operational experience and close working relationship with the Tier 2 services that are the recipients of most of the transfers.

The Review considers that ambulance services should be planned together and nationally managed. Road ambulance services should be managed to consistent national standards. NASO should continue its role, although in the future this would shift to Health NZ and there should be a more collaborative engagement with Tier 2 and Tier 1 providers in delivering these services.

Performance improvement embedded in the system

Performance management should be more holistic, bringing together outcomes, services, financial and consumer assessments to improve quality and clinical excellence in a system underpinned by continuous learning.

Equity issues and unwarranted variation need to be addressed

Reducing unwarranted variations in access to services and health outcomes that currently exist across multiple areas, including ethnicity, socioeconomic deprivation and locality must be a focus of the system in the future.

Māori experience of hospital services is characterised by poorer access, poorer outcomes and being exposed to institutional racism. The Health Quality & Safety Commission recently reported on Māori health equity.²³⁸ They found inequities in health outcomes and access and quality of care. For example:

- ▶ for Māori, diseases of old age start earlier, life expectancy is lower by seven years than non-Māori and deaths preventable by health care are 2.5 times as frequent as for non-Māori, non-Pacific peoples
- ▶ hospital appointments are not accessible for more Māori adults than non-Māori adults
- ▶ sixteen percent of Māori adults did not attend a specialist appointment between 2011 and 2014, compared with 6 percent of non-Māori
- ▶ specialist appointments have unacceptably long wait times and happen less frequently for Māori
- ▶ Māori have twice the number of hospital bed-days following an acute admission than non-Māori
- ▶ the percentage of Māori having an operation for their hip fracture on the same or next day of admission to hospital following a fall has decreased steadily since 2013, whereas the percentage for non-Māori has consistently improved (best practice is to treat as soon as possible).

The Review considers that improvements in Māori health outcomes require hospital and specialist services to be provided in ways that are culturally safe, and for Tier 1 and Tier 2 services to operate as a single system that ensures specialist services are more accessible for Māori communities.

Strengthening hospital performance and quality improvement

The triple aim provides a framework for assessing the performance of the health care system on three dimensions.

- ▶ Improve health and equity for all populations.
- ▶ Improve the quality, safety and experience of care.
- ▶ Ensure best value for public health system resources.

Our hospitals generally perform well against key indicators, and ultimate outcomes such as life expectancy continue to improve. There are, however, concerns about unwarranted variation in health outcomes by population group and concerns with financial sustainability.



The Health Quality & Safety Commission plays an active role in monitoring and improving performance. It provides analysis and commentary on the variation in the outcomes and quality of health care in several reports, including the Atlas of Healthcare Variation.

The Health Quality & Safety Commission also collects inpatient experience surveys across DHBs. The results suggest wide variation between DHBs, particularly with communication and medications, which are essential for patient safety.

While the Health Quality & Safety Commission is well respected for the function it provides, it is not accountable for ensuring that these variations are addressed. The Ministry provides some targeted hospital performance support, for example, in supporting improvements in the delivery of planned care, but lacks a holistic approach to supporting poor performance such as through using analytics, guidance and hands on support. Feedback from DHB quality managers supports the current quality work programme of the Health Quality & Safety Commission but would like to see the following additional support:

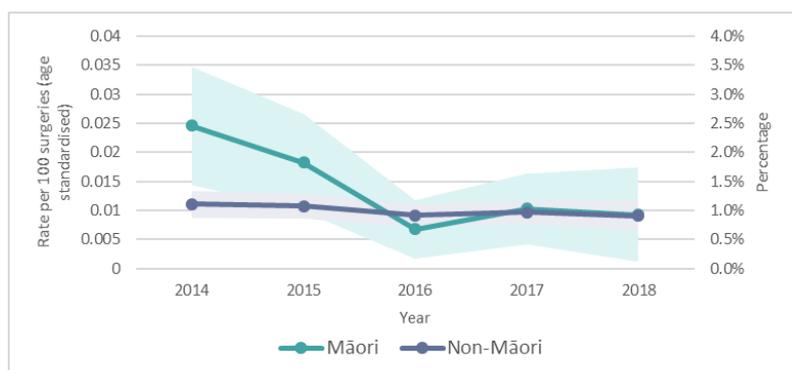
- ▶ a consolidation of resources on hospital standards and service quality expectations into a national policy framework available as an online toolkit for all DHB staff
- ▶ national quality standards and improvement training materials available for DHBs to use that are delivered locally
- ▶ a stronger national commissioning approach to the role delineation of facilities and services.

Atlas of Variation

The Health Quality & Safety Commission has facilitated a number of improvement programmes that have demonstrated the benefits of close attention to best practices and learning from larger groups of clinical teams across DHBs. Improving safety and quality has also led to more equitable care, quality and results.

- ▶ One example is lessening infections after hip or knee surgery. In 2014, Māori were more than twice as likely to experience a surgical site infection than non-Māori. An intensive national programme with multiple clinical teams delivered improvement activities that by 2018, had led to lower infection rates across all patients and dropped rates for Māori to equal the new, improved rates for non-Māori. Nationwide, improvements tracked closely with uptake of the programme activities. An evaluation found the risk profile of patients did not change and the programme improved patient outcomes and reduced costs to the system.²³⁹

Reduced orthopaedic surgical site infections for Māori and non-Māori 45 years and over 2014 to 2018²⁴⁰



Source: Health Quality & Safety Commission.2019. A window on the quality of Aotearoa New Zealand’s Health Care 2019: A view on Māori health equity. Wellington: Health Quality & Safety Commission.

- ▶ The Atlas of Healthcare Variation²⁴¹ allows people to examine hundreds of indicators across 23 domains, looking at geographic and ethnic spread. The dashboard of health system quality²⁴² allows anyone to see an overview of DHB performance across a selected group of indicators. DHBs can compare their results with those across the country and look into where improvement is needed.

Focusing on performance of hospital and specialist services

The Review is recommending greater focus on performance and delivery across the health and disability system. Health NZ would need to strengthen performance management functions and hold DHBs accountable across a more holistic performance management framework that brings together outcomes, services, financial and consumer assessments with the aim of supporting quality improvement and clinical excellence in a system underpinned by continuous learning. Strong clinical engagement would be essential.

Given current DHB financial pressures, driven largely from DHB provider arms, the initial priority for Health NZ should be the performance of hospital and specialist services.

The Ministry and DHBs collectively develop national reference prices each year that are used for hospital services IDF payments. There have been several issues raised by both payers and providers about the accuracy and fairness of these prices and the robustness and timeliness of current national pricing.

Improved costing information is required for national, regional and local purchasing. It is also an input to DHB hospital performance management and is used as an input for any other analysis that needs to know the cost of hospital outputs.

To support better costing and pricing, all DHBs should contribute the financial and cost data required under the Operating Policy Framework. There should be increased investment to curate and use this data to inform costing, national pricing (which may include tertiary and secondary prices) and performance management. This would allow Health NZ to set fair prices and also provide some of the information required to support the analysis of hospital performance.

DHBs would be expected to routinely submit all performance management information currently required by the Operating Policy Framework. Robust systems should be in place to provide consistent, timely information that could then be consolidated into a meaningful national view. Health NZ should develop platforms that provide open and collaborative sharing of hospital cost and performance data, and improve the quality of reporting and analysis.

Building the future

The Review proposes the following changes

Hospitals and specialist services operate within a national plan, and have clear regional and local plans

- ▶ The NZ Health Plan should provide a system-wide view of Tier 2 services and identify national and specialist services, where these would be provided and how equitable access would be ensured for all New Zealanders.
- ▶ Regional and district strategic plans would provide more detailed service plans for short- medium- and long-term timeframes.
- ▶ Health NZ should fund most secondary Tier 2 services using a population-based funding formula. Where there is agreement that services would be provided nationally funding should be via a top slice negotiated on a three- to five- year basis.
- ▶ Where a region agrees that a lead DHB would provide services for other DHBs, this may be funded via a regional top slice.
- ▶ The IDF process should be streamlined so that service changes are incorporated more quickly and there is greater transparency of IDF flows.

Hospitals and specialist services operate as a cohesive network

- ▶ Hospital and specialist services should be delivered through a network that works closely with Tier 1. Boundaries between DHBs and care settings should become less distinct.
- ▶ The majority of Tier 2 services should continue to be delivered in each DHB, but complex services should be led by agreed providers consistent with the national services plan or regional agreements.
- ▶ Rural services planning should recognise the unique challenges of geography and distance. Service delivery should be integrated (and may be delivered from the same facility) with Tier 1 services and be routinely supported by using telemedicine and telemetry links with Tier 2 service providers.
- ▶ Service development should be clinically led and use local and international evidence to systematically determine investment and disinvestment decisions.
- ▶ Enhanced integration and seamless transfers of care should underpin service design. Technology should support enhanced access to specialist advice, and admission and discharge planning should routinely involve a care management focus from both Tier 1 and Tier 2 perspectives.
- ▶ Tier 2 services should be delivered for extended hours to improve efficiency and consumer access and clinical rosters should routinely include virtual sessions as well as face-to-face sessions.
- ▶ DHBs should have transport plans to better support patient and whānau transfers where required. Air ambulance services should be nationally managed and road ambulance services should be managed to consistent national standards.

▶ *Continued*

Building the future – continued

The Review proposes the following changes – continued

Effective performance management systems are focused around high-quality, cost-effective service delivery

- ▶ Health NZ should work collaboratively with the sector to address unwarranted variation and drive sustained, better-quality care and better value for money.
- ▶ The Health Quality & Safety Commission should continue to monitor and improve the quality and safety of health and disability support services; and help providers across the health and disability system to improve the quality and safety of health and disability support services.
- ▶ Health NZ should enforce the open and collaborative sharing of hospital cost and performance data and improve the quality of reporting and analysis.
- ▶ DHBs should have robust systems in place to routinely provide data specified in the OPF that can be consolidated into a meaningful national view, and provide additional information when required.

Māori Commissioning - An alternate view / He Mana Kōmihana Whakae Tino Rangatiratanga Pou Tarawhao – Tō Tātou Mana Kōwhiri

Introduction

Commissioning is a strategic and ongoing process using purchasing and other strategies to translate population health objectives into a responsive system and services. The purpose of the Alternative View is to provide analysis and commentary on the future of Māori commissioning within the health system. The Alternative View is included in the report because the members of the Review Panel did not reach consensus on Māori commissioning and the authors of this section are committed to providing a vision of the future that they believe gives practical expression of Te Tiriti o Waitangi principles, rangatiratanga and mana motuhake through Māori commissioning roles that are embedded within and throughout the health system.

Māori commissioning

The findings in the interim report were clear that, overall, Māori have not been served well by the system. It has not consistently delivered on the development of commissioning talent; nor has it delivered the services and practices required to create the change or performance improvements needed to address Māori health inequities and wellbeing.

This report provides examples of system changes that should benefit Māori, but it does not recommend a fully empowered commissioning role for Māori. The report recommends, amongst other proposed changes, that the role of the Māori Health Authority includes commissioning Māori workforce development programmes and Māori provider development programmes, and the managing of innovation funds to improve Māori health outcomes. The report also envisages a role for the Māori Health Authority to advise on commissioning in partnership with HNZ and DHBs to ensure that the whole system is accountable for Māori outcomes.

These proposed changes are limited in their scope. The equity challenges that Māori face demand more than a clearer mandate for Māori policy development, more than the simple identification of strategy execution failures, and more than the identification of the systematic disadvantaging of Māori and Kaupapa providers by contracting arrangements. Similarly, the equity challenges demand more than a partnership role for Māori in the commissioning process because, in the worst case scenario, this would mean that Māori have little more than an advisory role.

In summary the changes proposed in the report are positive and would be beneficial for Māori. The Alternative View argues that the vision should be more ambitious. The recommendations, as they stand, do not provide the opportunity for Māori expertise to be fully empowered, they perpetuate universalist approaches that have not worked for Māori, and they fail to give expression to tino rangatiratanga because the Māori Health Authority has only a limited commissioning role and holds what is, relatively speaking, a small and marginal budget.

The Alternative View envisages a potentially transformational future where the Māori Health Authority has a role to commission health services as well as enabler services for Māori using an indigenous-driven model within the proposed system to achieve equity. The Alternative View is that, over time, substantial Māori commissioning roles should be incorporated within an integrated health system. This would provide the capacity and leadership required to alter the trajectory of Māori health inequities. In this view of the future, the Māori Health Authority would be established as a kaupapa Māori entity (Māori owned, governed and operated). An example of this type of approach is a recent model associated with revitalising te reo Māori (Te Mātāwai). The Māori Health Authority would be a full commissioner in its own right, operating within a coherent and unified system, as well as being required to support national, regional and local commissioning and workforce developments.

Consideration needs to be given to establishing a more consistent and focussed funding stream that prioritises Kaupapa Māori services and does not necessarily depend on DHB priorities. Such a funding stream would recognise the multi-sectorial nature of Kaupapa Māori services and the importance for Māori of early intervention coupled with better management of health-specific, social and cultural determinants of health.

As well, a Mātauranga Māori commissioning frame, which builds on the Whānau Ora Commissioning model and recognises the inseparability of health, education, housing, income, and civic responsibilities, warrants further consideration and would enable Mātauranga Māori to be prioritised and led by Māori experts.²⁴³

Conclusion and recommendation

As outlined in the interim report, there is significant evidence that universal health systems have not improved health outcomes for Māori, and existing health services design, purchasing and contracting approaches have increased inequity. The findings of the Hauora Report (Wai 2575) highlight the systemic bias in our health system and amongst those who determine health priorities and funding matters.

A comprehensive indigenous commissioning framework should be developed, which uses every enabler and lever, at every level, to ensure the system successfully delivers improved health and wellbeing outcomes for whānau. The commissioning framework should be Tiriti compliant and designed by Māori as an active expression of rangatiratanga and mana motuhake, in a way that is not possible within mainstream organisations, such as HNZ and DHBs, with broader population responsibilities. The time is right for action around a broader indigenous commissioning framework in Aotearoa/New Zealand, that could be world leading in addressing inequity at system and service levels.

A potential Indigenous Māori commissioning framework

Local		
Appropriation	Commission/Co Commission	Notes/examples
<p>Devolved to DHBs with decision-making authority shared between the DHBs and iwi/Māori</p>	<p>Local iwi/Māori are supported by Māori Health Authority in 50/50 governance arrangements to oversee and co-commission with their DHB partners all health services to their population.</p>	<ul style="list-style-type: none"> ▶ A 50/50 governance model has recently been confirmed by the Minister of Health in the Northern Region. This includes ADHB, WDHB and NDHB partnering with their respective Iwi. A new partnership has been established called “Northern Iwi-DHB Partnership Board”. ▶ The Partnership Board has legally delegated authority to determine Māori health equity priorities and outcomes; lead, advise and guide Treaty of Waitangi compliance, and oversee resource allocation and investment for Māori wellbeing. ▶ These new models will require increased support for iwi / Māori to develop skills in population health, commissioning tools and strategy. ▶ They will also need to be informed by local health needs analysis, long term service plans and Māori health strategies. ▶ They will be enabled further by the proposed new investment and ring-fenced Tier 1 funding. ▶ The commitment to a 50/50 local DHB and iwi governance model aligns with the proposed HNZ Board configuration model. ▶ Future commissioning role to be considered.
Regional		
Appropriation	Commission/Co Commission	Notes/examples
<p>Devolved to DHBs with decision-making authority shared between the DHBs and iwi/Māori</p>	<p>Regional iwi/Māori are supported by Māori Health Authority in 50/50 governance arrangements to oversee and co-commission regional equity strategies that are planned collaboratively, at scale and with greater specialist Māori expertise.</p>	<ul style="list-style-type: none"> ▶ Regional collaboration and planning with clear investment strategies. ▶ Te Manawa Taki in Midland is an example of regional equity planning. ▶ All Midland DHB Chairs have entered into a MOU to partner with their Iwi equivalents and develop a Regional Equity Plan to drive regional services planning and delivery. ▶ The 50/50 regional DHB and iwi governance model aligns with the HNZ Board model. ▶ They will be enabled further by the proposed new investment and ring-fenced Tier 1 funding. ▶ The regional equity plan priorities range from a common Māori outcomes framework, equitable funding strategies, Māori provider, service and workforce development through to exploring Māori commissioning approaches and shared DHB/iwi governance of Midland system performance. ▶ Future commissioning role to be considered.

A potential Indigenous Māori commissioning framework – continued

National		
Appropriation	Commission/Co Commission	Notes/examples
Māori Health Authority holds central appropriation of funds	<p>Māori Health Authority initially commissions for:</p> <ul style="list-style-type: none"> ▶ Māori innovation funds ▶ Māori provider development funds ▶ Māori workforce development funds ▶ Scaling and extending Kaupapa Māori providers ▶ Capital grants for Kaupapa Māori services <p>Phased commissioning roles over 2-3 years:</p> <ul style="list-style-type: none"> ▶ Innovative cross-government place-based initiatives for high needs groups tackling root causes of inequity ▶ Full commissioning of Kaupapa Māori services and Integration of Whānau Ora Commissioning ▶ Commissioning national population, prevention and screening initiatives and services targeted at Māori ▶ Commissioning Tier 1 services aligned with local and regional approaches 	<ul style="list-style-type: none"> ▶ Māori Health Authority engages in Māori-informed planning, procurement and monitoring of health services, enablers or other. ▶ Greater ability for Māori to influence the whole system and execute pro-equity strategies. ▶ Māori providers are assets and a critical building block for system wide success. ▶ Supported by MoH partners and increased population health intelligence function. ▶ To influence the system, Māori Health Authority needs levers such as the ability to co-approve HNZ investment plans and system-level levers which are risk and reward based. ▶ A racism free system – the Māori Health Authority could more effectively tackle institutional racism via its commissioning role.

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