Briefing

Implementing targets for the health system

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Security level:	IN CONFIDENCE	**Health Report number:**	H2023032864
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☒		

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Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Implementing targets for the health system

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Purpose of report

1. This briefing provides you with initial advice on implementing the 100-day plan commitment to introduce health targets to improve system performance in priority areas. Separate advice will be provided to you on the related commitment for immunisation incentive payments.

Summary

2. The Government has indicated an intention to implement health targets across five initial priority areas of service delivery as part of the 100-day plan.
3. You will have decisions in relation to the choice of specific target for each area, the expectations set for when targets should be achieved, and the approach that is taken by health entities to implement targets. The direction set by Cabinet will need to balance the level of ambition for improvement with the feasibility of achieving targets within a reasonable timeframe, and the resource and investment required to do so.
4. The previous successful implementation of health targets required a long-term commitment from all levels of the system, along with the use of a range of levers including clear accountability arrangements, clinical leadership, publication of comparative data, and financial incentives.
5. Performance targets can pose a risk of unintended consequences and perverse incentives, including to divert attention and effort from other priorities. The risks and opportunities of targets should be considered in the approach to implementation, and clarity on Ministers' expectations will be important.
6. Targets can also have a significant financial impact, and decisions should be taken in the context of wider Budget processes to ensure that assumptions are clear, consistent and aligned with the health system's wider planning. This is particularly the case where a target is set some way from existing service performance. A phased approach to implementation may be necessary to provide interim milestones towards a longer-term target.
7. For example, the Shorter Stays in Emergency Departments (SSED) target of 95 percent will be challenging to achieve across all regions and nationally. SSED performance is a 'barometer' for hospital flow, and is impacted by access to primary and community services. A focus on stabilising SSED performance will be an important first step.

8. You have also committed to set targets for a meaningful reduction in the number of people waiting more than four months for a first specialist appointment and elective treatment. This will also be a challenging area to address over the medium term given the pressures on the health system and the size of the current waitlists. Modelling suggests that a 50 percent reduction in the number of people waiting more than four months could have significant financial implications, and a more phased approach to delivery may be achievable over the next three years.

9. Options for phasing progress on wait times include setting milestones to eliminate the longest waits, reducing targets from 12 months to 4 months over a number of years, or focusing on progressively increasing the number of people being seen and treated each year. Expectations could be adjusted each year to improve performance and reduce wait times.

10. The Ministry of Health I Manatū Hauora is working with the other health entities to develop options for targets and the associated approach to delivery and will provide you with further advice based on your response to this briefing.

11. Health targets can be implemented through letters of expectation for Crown entities, the Government Policy Statement on Health 2024-2027 and other entity accountability documents. Replacing the current set of Cabinet-mandated performance metrics for public accountability (Health System Indicators (HSIs)) with your chosen health targets will remove confusion from having multiple priority frameworks.

Recommendations

We recommend you:

a) **Note** that achieving health targets will require a step change in performance in many areas, and these may not all be achievable within three years.

b) **Indicate** your preferred approach to the introduction of targets for first specialist assessment and elective surgery wait times:

i. Set a longer-term stretch goal to achieve a specific reduction in waiting times (e.g. of 30-50%), and/or **Yes/No**

ii. Set phased milestones for reducing waiting times, starting with 12 or 6 month wait targets and progressing to four-month targets over a number of years, and/or **Yes/No**

iii. Set phased milestones to progressively increase the number of people being seen and treated each year. **Yes/No**

c) **Note** that the Ministry's provisional analysis indicates that the cost of implementing four-month waiting times for planned care may cost $1.3 billion over four years and that the implementation of the other health targets has yet to be costed.

d) **Note** that as targets will have significant implications for health funding and wider system planning, decisions on the timetable for achieving targets should be made in the context of Budget processes.

e) **Note** that the Ministry is working with Health New Zealand | Te Whatu Ora (HNZ) to provide further advice on implementing your stated targets.

f) **Note** that there are options available to support effective implementation of health targets, from leadership to financial incentives, and that data quality will be an important enabler of success.

g) **Direct** the Ministry to provide further advice on setting direction for health entities to put in place the arrangements to implement health targets. **Yes/No**

h) **Direct** the Ministry to prepare a Cabinet paper by the end of January 2024, incorporating Cabinet decisions on implementing broader public service targets, for agreement to:

i. introduce initial health targets during the current 2023/24 year **Yes/No**

ii. provide advice on implementing the full suite of targets in the context of resourcing and planning requirements **Yes/No**

iii. replace the current Health System Indicator framework. **Yes/No**

i) **Note** that the Ministry recommends that a mental health and addiction related target be developed and can provide further advice on options to you and the Minister for Mental Health.

Dr Diana Sarfati

Director-General of Health

Te Tumu Whakarae mō te Hauora

Date:1/12/23

Hon Dr Shane Reti

Minister of Health

Date:

Implementing targets for the health system

Background

1. You have committed to introducing five health targets (outlined in Table 1) as part of the 100-day plan to focus the health system's attention on improving areas of poor performance. You have determined specific targets for three of these areas, with two to be agreed after receiving advice. The proposed priority areas are well-established areas of system performance measurement, previously used for accountability purposes and driving system improvements.

2. Performance in the five areas is currently lower than expectations and historic performance prior to the COVID-19 pandemic. Creating the step change in performance required to address delivery in these areas is likely to require a phased response over a number of years and significant focus and resourcing.

Table 1: Proposed health target areas and current performance

Proposed targets	Current performance	
	Total population	Māori
1. **Shorter stays in emergency department (ED)** – 95% of patients to be admitted, discharged or transferred from an emergency department within six hours.	70.0% (June 2023 result)	74.6% (June 2023 result)
2. **Faster cancer treatment** – 85% of patients to receive cancer management within 31 days of the decision to treat.	84.0% (Q4 22/23 – results provisional)	84.5% (Q4 22/23 – results provisional)
3. **Improved immunisation** – 95% of two-year-olds receiving their full age-appropriate immunisations.	83.1% (Q4 22-23 (1 Apr -30 June 2023))	69.6% (Q4 22-23 (1 Apr -30 June 2023))
4. **Shorter wait times for first specialist assessment (FSA)** – a meaningful reduction in the number of people waiting more than four months to see a specialist (target to be set).	30.5% waiting longer than 4 months (June 2023 result)	Wait list data is available at a summary level only (volume per specialty)
5. **Shorter wait times for elective treatment** – a meaningful reduction in the number of people waiting more than four months for elective treatment (target to be set)	38.1% waiting longer than 4 months (June 2023 result)	40.5% waiting longer than 4 months (June 2023 result)

3. This briefing:

   a. provides initial advice on the approach to implementing health targets including success factors and identified risks; and

   b. proposes options for setting targets for shorter wait times for first specialist assessments and elective treatment.

4. This briefing seeks your initial views and preferred approach to setting health targets. Subject to your response, further advice will be prepared for you on each individual target area to support your in-principle decisions and inform development of Cabinet advice. We anticipate your taking this advice to Cabinet in early 2024 to seek decisions on introducing new health targets.

5. A coalition commitment related to the immunisation target proposes a one-off financial incentive for general practice linked to immunisation rates. A separate briefing will be provided to you with advice on implementing this payment.

Setting health targets

6. You will have decisions relating to:

   a. the precise target that is set in relation to a particular area;

   b. the expected timetable for delivery of each target, including any interim milestones; and

   c. the approach to implementation, including how targets are integrated into the wider health system performance framework.

7. There is an important interdependence between these questions. A more ambitious target could drive greater improvement but will require a longer time and greater resource to achieve, especially in the context of competing demands for funding and prioritisation.

8. We expect that you will wish to see meaningful progress against your health targets over the term of this Parliament. However, in some cases, delivery of the stated target within three years is unlikely to be achievable unless at the expense of wider priorities. For instance, Table 1 above indicates that current performance on waiting times in emergency departments (70 percent) is some distance away from the proposed target (95 percent), and this average performance is worse for some communities and places. Closing this gap will require sustained effort and investment over several years.

9. Decisions on health targets may therefore have a significant impact on budgets. To address this risk while ensuring early action this year towards targets, we recommend that you take a graduated approach. For instance, this might entail:

   a. Introducing initial health targets during the current 2023/24 year, but not setting a firm expectation for when the targets should be delivered. This would allow for the right structures and processes to be put in place now to support successful implementation in the medium term (see the section below, which outlines some considerations for implementation). It would also support a baseline of performance and benchmarking at appropriate system levels as the starting point for monitoring.

   b. Making final decisions on the full suite of targets in the context of the Budget 2024 process to ensure alignment with total health funding and the Government's priorities. This would enable a public timetable to be set for targets that reflects investment decisions and could be confirmed through the Government Policy Statement on Health for 2024-2027. This will allow time for requisite plans for targets to be developed by health entities and approved. It could include additional targets as part of a broader performance framework that is aligned with your priorities.

10. This staged approach would allow early Cabinet decisions (by end January 2024) to implement new targets within the first 100 days of the new government. It would then seek further agreement to the fuller, medium-term performance approach, including any additional targets you may determine, later in early 2024 alongside Budget 2024.

11. As part of this approach, you may wish to set interim milestones or performance markers to demonstrate sufficient progress towards targets. This may be useful for targets that will require a number of years to reach and could support monitoring and accountability. These milestones would need to be agreed as part of the medium-term plan for targets to ensure that they are themselves achievable.

We welcome your views on taking a staged approach to health targets, including setting interim milestones to support focus and monitoring.

12. Under any approach, the way that targets are implemented through the health system will be critical to securing their benefits and mitigating risks. The section below summarises issues to be considered in implementation.

Implementing health targets

Addressing health system challenges

13. Health system performance has come under significant pressure over the past few years due to a range of factors including the COVID-19 pandemic, an ageing and growing population, and widespread capacity and workforce challenges. In the global context, health systems around the world are looking to address the health care services delayed or disrupted by the COVID-19 response.

14. The health target approach has historically contributed to success in lifting health system performance in specific areas. Health targets can ensure all elements of the system move together to achieve the same goals and provide prioritised focus for effort and resource. They can also support improved public trust and confidence in the health system, reinforcing public accountability.

15. Previous health targets were introduced in the context of the district health board (DHBs) system. The role of targets in part sought to force common expectations, measurement and reporting across the 20 DHBs. The advent of Health New Zealand | Te Whatu Ora (HNZ) provides new opportunities to address some of the issues at which previous targets were directed, including through coordinated national activities, optimised use of resources, and consistent leadership. For example, HNZ has programmes of work underway to address planned care and immunisation rates and is currently working on implementing a comprehensive acute care work programme. These programmes and initiatives will be critical enablers to achieving your health targets.

Supporting the success of health targets

16. The approach to setting and implementing health targets will have a significant impact on the likelihood of targets driving the expected change and improvement. Learning from previous approaches to targets indicates that successful implementation requires the following:

a. **Clear ownership and leadership for delivery of targets.** This includes the role of the HNZ Board for achieving health targets and holding the executive accountable for delivery against plan, and clear clinical ownership. Previous health targets were supported by named clinical leaders who worked with clinicians on improving performance through a continual focus on accountability, best practice, and organisational alignment. Such an approach could be led from within HNZ and aligned with clinical networks.

b. **A detailed implementation plan**. HNZ will need to develop an implementation plan for each target that includes prioritised actions, resources that will be applied to the target areas, an internal performance framework to set and monitor expectations aligned to budget, and a plan to identify and mitigate risk. Plans for the delivery of targets should be integrated with wider service plans to ensure that focus and incentives are aligned – the forthcoming 2024-2027 New Zealand Health Plan offers an opportunity to ensure that targets are built into core plans for the coming years.

c. **Funding for target delivery.** Additional funding will be required to deliver the health targets, depending on where targets are set and the timescales for their delivery. HNZ is currently reviewing its expectations for activity that can be delivered through its baseline funding and will provide advice on where additional funding may be required to deliver health targets. This information will be fed into the Budget 2024 process and will underpin the next New Zealand Health Plan.

d. **Effective use of levers and incentives.** Transparency of reporting and benchmarking is crucial to achieving targets, and should be expected within HNZ to demonstrate regional, district and service or facility-level information, as well as breakdowns for different communities. Payment for performance has proven effective in the past, for example in planned care where access to a performance fund was contingent on meeting agreed delivery and was withheld where expectations were not met. Financial levers previously retained with the Ministry have now been devolved to the entities; however, further expectations could be set for HNZ, including the establishment of internal systems for performance incentives.

e. **Recognition of the impact of wider determinants.** Many of the factors driving demand for health services are outside of the remit of health entities, and therefore a focus on targets should consider the extent to which delivery relies on the actions of other public services or the contribution of other levers such as regulation. A credible approach to delivery should involve the Ministry and other agencies to identify the role and potential impact of each. This could also link to any future cross-Government targets that may be implemented.

*Risks and issue*s

17. Domestic and international experience has shown risks associated with the health target approach, including the potential for targets to produce perverse incentives or unintended consequences. Being aware of these risks enables mitigation strategies to be put in place in the design and monitoring of our approach.

18. Key risks and mitigations include:

a. **Misalignment between targets and system capacity.** Both the specific target itself and the timetable for its delivery must be feasible and achievable within current and likely future resource. While aspirational targets can drive focus, if targets are held to be unachievable then this may lead to efforts dissipating. The balance between ambition and pragmatism in setting targets is therefore critical.

b. **A focus on meeting targets detracts from broader improvement efforts.** Many areas of the reformed health system require attention to achieve the transformation required, and focus may be diverted from this effort to meet health targets. Comprehensive reporting and monitoring across the health system will help identify where this might be occurring. Other targets could be included in the suite to support improvement and public accountability in other areas of the system such as mental health and addictions. The Ministry can provide options for additional targets if you wish to explore this further.

c. **Attention to target areas compromises performance in other areas**. Examples of this include first specialist assessments being improved at the expense of follow up appointments, or immunisation rates for two year-olds being improved at the expense of other age groups. Unintended consequences of target-focused activity can be mitigated by a strong monitoring system that covers a broad range of performance metrics and includes appropriate balancing/support measures to ensure the overall aim of the target is achieved without negative impact on associated areas. This is particularly important given that the health targets announced to date predominantly measure hospital and specialist services, but their success requires material improvement in community-based service delivery.

d. **Gaming – making results appear better than they are – impacts on equitable delivery**. Service providers may look to achieve targets by focusing improvement on the population groups easiest to reach. In this instance, Māori and Pacific populations are likely to be disproportionately impacted. Likewise, current variances in district and regional performance, and performance between service areas may be disguised through aggregated reporting. Consideration will need to be given as to how the national-regional-locality model in the reformed system is expected to work to achieve health targets, and how performance at each of these levels can best be driven.

e. **Integrity issues with the data used to monitor health targets**. There are a number of issues with quality and timeliness of data used to monitor system performance, and these have increased as HNZ has begun to build new national collections from the previous DHB systems. These data issues have delayed public release of information, delayed advice on performance from the Ministry and HNZ, and impacted on the Ministry's ability to provide expected datasets as part of its audited annual plan. Entities continue to work together to ensure stability and completeness of national collections data.

19. To build on this learning and support the success of targets, we recommend working with HNZ to agree an approach to implementation that reflects the opportunities above. Clarity around your objectives and practical expectations at the outset will help to ensure that the approach is developed with these in mind. We suggest that you consider the use of formal directive powers to health entities to reinforce next steps and can provide you with advice on options.

We welcome your views on the approach to implementing targets, and the directions you may wish to set for health entities to be clear on your expectations.

First specialist assessment and treatment wait times

20. You have indicated an intention to set targets for a meaningful reduction in the number of people waiting more than four months for a first specialist appointment and elective treatment. The following section provides an overview of current performance in this area and some preliminary options for setting targets.

21. Waitlists for these areas have increased steadily since 2015/16 (see **Appendix 1**).

Waitlists as at August 2023	**Total**	**Waiting over 4 months**
First Specialist Assessment	172,302	55,188
Elective surgical treatment	74,916	28,401

22. Growth in the number of people on the planned care[1] waitlist is the result of more people being added to the waitlist than are seen or treated each year, within constrained hospital and specialist service capacity. Factors influencing waitlist growth include:

    a. population growth and changing population demographics;

    b. pauses to normal planned care throughput during the COVID-19 pandemic;

    c. access to primary care in order to receive a referral for treatment, and clinical thresholds for referral acceptance and treatment;

    d. pressures on service capacity, in particular related to workforce constraints and the state of infrastructure.

23. The growth in the waitlist for planned care has also been due in part to the overall increase in demand for hospital services. The increase in the proportion of hospital capacity being used for acute and arranged[2] admissions, and the associated increased length of stay, has meant that resources have been directed away from planned care (refer **Appendix 2**).

24. Improving performance would require sustained effort over a number of years and involve a combination of:

    a. Increased production: by adjusting capacity (including physical capacity), workforce and funding to address variation in performance. This includes outsourcing where appropriate without impacting on the staffing necessary for public sector provision. HNZ has been making increasing use of the outsourcing option.

    b. Improved effectiveness and efficiency: through actively maximising capacity available (reducing waste), operational policy and models of care, incentives, aligned clinical, management and governance focus.

[1] 'Planned care' interventions include both inpatient surgeries and a range of minor procedures that can be delivered in less intensive care settings (such as Avastin eye injections and skin lesions). The surgical waiting list being measured here (ESPI 5) does not include the minor procedures.

[2] Arranged admission: admission date is less than seven days after the date the decision was made to admit, or the admission relates to normal maternity cases, 36 to 42 weeks gestation, delivered during the event.

c. Managing demand: through improved health status, healthcare provided through alternate pathways to surgical intervention, restricting access.

Meeting four-month wait time targets will be challenging in this parliamentary term

25. Addressing the overall number of people on the planned care waitlist, to impact wait times, will require exiting more people from the waitlist than are added each year. (Exiting from the waitlist refers to being removed from the waitlist for any reason, including because treatment has been delivered). While focusing on reducing the waitlist, it will also be important to ensure access to planned care services is being maintained and people continue to be referred for the health care they need.

26. You have a range of options for setting targets for first specialist assessments and elective surgical treatment, and the timetable for delivering them. However, the Ministry considers that meaningful four-month wait time targets will be challenging to establish and meet in the next three years, especially in the context of system constraints. For example:

a. s 9(2)(g)(i)

b. [redacted]

27. It should be noted that delivery of this additional number of first specialist appointments and exits from the elective treatment wait list will require the system to sustainably deliver at a higher level than ever delivered previously.

28. While some element of the costs above may be expected to be delivered within baseline health funding, as this modelling demonstrates, the cost of achieving some options for targets in the next three years is likely to be prohibitive. This financial modelling however presumes the availability of sufficient workforce to deliver the services required.

29. You have options to address this challenge – including to set a lower target for delivery within this term of Parliament, or setting a longer timetable for achieving a more ambitious target. In both cases, the targets that are confirmed should be underpinned by a clear understanding of likely cost and activity assumptions to support monitoring.

30. You may wish to consider setting a more ambitious longer-term target and combine this with a phased approach that sets milestones for health entities over the coming years. For instance:

a. Phasing of waitlist reduction targets could start with setting a 12 or 6-month target and move to 4 months over time. This will mean a focus on reducing wait times for fewer people in the first instance, while delivering on the aim of providing improved certainty to patients and building trust and confidence in the public system over the long term.

b. Alternatively, the headline target could remain focused on waiting for less than 4 months, but with milestones to move towards a 50 percent reduction over time (e.g. setting an expected profile for improvement year-on-year). The profile could be adjusted each year, with service volume expectations to support progressively reduced wait times as part of this process.

31. These phased options recognise the importance of both supporting increased capacity in the short term to bring service volumes back to pre-COVID-19 levels as the basis for sustainable wait lists, and planning and establishing new capacity that matches population growth to support reductions in waitlists in the medium-term. They also acknowledge that clinicians will continue to be responsible for setting appropriate wait times on an individual basis based on clinical need, and for certain groups such as children.

32. It should be noted that implementing other coalition government commitments such as expanding eligibility for screening programmes and extending post-natal stays will make the attainment of any wait list target more challenging.

33. There is benefit in moving quickly to address the FSA waiting list, both from a clinical risk management perspective, and to give people certainty on the treatment path. However, with approximately 40 percent of FSAs resulting in an addition to a treatment waiting list, the temptation to move too fast in addressing FSAs should be tempered so to not unduly exacerbate the treatment waiting list in the short term.

We welcome your views on the approach to setting targets for first specialist assessment and elective treatment, including the level of meaningful improvement and options to phase delivery towards targets.

Equity

34. The approach to implementing health targets will need to ensure equitable improvements in the target services areas for all population groups and geographical areas. Data will need to be available by priority population group and geographical area to enable effective monitoring and provide insights to the barriers to access experienced by those groups.

35. There are also opportunities to partner with iwi, Māori and whānau to design approaches to addressing areas like low rates of childhood immunisation through the iwi-Māori partnership boards.

36. Access throughout the system to good quality and timely data is essential for any approach which involves partnering with communities to improve performance and enable effective monitoring and accountability to Māori on progress in improving hauora Māori.

Next steps

37. The Ministry is now working with the other health entities to agree:

a. recommendations for target levels for shorter wait times for elective treatment and first specialist assessments,

b. recommendations for balancing and supporting measures for the proposed health targets,

c. baselines for each of the proposed health targets,

d. leadership, accountability, reporting and performance escalation arrangements.

38. We are aware other health entities will provide advice on approaches to health targets related to their roles and functions.

39. Crown entities can be informed of the Government's health targets and required action against them through your Letter of Expectations. There will need to be strong alignment between health targets and wider arrangements for accountability and expectations. To achieve this, we recommend the targets also be included in the Government Policy Statement on Health 2024-2027.

40. The Ministry is able to prepare the appropriate documentation for you to have Cabinet discussions and set expectations for Crown entities, once you have confirmed your final suite of targets.

Replacing the current metrics for system performance accountability

41. The Health System Indicators framework (see **Appendix 5**) is the current Cabinet-mandated set of performance metrics in place for public accountability purposes. Crown entities and the Ministry currently use the HSIs in their formal accountability documents. Public reporting on HSIs is available on Health, Quality and Safety Commission | Te Tāhū Hauora's website.

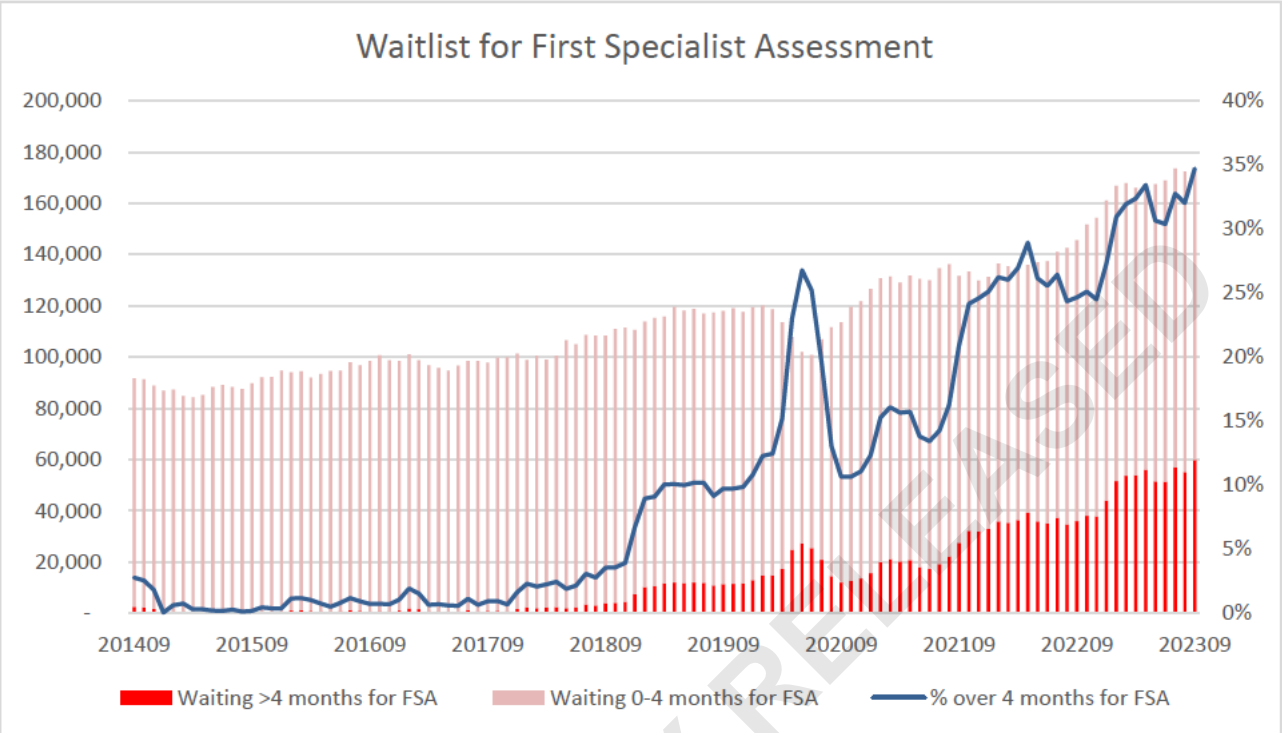
42. There are no performance targets associated with the HSIs, however, to avoid any confusion that might follow having multiple performance accountability frameworks in place, the Ministry recommends removing their formal status and replacing the HSIs with health targets and any other key measures chosen to accompany the Government Policy Statement on Health 2024-2027.

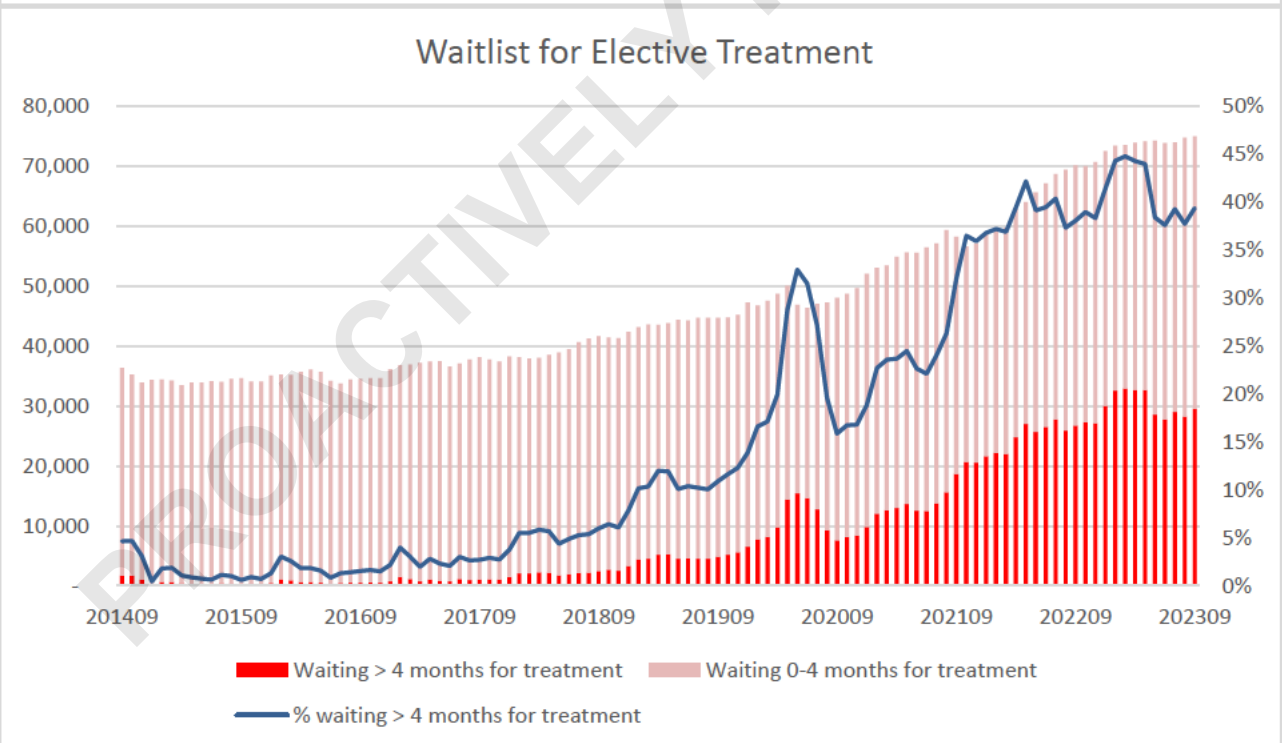
43. HSIs continue to represent relevant indicators for health system performance, and the data for those indicators will continue to be available as supporting metrics for monitoring.

44. Once health targets are introduced, we recommend accountability documents, the Statement of Performance Expectations (SPE) for HNZ, are updated to reflect the expected performance.

ENDS.

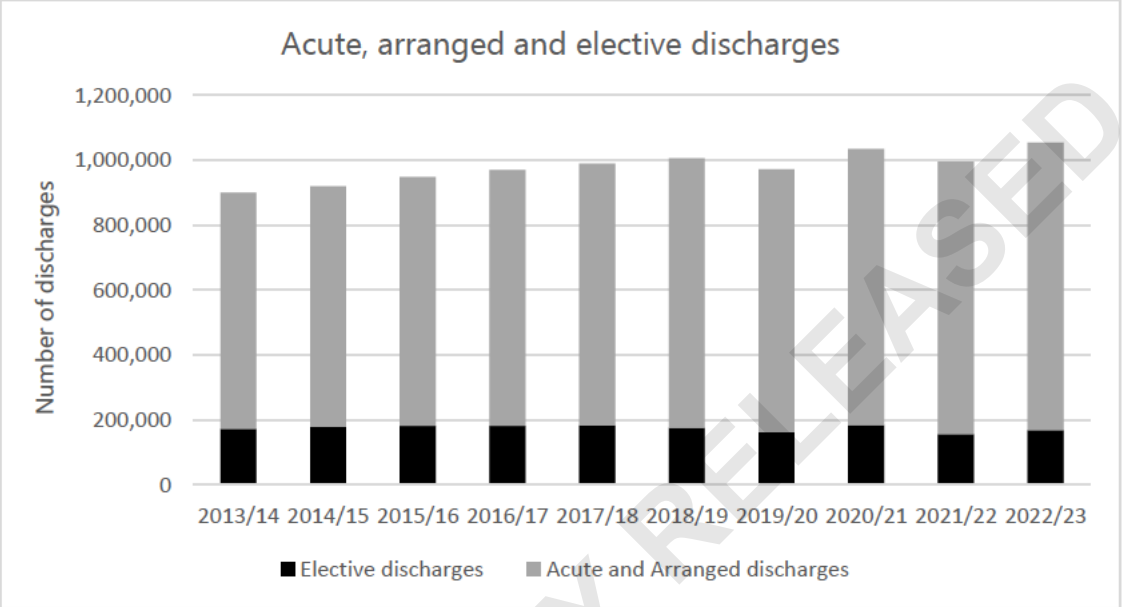
Appendix 1: Trend in wait lists for first specialist assessments and elective surgical treatment





Appendix 2: Trend in proportion of hospital discharges that are elective versus acute and arranged

Between 2013/14 and 2022/23, acute and arranged admissions increased by an average 2.4 percent annually, which is greater than population growth. In comparison, between 2013/14 and 2022/23, elective surgical discharges remained largely flat. In 2013/14 elective surgical discharges represented 19 percent of all discharges, however by 2022/23, they represented 16 percent of overall discharges.



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Acute and arranged discharges	727,246	741,078	767,243	788,102	806,574	830,719	809,494	851,577	839,135	886,298
% change between 2013/14 and 2022/23 per year on average										2.4%
Elective discharges	172,881	179,092	181,503	182,046	182,910	175,571	162,306	183,583	156,356	168,616
% change between 2013/14 and 2022/23 per year on average										-0.3%
Total discharges	**900,127**	**920,170**	**948,746**	**970,148**	**989,484**	**1,006,290**	**971,800**	**1,035,160**	**995,491**	**1,054,914**
% change between 2013/14 and 2022/23 per year on average										1.9%

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Added to elective surgical waitlist	209,367	215,785	218,352	224,090	231,006	234,348	208,221	234,058	199,384	216,826
Exited from the elective surgical waitlist	156,709	218,334	218,123	221,697	227,674	228,864	207,150	224,018	188,382	210,407

Definitions

- **Acute and arranged discharges:** the result of an unplanned admission or when the admission is less than seven days after the date the decision was made by the specialist to admit, or the admission relates to normal maternity cases, 36 to 42 weeks
- **Elective discharges:** include planned admissions where the admission date is seven or more days after the date the decision was made by the specialist that the admission was necessary.

Appendix 3: Options for reducing wait times for first specialist assessments

s 9(2)(g)(i)

[3] Additional to 2022/23 performance

s 9(2)(g)(i)

[redacted]

[4] **Additional to 2022/23 exits**

Appendix 5: Health System Indicator (HSI) framework

The HSI framework was approved by Cabinet in February 2021 (SWC-21-MIN-0002 refers) and includes the following set of measures designed to drive improvement in five priority areas for the health system.

Government Priority	High-level indicator	Description
Improving child wellbeing	Immunisation rates for children at 24 months.	Percentage of children who have all their age-appropriate schedule vaccinations by the time they are two years old.
	Ambulatory sensitive hospitalisations for children (age range 0–4).	Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community.
Improving mental wellbeing	Under 25s able to access specialist mental health services within three weeks of referral	Percentage of child and youth (under 25) accessing mental health services within three weeks of referral.
	Access to primary mental health and addiction services.	In development.
Improving wellbeing through prevention	Ambulatory sensitive hospitalisations for adults (age range 45-64).	Rate of hospital admissions for people aged 45–64 for an illness that might have been prevented or better managed in the community.
	Participation in the bowel screening programme.	In development.
Strong and equitable public health system	Acute hospital bed day rate.	Number of days spent in hospital for unplanned care including emergencies.
	Access to planned care.	People who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the delivery plan.
Better primary health care	People report they can get primary care when they need it.	Percentage of people who say they can get primary care from a General Practitioners (GP) or nurse when they need it.
	People report being involved in the decisions about their care and treatment.	Percentage of people who say they felt involved in their own care and treatment with their GP or nurse.
Financially sustainable health system	Annual surplus/deficit at financial year end.	Net surplus/deficit as a percentage of total revenue.
	Variance between planned budget and year end actuals.	Budget versus actuals variance as a percentage of budget.

Minister's Notes