The New Zealand Health System
Independent Capability and Capacity Review

Suckling, Connolly, Mueller, Russell - June 2015

ACKNOWLEDGEMENTS

Thanks are extended to the numerous stakeholders and providers within the wider New Zealand health system and related public sector organisations for their candid, well-considered input into the review either directly in interviews, preparing other colleagues for interviews, through contribution at workshops, through submissions and by completing the survey. This input was critical in formulating our review findings.

All quotes used in this report were from stakeholders we interviewed and were selected because they captured sentiments expressed by many. All interviews were carried out on the basis of complete confidentiality and anonymity and thus are not attributed to any individuals. For the same reason none of the submitted information discussed during the interview process has been included in the report.

EXECUTIVE SUMMARY

The Minister of Health asked the Ministry of Health (MoH) to lead a refresh of the 2000 New Zealand Health Strategy to build on the current progress of the New Zealand health and disability system and improve its adaptability and responsiveness to meet future needs. In parallel to this strategy refresh activity, two additional reviews were commissioned to (a) support and enable successful implementation of the revised strategy through the identification of capability and capacity gaps that must be addressed (Appendix I), and (b) suggest a revised funding model for the system.

This Capability and Capacity Review involved almost 100 inquiry diagnostic interviews (Appendix II) of leaders and participants in the New Zealand health and social sectors. In addition, the reviewers offered to the wider sector opportunities to contribute, through an online survey distributed through the MoH, and then on-distributed to various web pages of sector groups. Further input from stakeholders was received at two workshops facilitated by the MoH.

This wide and deep consultation reach provided a clear mandate for this review's findings and recommendations. The themes identified from all strands of contributions were aligned, consistent, concise, and mirrored the themes identified in the strategy refresh work stream.

This Capability and Capacity Review identified that an enhanced operating model was needed to support the refreshed strategy for New Zealand's future health system. The vision for the health and disability system is that *"we are a 21st century health and disability system that operates as one, focuses on wellbeing and prevention, and is people-centred. We use our skills and resources in the best ways to support all New Zealanders to live well, stay well, get well".*

This revised operating model must embrace the following principles in order to achieve the vision of better health outcomes for all New Zealanders. These principles are:.

- Be consumer-centric (not provider-centric) where future enhancements centre on emphasis and prioritisation, informed by customer needs.
- Achieve equity of access and outcomes irrespective of ethnicity, health status or social circumstances.

- Recognise that strong focus should be placed primarily on community and primary care and then be supported by secondary and tertiary care. Currently, the priority of District Health Boards' (DHBs') long-range planning centres around secondary/tertiary care, due to the historic emphasis on treatment rather than early identification and prevention, exacerbated by the disproportionately high costs of providing quality secondary/tertiary care.
- Be outcome-centric not input-centric. Rather than placing a focus on the health transaction, and accounting for those in reporting and evaluation, the emphasis should shift to a reporting/accountability framework of qualitative outcomes, not isolated to health but inclusive of related/connected social conditions, where applicable.
- Strongly reject the approach that regional and DHB silos are acceptable, rather than a cooperative and collaborative across-system approach of delivery of outcomes - i.e. for specific populations, models of care or disease categories.
- Commission providers at the "coal face" to collaboratively co-create service solutions that address targeted population needs, utilising where appropriate, a long-term forward investment approach.
- Include systematic and transparent workforce development including development of emerging leaders in the sector.
- Use evidence-based decision-making, supported by smart analytics. The current system is rich in data but requires improved translation into actionable information.
- Include an agile system approach to identify, assess and roll-out service innovations that recognise new digital technologies, especially in community care settings.
- Ensure that ICT infrastructure is developed with a national mandate to implement and make operational a system that allows information to be shared nationwide to a prescribed standard.
- Embed a solid understanding of long-term holistic system risk rather than managing a transactional short-term based system, in isolation.
- Stabilise provider relationships and incentives to allow providers to innovate through multi-year contracting, based wherever possible on a forward investment approach (which means quantifying future outcome advantages versus upfront investments).

The review identified clinical and non-clinical human resource capability and capacity gaps that have to be addressed, as well as system capability and capacity gaps that need to be unblocked to support the enhanced operating model.

Professional gaps in the clinical workforce such as ageing GPs and midwives and changing GP practice ownership models are generally understood, and their respective professional bodies have made varying progress in addressing the impacts. In some cases the noise in the system is about short-term issues that need a tactical response and is a distraction from medium to long-term service sustainability.

However, whilst these professional clinical workforce gaps cannot be ignored, they are not seen as the most pressing issues going forward. The most important issues centre on preparing the workforce for changing practice attitudes and models of care required in the future. This includes the development of new supporting roles to the traditional clinical roles (such as navigators and the home help workforce in community care), as well as linking to resources in non-medical sectors such as Education, Police, etc.

The main issue across the system is the variability in capability, and general lack of strong governance, leadership and technical managerial skills to support a purposeful and collaborative operating model. Specific system-wide skills gaps identified include managing system risk, managing dynamic change, co-creating and commissioning consumer-centric outcome service models in community care, data analysis, ICT skills, etc.

The system capability and capacity gaps which must be addressed to support the refreshed strategy and enhanced operating model include:

- The ability to embed the voice of the consumer as the basis to anchor the new operating model.
- The need to seriously strengthen the MoH so that it is empowered for system leadership.
- The need for a system approach to workforce development including governance, leadership, risk management, and non-clinical delivery.
- The need for a national approach to ICT – especially in regard to the e-health records, patient portals, and ICT standards for providers.
- The need for a system approach to encourage and share innovation - particularly in the community and primary care areas.
- The need to address any funding issues which currently are not aligned with this enhanced operating model.

The first priority to move forward is to agree and adopt the refreshed strategy and the corresponding new operating model. This must include a strong narrative around the strategy and its benefits and what it will mean for consumers and providers, as well as the milestones that will mark specific achievements of this refreshed approach. This transformation should occur over the next five years. This should be supported in the first instance by specific initiatives in priority areas with significant investment payback and where capability and capacity gaps exist, and solutions can be developed and embedded. During the initial two to three years there will be no change in approach for many services, and it will be business as usual.

The specific review recommendations for 2016-17 below will focus on the journey to transition the current operating model into an enhanced and sustainable state, without compromising its interim effectiveness. To achieve the desired outcome, additional capacity and capability will need to be sourced from outside and/or developed internally through upskilling and moving people around the system. The recommendations cover:

1. Commencing anchoring of the voice of consumer in the new operating model through the implementation of three consumer-centric population programmes embracing the new operating model

2. Strengthening the MoH leadership and mandate

3. Taking a system approach to workforce development including governance, leadership and risk management

4. Moving to a national approach to ICT

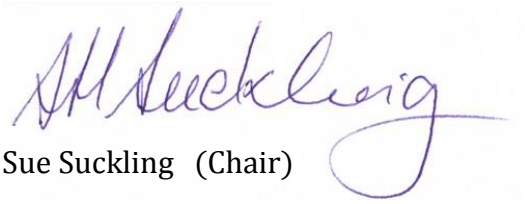
5. Building a system that encourages innovation- particularly in the community and primary care areas

6. Addressing funding issues to enable the new operating model.

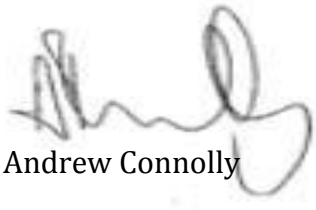
We see the New Zealand health system as capable and competent, already beginning to embrace several national initiatives, such as the recent National Telehealth Service. With a strong and unambiguous approach to good health for all being a national imperative, we believe all New Zealanders will be able to enjoy greater access to better care, to live longer, healthier lives.

The themes identified from all strands of work were aligned and consistent. The panel unanimously supports the findings and recommendations contained in this report.

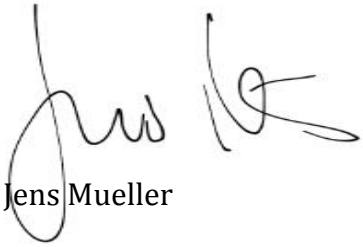
30 June 2015



Sue Suckling (Chair)



Andrew Connolly



Jens Mueller

David Russell

(see Appendix IV for reviewer background information)

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SECTION ONE - REVIEW PURPOSE AND METHODOLOGY

> The New Zealand health strategy was last reviewed in 2000

The Minister of Health asked the Ministry of Health (MoH) to lead a refresh of the 2000 New Zealand Health strategy to build on the current progress of the New Zealand health and disability system and improve its adaptability and responsiveness to meet future needs. In parallel to this strategy refresh activity, two additional reviews were commissioned to (a) support and enable successful implementation of the revised strategy through the identification of capability and capacity gaps that must be addressed, and (b) suggest a revised funding model for the system.

> It is essential this is comprehensively reviewed and we put citizens at the centre

An independent panel to the Ministry of Health undertook the Capability and Capacity Review. Panel membership comprised (see Appendix IV):

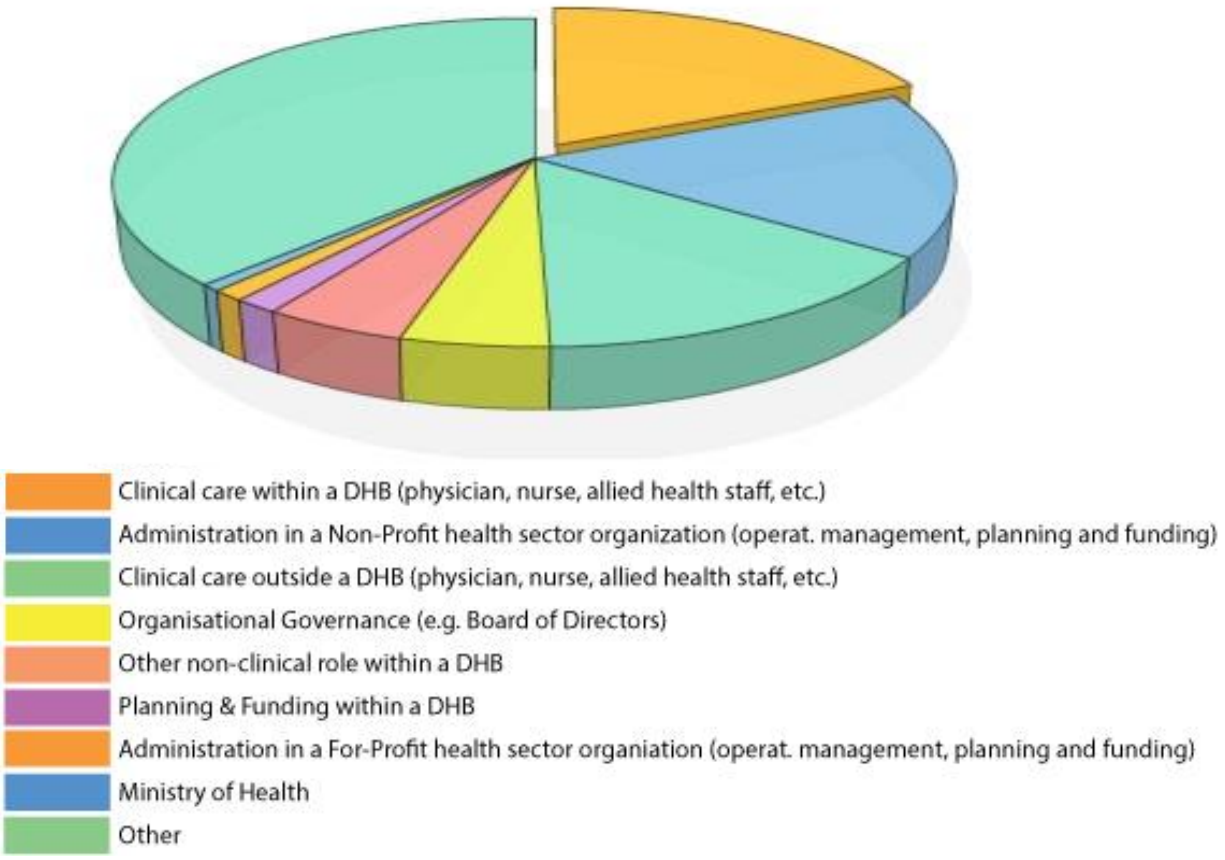
- Sue Suckling (Chair)
- Andrew Connolly
- Professor Jens Mueller
- David Russell.

The Capability and Capacity Review involved almost 100 interviews of leaders and participants in the New Zealand health sector between May and June 2015. Individuals interviewed and their affiliations are shown in Appendix II. In addition the reviewers offered opportunities to contribute from the wider sector, through an online survey

> The consultation reach provided a clear mandate for the review findings and recommendations

distributed through the MoH, and then further distributed to various web pages of sector groups. 187 responses were received through the survey. We received further input from stakeholders at two workshops facilitated by the MoH, in May and June 2015, attended by 152 participants. Eighteen web submissions were also received and considered.

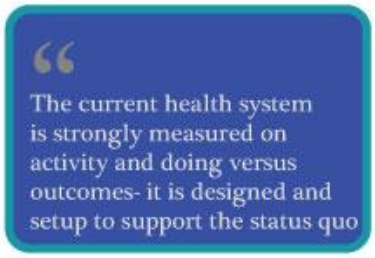
The distribution of responses from the survey by sector and by region shows an appropriate representation of sectors and regions (Table 1)



The review approach required a short, targeted and focused evaluation of the current capability and capacity in the health sector. This process identified the key strategic capability and capacity issues, which underpin the system's readiness to deliver a refreshed strategy. This Review's key purpose was to indicate areas where future operational changes would be helpful to accomplish strategic objectives, but not to discuss detailed operational matters as these are for the sector to identify.

SECTION TWO - REVIEW CONTEXT

1. Characteristics of the current system



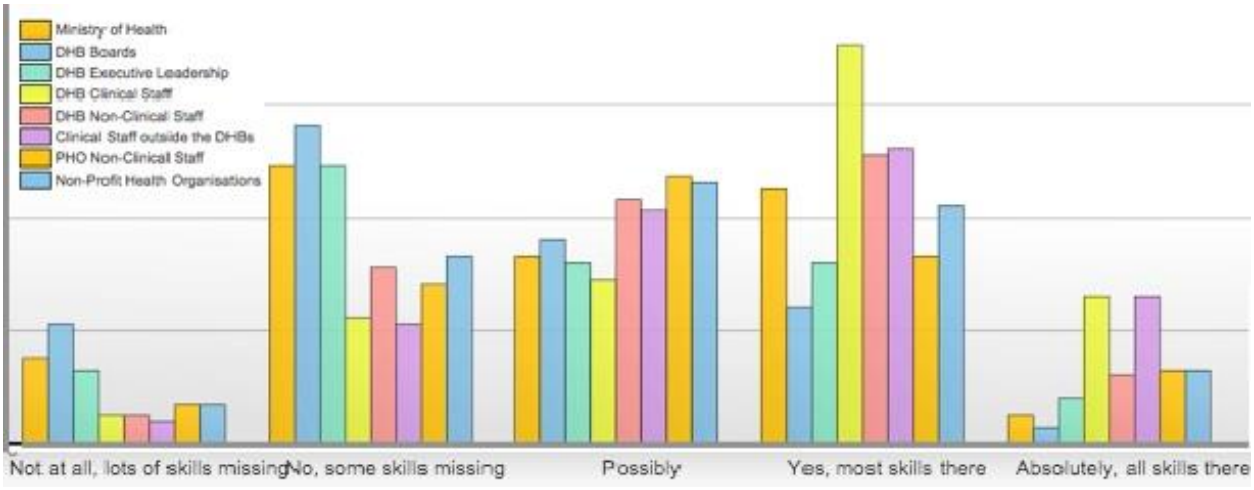
The current New Zealand health system is basically sound and has built-in resilience to continue to meet the current objectives. However, there is a resounding view that it must change in order to reach the desired vision of live well, stay well, get well.

There are concerns that without a system redesign the current and future clinical and financial demands of the health care system in New Zealand will not be sustainable. As with other nations, we face the pressures of an ageing population, newly emerging technologies and costly interventions, mainly in the secondary/tertiary sector. The expectations of our consumers for access to the latest medical innovations will put additional pressure on the system.

There are many very good aspects of the current New Zealand health system that should be preserved, while its limiting characteristics are remedied and these remedies are then embedded into the future health strategy. The health workforce is incredibly motivated, and individuals within it have a strong desire to do better. There is recognition and respect for clinical capability within the system.

Further, there is a shift in thinking within the MoH. For example, the Putting People First Steering Group is addressing the recommendations made in the report on the Ministry's disability support services.

Skills distribution among the key sector providers within the New Zealand health system is highly regarded, with especially the clinical staff being valued for their highly developed skills (Table 2).

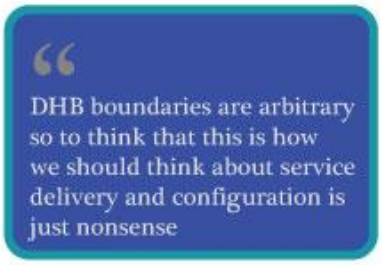


The system has also demonstrated an ability to significantly increase productivity in priority areas such as elective surgery, for cancer treatment access, reduction of smoking rates and in specific clinical areas, such as rheumatic fever prevention. Regional cooperation has occurred in some areas, for example the South Island paediatric alliance, improving access to the right service at the right time.

> "NZs biggest asset is our clinical staff - their skills and their engagement

The achievement of the 6-hour waiting time target in emergency departments and the reduction in total waiting times in secondary care (for example in elective and oncology

services), along with the success of childhood immunisation programmes also demonstrate the ability of the health system to achieve targets.



However, the system design is fragmented in a potentially divisive and competitive mold, with devolved design and decision-making being delegated predominately to 20 DHBs. These DHBs are funded and contracted on a population-based formula to provide hospital services in their designated geographic area, and to fund and contract the provision of community and primary health services for the same population. The latter is through 32 Primary Health Organisations (PHOs). Both DHBs and PHOs contract with a large number of NGOs (including large private sector organisations, commercial not-for-profit organisations, through to very small community organisations). PHOs operate their own provider networks predominantly for primary and community care. It appears that the DHBs apportion the flow-on funding to third parties, such as PHOs and NGOs, not with a view on a long-term sustainable relationship but rather as a short-term contractor transaction.

Over time, the system has become more and more devolved and fragmented, with the MoH becoming more of a system administration/monitoring organisation, versus being the effective central policy leader and steward of the New Zealand health system strategy. The fragmentation has allowed groupings of DHBs to emerge where proximity, population density, funding strength, and other factors, create a competitive environment towards other DHBs. We have even seen evidence of the emergence of apparently for-profit enterprise activities at some DHBs, where some services are established as revenue sources and/or 'sold' to other DHBs, with a profit objective. This trend compromises a nationally homogenous approach to equitable care for all, occupies resources and distracts DHB management from a clear focus on health objectives and is highly undesirable.

The current model is provider-centric and activity-based. It is driven by the requirement to operate hospitals within the agreed DHB funding envelopes, while meeting a number of specific input-based performance targets, mandated by both Minister and Ministry. While significant monies are allocated for community and primary care and cannot be used for secondary care, there is a grey area where the DHBs are pushed to direct the money to areas where they believe they can easiest meet their respective fiscal pressures. This can trigger short-term contracting uncertainties for down-stream providers, stifles investment for innovation and curtails important workforce development activities. It further can cause DHBs to disinvest from preventative and early-intervention strategies, particularly in the primary/community care arenas. Under the current funding model some DHBs appear unable to rapidly move their emphasis from secondary to primary/community care.

> “
> The system is very transactional structured around 1-year contracts. Primary care is more remedial focused than prevention focused

The approach to short-term contracting for primary/community care, rather than a long-term outcome-driven contract basis, compromises the ability of the system to manage whole-of-system risk.

> “
> Every DHB has a different patient pathway even in the instances like aged care where there is one national contract

The approach to health services delivery varies from DHB to DHB and there is limited sharing of best practice across the system. In fact, there is evidence that innovations are directed by commercial self-interest of some DHBs, rather than being made available to the sector at large. There appears to be an inability for innovative practices to be easily rolled out across the New Zealand system.

This siloed and short-term fiscally-dominated focus creates a number of systemic deficiencies which limit the ability of the New Zealand health system to evolve for the benefit of all New Zealanders. It limits the ability to effectively respond to the increasing demands arising from our ageing population, equity disparities, expensive technology, and the increasing pressures and rising impact of long-term conditions as associated risk factors. This covers an array of conditions including diabetes, respiratory disease, renal disease, dementia and obesity. Many of these conditions do not exist in isolation, nor are limited to a health focus only, yet care is often siloed by diagnostic category. Outcome results can be significantly enhanced when health issues are considered in the context of social circumstances, such as employment, education, housing, poverty and others.

2. The 2009 Ministerial Review Group Report and Outcomes

While there has been no formal reflection on the New Zealand health strategy since 2000 (and 2001 for the Primary Care strategy), an independent review of the sustainability of the current system was undertaken in 2009. That review made a large number of recommendations around nine key themes, and recommended several structural changes.

A large number of these recommendations were adopted, including the establishment of a number of committees operating in parallel to the MoH and as Crown entities (each with their own governance boards and Chief Executives to undertake work that had previously been in the full domain of the MoH, see Appendix III for details of the recommended purpose and structures of these committees). The rationale given for these new structures was to enable the Ministry to better focus on core policy and regulatory functions.

This 2015 capability and capacity review was asked to consider the purpose, and effectiveness of several of these committees, in particular the National Health Board, National Health Committee, National Health IT Board, Capital Investment Committee, and Health Workforce New Zealand. We also considered the role of the Health Quality and Safety Commission, which was formed by legislation in 2010, and the Health Promotion Agency.

3. The refreshed strategies for the New Zealand health system

In parallel with this review the Minister of Health asked the MoH to lead an update of the 2000 New Zealand health strategy.

The update of the New Zealand Health Strategy seeks to provide a unifying vision for the health sector, a compelling case for change and road map of actions (and implementation plan) for the next three to five years. It establishes seven priority areas for accelerated progress to move toward a vision of the health system that is:

"caring and people centred, operates as one with a focus on wellbeing and prevention throughout people's life span, uses skills and resources in the best ways, and joins up with communities and other government services to support ***all*** *New Zealanders to* ***live well, stay well, get well."***

The Strategy identifies strategic challenges for the New Zealand health system and priority areas for change over the next five years, based on engagement and feedback from stakeholders. This involves a mixture of population-focus areas and system enablers, which are summarised below.

Focus areas:

- Partnering with people
- Living well in healthy communities
- A great start for children and families.

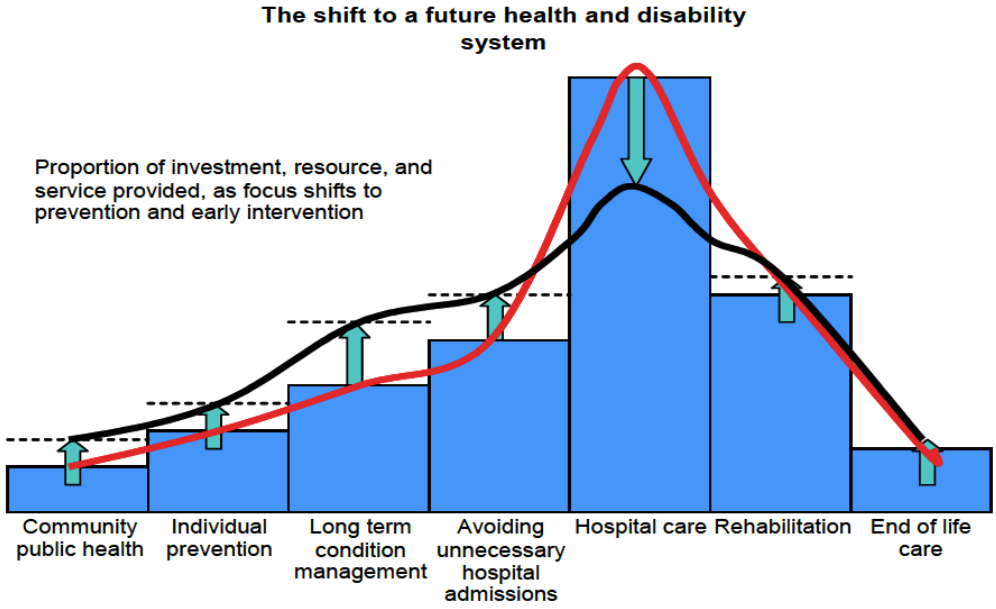
System Enablers:

- Working together in a high-trust public system
- Building leaders and capability for the future
- Fostering and spreading innovation and quality improvement
- Best use of technology and information.

The Strategy seeks to improve the health of all New Zealanders, ensure better experiences of care by people and communities and encourage more sustainable use of resources. As well as presenting the vision and case for change, the Strategy contains a road map of actions for the upcoming 2016-17 financial year and next three to five years to help guide activity in the sector and wider social sector.

The Capability and Capacity Review intersected regularly with this Strategy Refresh project to share findings, themes, and trends. In all cases the key elements identified in the capability and capacity review were completely aligned with those identified by this strategy refresh work stream. The capability and capacity review identified steps to be

taken to support the refreshed strategy. A potential long-term redistribution of Vote Health across the core spending areas is highlighted by the graph below (Table 3) taken from the *Briefing for Incoming Minister* document.



Irrespective of the actual dollar amounts involved and the proportional redistribution achieved, the clear message is that a significant amount of activity currently provided in the secondary and tertiary hospital sector will need to be redistributed to non-hospital based settings. The area in which greatest shift is anticipated is in the management of acute exacerbations of chronic medical conditions. Multiple interviewees emphasised the importance of this redistribution if the system is to contain costs, improve outcomes and meet the objective of the Health Strategy Vision.

4. The impact of the Digital World on New Zealand consumers and the health system

By 2025 the majority of the world's population will in one generation have gone from having virtually no access to unfiltered information to accessing most of the world's information through a device that fits in the palm of their hand. Further, all 13-year olds and younger are mostly digital natives and do not know a world without the Internet and its connected devices. This change will have profound and likely positive effects on the New Zealand health system, the roles of providers (both organisations and individual providers), and on the knowledge and demands of our consumers. Digital technology will

change health institutions of all sizes and in all sectors from within and without. The most significant impact of the spread of communication technologies will be the way they help re-allocate the concentration of power away from the traditional power brokers in the system (i.e. DHBs, provider groups, individual providers), to consumers.

Access to information and to new communication channels has meant new opportunities for consumers to participate, to hold powers to account and to direct and manage the course of one's own life. It enables consumers to be heard, counted, taken seriously and to more actively engage in the management of their own lives and health, through the application of technologies and Apps which were once only in the purview of the providers. Examples, which are available now and have shown improved health management outcomes, include Google X's contact lens digital blood sugar monitor, peak flow monitoring and alerts etc.

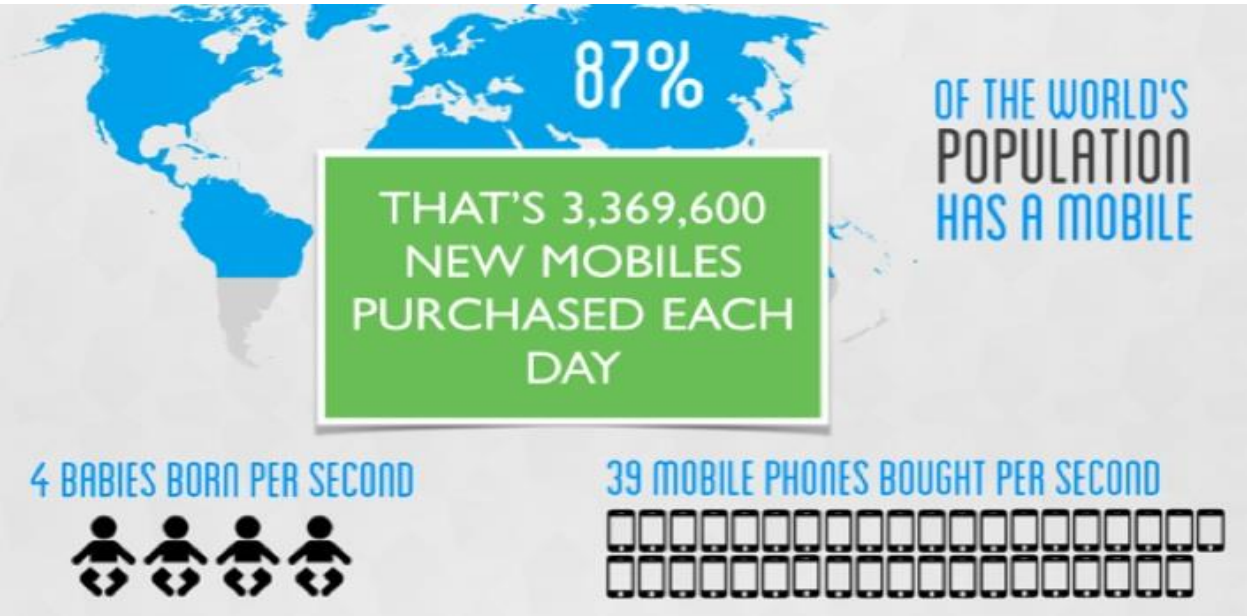


Table 4 above illustrates the consumer reach of digital globally- it is not a choice – it is here.

The digital economy will provide real opportunities (in terms of outcomes and efficiency), and the New Zealand health system must be ready to utilise them in an equitable and efficient way. This will demand minimum ICT standards across the system (including basics like Wi-Fi access in any provider premises), integrated e-Health records, and the ability of all providers to access and update a common health record as appropriate. The benefits and threats of the digital economy must underpin the New Zealand refreshed health strategy and enhanced operating model. The current fragmentation of the health ICT

system is a significant risk to the future capability of the Health system. It is noted that although the National Health IT Board has valiantly tried to establish a system hardware and software approach to create a unified patient record and medical data sharing platform, DHBs have been able to 'opt out' of performance, for a number of reasons. For a country with a relatively small population pool of 4.5 million people, not having the ability to share relevant information through a national system is limiting performance and the ability to leverage the digitisation for the benefit of consumers.

SECTION THREE - REVIEW FINDINGS AND RECOMMENDATIONS

1.The Need to Change

Our current health system is widely recognised for its strengths. However, the review received consistent and resounding feedback that the system would perform better within the same budget if it could reduce fragmentation and duplication, and move away from the short-term transactional nature of the current construct. This would give more focus and support to community and primary care, to consider the provision of services as the basis of a relationship rather than being a transaction, and to enable greater maintenance of health for each person. This will require a shift from the current strong emphasis on the secondary/hospital provider to a more balanced focus that also includes rigorous performance to standards indicating the success in providing long-term effective community and primary services.

It will require the development of new incentives and capabilities to work across the arbitrary boundaries of our current organisations - especially for DHBs - and to readily transfer practice and learnings between health care providers nationwide. Workforce development must include a focus on care delivery within a team-based framework that has the capacity, where needed, to work across practice settings and professional groups.

Finally, it will require some key enabling infrastructure developments to be managed centrally, rather than by individual participants of the system. This is especially the case for ICT-related investments. There is sufficient evidence to suggest that the fragmentation of ICT activities between DHBs is not in the interest of a small country, where the homogenous application of ongoing best-quality care should be possible.

Whilst wellness is an ideal outcome, reduction in deterioration of existing diseases is also required in a well-functioning health system. Such a balanced approach will reduce acute demand for secondary services and improve quality-of-life outcomes for the community.

The review identified the following features of our current health system which can be barriers to achieving the proposed 2015 MoH strategy:

- DHBs often operating in regional and financial isolation, rather than jointly within a New Zealand-wide system, focused on long-term health outcomes.
- Boards and executives are primarily held accountable for their DHB "working within their financial means" while meeting the Government's priority KPIs (in primary and secondary care). There is a lack of incentives to support improved performance in other DHBs, especially those nearby in terms of geography or care specialties.
- Community and primary services are often subordinated in funding to secondary care services, which runs counter-intuitive to where the system can achieve the best outcomes.
- The DHB Board structure presumes competence in governance and leadership, including from elected members, which appears to be lacking in practical day-to-day execution
- Enabling infrastructure issues which impact the whole system are often negotiated with each of the 20 individual DHBs. Decisions are then made based on the short-term fiscal impact on each of the DHBs, rather than for a national whole-of-system benefit.
- While DHBs are charged with understanding their entire community and their part of the health system, the current modus operandi is transactional; based around annual contracts. Risk therefore is often being passed through to several layers of down-stream providers with a corresponding short-term focus and a dilution of funds, resulting with risks remaining unaccounted – ultimately burdening the Crown. This is illustrated by the current $300 - $500 million per year of liability related to the unregulated homecare workforce.
- Limited ability to focus across DHB boundaries on regional and national opportunities such as priority clinical pathways for mental health, and/or segmented population and/or approaches including working with other government organisations with common interests, including New Zealand Police, Justice, Social Development, Sport, Education, etc.
- The currently available data is not being effectively analysed and used to segment and target services based on a forward investment approach.
- The capacity for leaders in the system to become effective change agents is insufficient for our future needs. This can result in a loss of opportunity to produce and disseminate innovation and best practice throughout the sector nationwide.
- The national potential for innovation in health can be constrained by the current emphasis on commercial viability expressed separately by each of the DHBs.

These characteristics underpin the current operating model. There is a gap between the capability and capacity of the current model and the desired enhanced operating model we recommend.

2. The need for a new operating model

The refreshed New Zealand health strategy will only be successful if a clear system-wide operating model underpins it.

The capability and capacity review identified that a future-operating model for the New Zealand health system must embrace the following principles:

- Be consumer-centric (not provider-centric) where future enhancements centre on emphasis and prioritisation, informed by customer needs. This will require discussion with the community in a way that demonstrates a genuine partnership between health service providers and consumers. The review team acknowledges that there are pockets in the system where this is happening already. These islands of excellence must be promoted as models to be followed by the less progressive elements of the health sector. The executive teams of DHBs, PHOs and other health providers must play an active leadership role in the partnership with the communities they serve.
- Recognise that strong focus should be placed primarily on community and primary care and then be supported by secondary and tertiary care. Currently, the DHBs' long-range planning centres around secondary/tertiary care, due to the historic emphasis on treatment rather than early identification and prevention, exacerbated by the disproportionately high costs of providing quality secondary/tertiary care.
- Be outcome-centric not input-centric. Rather than placing a focus on the health transaction, and accounting for those in reporting and evaluation, the emphasis should shift to a reporting/accountability framework of qualitative outcomes, not isolated to health but inclusive of related/connected social conditions, where applicable.
- Reject the approach that regional DHB silos are acceptable, rather than a cooperative and collaborative national approach of delivery of outcomes, i.e. for specific populations, models of care or disease categories. A system that effectively commissions providers to collaboratively address targeted population needs, utilising where appropriate, a long-term forward investment approach.
- Strongly underpin this system approach through competent leadership in management and governance, both clinical and non-clinical, with adequate skills to perform. There should be effective capacity for the future of leadership, through the systematic and transparent development of emerging leaders in the sector.
- Make decisions that are evidence-based, supported by smart analytics. The current system is rich of data but requires improved translation into actionable information.

- Be agile to identify, assess and rollout service innovations and recognise new digital technologies, especially in community care settings.
- Provide the ICT infrastructure a national mandate to implement and make operational, a system that allows information to be shared nationwide to a prescribed standard. A solid understanding of long-term holistic system risk is needed rather than managing a transactional short-term based system, in isolation.
- Stabilise provider relationships through multi-year contracting based on a forward investment approach, which means quantifying future outcome advantages versus upfront investments.

SECTION FOUR - CLOSING CAPABILITY AND CAPACITY GAPS

> We will all need spine to do this - things will not be the same or nothing will change

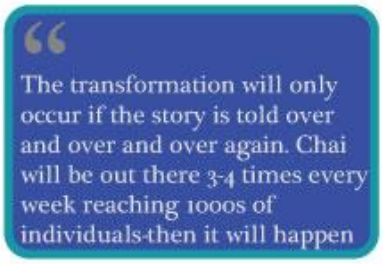
The 2015 Capability and Capacity Review Panel recommends the MoH consider the following changes to the New Zealand health and disability system:

1. Make the health consumer central to the performance of the system
2. Strengthen the MoH mandate to expand from policy advisor and system administrator into system leadership
3. Support a system approach to priority models of care (for population and/or clinical issues)
4. Lead the development of a system that uses data analytics and segmentation for prioitisation and optimisation
5. Supervise the development of a "whole of system" approach to ICT
6. Develop an evidence-based system performance focus to be equally weighted across community/primary to secondary/tertiary and outcome focused
7. Help instill a system approach to workforce development including leadership and risk
8. Develop a system that actively identifies, trials and rolls out innovation
9. Adopt agreed data sets to be collected nationally, including from the private sector.

In order to achieve success, it is critical that an enhanced operating model supports the 2015 strategy refresh with extensive communication to, and consultation with, the national health sector participants. This will include the strong narrative around the strategy and its benefits and what it will mean for consumers and providers, as well as the milestones that will mark achievement of this 2015 strategy refresh.

This sector should be able to complete this transformation within the next five years, supported in the first instance by specific initiatives in priority areas where there is significant investment payback and where existing capability and capacity gaps can be remedied and embedded speedily. During the first two to three years there likely will be limited change in activity for many providers, and it will be business as usual with the promise of better things to come. In parallel with this finalisation of the refreshed strategy with the sector we recommend the following actions be taken in 2016-17 to move toward

the new improved state. These activities can be implemented with confidence while finalising the refreshed strategy because of the strong alignment throughout the sector in regard to the changes that are required.



1. Embedded voice of customer anchoring the new operating model

The move to the new operating model will see success measured through what is achieved collaboratively across the boundaries of health organisations, starting with the health consumer's need at the heart of the design of the service model. This takes precedence over the current system operating within the boundaries of our existing organisations and based on transactions.

Review Recommendation: Implement three consumer-centric population programmes to initiate the shift to the enhanced operating model

MoH and the DHBs do not have the embedded capability and experience in operating across boundaries, collaborating, co-creating with health consumers and regional/national communities to achieve the commissioning of innovative services. To identify and learn how to develop and embed these critical capabilities (such as consumer centric design, meaningful analytics, commissioning expertise, and change management expertise, expertise in active evaluation etc.) needed for the future, and to signal the move away from fragmentation, it is recommended that the following three collaborative programmes commence in the 2016-17 year.

For each programme there are obvious clear gains in outcomes for health consumers. While these are relatively small programmes they would strongly signal the change to this enhanced operating model.

<u>The three programmes are:</u>

1 Providing integrated fit-for-purpose services for targeted "in need" populations of northern Northland, combining resources between the Ministry of Health, Ministry of Social Development, Child Youth and Family Services, New Zealand Police, Ministry of Justice, Ministry of Education and the sports sector providers.
2. Implement enhanced service strategies for the total Pacific Island population, currently covered separately by the three Auckland metropolitan DHBs
3. Target south Auckland youth to early recognise early mental health needs through an integrated approach between the Ministry of Health, Ministry of Social Development, Child Youth and Family Services, New Zealand Police, Ministry of Justice, Ministry of Education, the sports sector providers and other community programme providers.

The critical elements common to the design and implementation of these three programmes should be:

1. The design and approach of the programme must be informed by robust input from the health consumer, to clearly identify needs. For example, ACC has developed an effective model to solicit consumer input/research information, and their approach and learnings could become a starting point for health providers.
2. A hallmark for an effective implementation will be the co-creation of content by local communities, front-line providers, health consumers and their advocates.
3. The successful outcome of the programme requires the assignment of ultimate accountability to one local person or organisation, with appropriately delegated authorities and funding, for agreed outcomes.
4. As a basis for the design of the programme, relevant data must be collected to develop scope.
5. Outcomes and expectations must be based on a multi-year horizon and, where possible, be accompanied by a forward-investment assessment.
6. Rather than MoH and DHBs leading the commissioning process, this must be delegated as above.

7. From the commencement of the programme, learnings will be collected and used to inform future steps of the activities, also to be shared sector-wide for transparent reporting of progress and ultimate outcomes.
8. The funding for these three programmes should come from currently apportioned funds for these respective populations and not exclusively from Vote Health.
9. External expertise will likely be required for the establishment of these programmes as this capability may not currently exist within MoH, DHBs or PHOs.

In addition to these three proposed programmes, the MoH may also approve a limited number of additional collaborative programmes in 2016-17, across current DHB boundary lines, if they are proposed by the DHBs. The MoH would then likely test any newly proposed programmes for similar design characteristics and ensure appropriate capability is available as shown in the above three programmes.

2. A strengthened MoH recognised and empowered for system leadership

The MoH is responsible for the management of the biggest long-term fiscal exposure to the New Zealand taxpayer, and also indirectly leads the largest public sector workforce. Therefore New Zealand needs the MoH to be the effective system-wide strategic leader, and for that it needs the capability, capacity and authority to deliver.

Over the past decade the leadership mandate and capability at the MoH has been diluted for a variety of reasons, including through the establishment of a number of national committees and organisations, with devolved authorities and blurred accountabilities, not always performing to expectations. The review found that a number of these structural arrangements do not have a clear purpose, can confuse accountabilities between the MoH and the Minister of Health, require a large number of capable governors who are not readily available in New Zealand, do not always have the authority needed to be effective, and are not always operating in line with the overall health system strategy and priorities.

With the appointment of a new Director-General of Health and the adoption of the Ministry's 2015 strategy refresh, the time is right to refocus and strengthen the capability of the MoH and its mandate.

The National Health Board was set up as a whole-of-system health planning, advice, and funding organisation. However, given the imperative for the Ministry of Health itself to be

the effective system-wide strategic health leader the functions of the NHB need to be fully within the MoH. This will enhance the strategic ability and role of the MoH.

The National Health Committee was established specifically to make recommendations to the Minister of Health on the prioritisation of new and existing health technologies. Whilst independent advice to the Minister is of importance the "stand alone" nature of this committee is inconsistent with the need to have a single point of strategic responsibility within the MoH. Advice on technology needs to be made within the overall strategic plan of the MoH. In addition, the need to create a more efficient and system-wide approach to innovation supports assessment of technology being a core Ministry function. Some of the recent activity of the NHC on clinical pathways is work that should be performed across the sector. The Review recommendations regarding integration and cooperation within the health system are consistent with groups other than the NHC needing to perform this role.

Review Recommendations:

Remove the impediments to efficient decision-making with the New Zealand health system, by:

1. Creating a new Health Guidance Committee that advises the Director-General of Health on matters previously covered by several individual committees, such as:
    - National Health Board. This board should be disbanded and its residual skills and expertise should continue to be operated by the MoH.
    - National Health Committee. This committee should be disbanded and its residual skills and expertise should continue to be operated by the MoH

2. Health Workforce New Zealand: This group should continue as a section 11 committee (see specific recommendation below)

3. Health Quality and Safety Commission: This committee should remain functioning as it currently does. The MoH and health sector should work with HQSC to define the role of the HQSC in data collection, the format for publication of the data and dissemination of the information.

4. Health Promotion Agency: This agency should remain functioning as it currently does and be the centre of capability for health promotion activity for the system but with their future outcomes to be aligned with the 2015 strategy refresh and accountability directly to the Director-General.

5. The MoH needs to build additional senior clinical capability to articulate the clinical importance of the New Zealand-wide health strategies.

6. A new small Change Implementation Board (limited to an initial term of three years) should be appointed to support, challenge and guide the Director-General of Health during the implementation efforts of the multi-year work programmes associated with the 2015 strategy refresh.

7. Support a consistent nationwide focus among the DHB Chief Executives, by involving the Director-General of Health in the setting of the criteria for up to one third of a CEO's incentive compensation. The award of that incentive compensation part shall be assessed by the DG together with the respective Board Chair in the context of having contributed or achieved nationally important activities in health.

8. Provide for more effective governance leadership of DHB Boards by enhancing the DHB Boards through greater community input and a better focus on competence in decision-making. Specifically, DHB Boards should be reduced from 11 to 9 members (as described in detail below).

9. The MoH should expand the current transparent reporting of key performance categories to include at least two additional categories which, in consultation with the wider sector, will report year on year accomplishments specific to primary and community care outcomes consistent with the 2015 strategy refresh.

3. A system approach to workforce development including governance, leadership and risk management

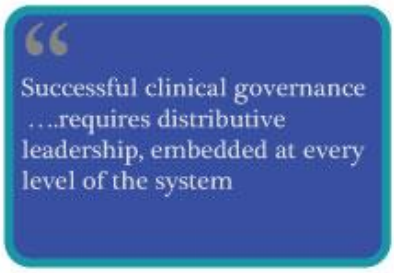
a) Governance

There are many leaders in the New Zealand health system with enthusiasm to contribute, but that aspirational interest alone is not sufficient to achieve competent governance, especially at the DHB board level. The current system of seven elected members contributing community input, together with four appointed members is not respectful of the leadership requirements needed to competently operate large, complex organisations. This can lead to a disproportionate influence of executive management on Board decisions and compromise the separation of leadership and operations.

Review Recommendations:

Enhance the structure and capability of the current DHB Governance structure:

1. DHB Boards should reduce from 11 to 9 members.
   - The Minister appoints 6 of those 9 members.
   - 3 of those 9 members rotate onto the DHB Board for a staggered 6-monthly term from a new Community Advisory Board.
   - The new Community Advisory Board consists of 12 members, elected by the community every 3 years.
2. Operate a redesigned nationwide governance training programme mandatory for all Board members, and for all top leaders in DHBs.
3. Introduce a mandatory annual review of governance performance of entities and directors by an agreed independent assessor or process.



b) Workforce Capability and Capacity

Professional clinical workforce gaps do exist but are not seen as the most pressing issue for the future capacity and capability of the health system. Rather, the issue is preparing the workforce for changing practice attitudes and models of care required in the future. This will include the development of supporting roles that work with traditional clinical roles (such as care-navigators and home help workforce in community care), as well as linking with non-medical providers such as education, police, etc. There currently are no effective recruitment strategies, adequate compensation models and standards of performance available for such non-clinical contributors in the community.

Professional gaps in the clinical workforce such as ageing GPs and midwives and changing GP practice ownership models are generally understood, and their respective professional bodies have made varying progress in addressing the impacts. In some cases the noise in the system is about short-term issues that need a tactical response and is a distraction from medium- to long-term service sustainability.

Health Workforce New Zealand has developed "health intelligence" around workforce demands. Whilst initially focused on the medical workforce, progress is now being made in nursing, midwifery and allied workforce needs.

The Review heard several examples of defined and sustained benefits from innovative practice models. For instance, Nurse Practitioner models in community settings have led to a durable 20-30 percent reduction in acute presentation for chronic respiratory patients. Similar reductions have occurred in a PHO-DHB integrated model where hospital – employed respiratory physicians spend part of their time in community-based care settings. Integrated care models, identification and case management of "frequent flyer" cases and localities-based advice and management teams have all demonstrated positive reductions in acute care needs for at-risk patient populations. However, current funding models and employment contracts are a barrier to further developments of these initiatives. For example, Nurse Practitioners in community-based settings are likely to be effective both within a practice and across practices depending on patient volumes; rather, current Primary Care funding is directed in large part to an individual practice.

Predicted Nurse Practitioner numbers have not been met, however there is a trend toward younger nurses entering training for these roles. Nurse Practitioners, particularly in the community, are vulnerable to uncertainty about long-term employment. This is a barrier to further role development.

The recent decision of the Medical Council of New Zealand to mandate community experience for intern doctors is a positive step. The Nursing Council of New Zealand could consider expanding nursing students' exposure to community-focused practice.

Good progress is being made in targeting and training Maori and Pacific clinical workforce but more support is required for these graduates to manage their workload based on community expectations of their contribution. Clinical practitioners of Asian descent are still under-represented in the New Zealand health system, with midwifery a particular example.

A real capacity issue across the system is the lack of leadership and technical managerial skills to operate in a purposeful collaborative model, including managing system risk, managing dynamic change, and co-creating and commissioning consumer-centric outcome service models in community care. In these areas, data availability and analysis is weak.

There is a lack of recognition of the time necessary to develop effective clinical leaders. In addition, some employment practices do not allow existing leaders enough time to fulfill their leadership roles.

There is no systematic leadership development, talent identification and career management for non-clinical leaders within the public health system, despite it being the largest employer in the public sector. Further, there is no whole-of-system view on capability gaps and how these will be addressed to meet future demand such as the role of the unregulated workforce, clinical care navigators, transforming general practice models and scopes of practice etc. The sector lacks the capability or systems to effectively test and refine models of care that can then be rapidly adopted across the country.

The future operating model requires:

- a focus on purposeful collaborative leadership
- leadership that embraces and owns an end-to-end view of the system
- leadership that is committed to and good at dissemination of good practice across the system
- leadership that empowers flexible clinical delivery models
- leadership that can assess outcome effectiveness of these new models
- leadership that is nimble and responsive to the differing circumstances for health consumer groups
- recognition within employment contracts of the time-commitments needed to develop leadership and for these leaders to perform their leadership roles.

Learnings should be generated from those DHBs that have put in place good local models of leadership development programmes that can include linking to offshore providers and approaches. However, there seems to be a hesitation by some sector participants to share and by others to adopt.

Review Recommendation:

That the Health Workforce New Zealand be retained as a section 11committee but that its accountability be shifted to the Director-General of Health, as described above. It should be accountable for developing and delivering a rolling five-year workforce plan to:

1. Create a systematic approach to leadership development, talent identification and career management leveraging off successful approaches within the wider public sector and within pockets of the current health system.
2. Work with training providers to address specific strategic needs. For example, the ability to deliver high-quality palliative care in aged care and home settings is in part dependent on the General Practice palliative care training programme being emphasised as part of the GP's training schedule.
3. Work with Government on eliminating legislative barriers to expanded scopes of practice, especially of nurses and pharmacists.
4. Work with the Ministry of Education to highlight opportunities for future participation in science disciplines.
5. Help the various specialist training bodies to attract and retain participants from minorities, particularly Māori and Pacific people.

4. A National Approach to ICT

The vision of the National Health IT Board was to give all New Zealanders electronic access to a core set of their own health information by the end of 2014. Then and now even more there is overwhelming national support from health consumers, clinicians and provider organisations for integrated patient records and patient portals. While there have been some significant successes to date, the speed of accomplishing this overarching objective has been slow. The key capability and capacity challenge across this part of the sector is that leadership knowledge, plus ICT skill and experience across DHBs and within PHOs, is variable where ICT enabled e-Health initiatives need to be developed and implemented.

To date, only 40,000 New Zealanders have access to their health information via a patient portal provided by their GP. While a marketing campaign was launched by the Minister of Health in April 2015, encouraging consumers and GP practices to increase these numbers, further progress in this area is needed.

In addition to the individual patient portal, New Zealanders and healthcare providers also consider it essential to have an integrated health record immediately available online, regardless of the consumer's circumstances of the contact with the health system. Achieving this goal will positively impact on service quality, outcomes and efficiency. Regrettably, limited progress has been made on this initiative. A target of 31 October 2018 has now been set to complete this effort. The project goal is to implement a real-time

electronic view of an individual's health information (known as the 'eHealth Record') throughout the health and disability sector. Organisations providing health services in New Zealand, including public, private and non-government organisations, must make their information available in real-time to populate this eHealth Record. This requires appropriate systems in place to achieve this objective.

Currently, the National Health IT Board must work with each DHB individually to achieve this national objective, and each DHB has the delegated authority to decide whether to support the project or not. In the end the National Health IT Board has 'no teeth' to mandate any progress across the system, with all decision rights being held individually by each of the 20 DHBs. This is an unacceptable muting of the National Health IT Board's national mandate.

Review Recommendation:

1. The National Health IT Board should remain in place, and be directly accountable to the Director-General Health.
2. The National Health IT Board should be given the appropriate authority, including budget, to achieve implementation of the national eHealth record and patient portal system by the end of 2018.
3. The Director-General of Health and the National Health IT Board may also identify other ICT and infrastructure enablement projects that should be centrally mandated and managed to achieve effective outcomes.
4. A minimum mandatory ICT capability standard needs to be established for the system. While DHBs would have the responsibility to select their own ICT implementation partners, the National Health IT Board would prescribe the required minimum functionality.

5. A system that encourages innovation- particularly in the community and primary care areas

Throughout our interviews we came across numerous service delivery innovations, operating in isolated and fragmented ways. Some included measurable positive outcomes for health consumers and/or efficiency gains across boundaries. However, most reported that their innovation was limited to just their geographic area and was mostly unknown to the other providers throughout this small country. Similarly, they themselves were unaware of progress outside their regions.

Further, we saw a number of new programmes and approaches being "touted" around Ministers and funders, soliciting support, as there currently is no effective way to have initiatives evaluated and funded centrally.

NGOs report that they are aware of service innovations that could add value to health consumers and improve outcomes, but that there is no incentive (or even interest) from their funders to evaluate and/or introduce these initiatives. This is because of the current transactional approach to funding and the limitation of one-year contracts issued by DHBs. These contracts are often rolled over with minimal change, often only demanding a net real decrease in funding, while costs increased in the system (e.g. increases of 0.5% while the MECA settlement is significantly greater). Therefore, it appears that 1-year length of the service contracting is merely a tool to pressure NGOs into accepting price reductions. Due to this short-term funding approach there would be little chance of community service providers undertaking Research and Development – yet improved development in this area could reduce the anticipated increase of demand for secondary hospital-based services.

Introduction of technology innovations in the New Zealand health sector is procedurally burdensome and therefore slow. The review team was surprised that the Health Innovation hub now essentially reports to only one DHB. This was after it failed to get traction and support from multiple DHBs as a whole of system approach to technology innovation. It now consequently takes instructions from that DHB as to which innovations to pursue or to cull. This might depend on the potential for that DHB to on-sell such innovations to other DHBs at a profit. This 'sub franchising' of opportunities is unhelpful in a small country with limited resources and great opportunities to quickly trial innovations nationally. Such innovation activities should by all means accept contributions from DHBs and other sector participants, but should take instructions directly from the Ministry to prevent the skewing of opportunities.

Review Recommendation:

1. The MoH undertakes further work to determine how to systematically incentivise and fund a process (or processes) by which there is national sharing of best practice and roll out of service innovation and technology innovation across the system.

6. Address funding issues to enable the new operating model

Review Recommendation:

The key funding issues that must be addressed to achieve the suggested achievements for 2016-17 are:

2. The recommended new operating model initiatives need to be funded adequately from existing funding, re-directed for these specific outcomes. In some instances this will also include funds allocated from sectors outside of Health (see Funding Review).
3. The revised funding model should also:
    - Ensure that the health consumer is not paying different amounts for the same service at different provider levels. For example, rehabilitation at primary care level often requires part personal payment, but no such part payment is needed when the same rehabilitation service is delivered in a secondary care setting.
    - Redesign Inter-District Flow rules to remove barriers to patients receiving the most appropriate care in the most suitable setting.
    - Provide DHBs with funding certainty so that they in turn can lengthen down-stream contracts with provider beyond the current one-year lengths.
    - Remove the irrational effects of means testing, triggering home sales, when patients enter the health system late in life, to encourage a return to unassisted living at home.
    - Re-calculate capitation payments to appropriately compensate for actual patient needs, rather than calculate capitation payments based on practice demographic features of each practice.
    - Incentivise PHO and primary care organisations and providers to develop and employ new models of care such as utilising nurse practitioners, and/or configuring greater team-based care models, integrating pharmacists and allied medical providers into the team, etc.

The system should be flexible and sufficiently agile to identify and then address the numerous other opportunities to enhance care in the community and primary sectors. Priority should be given to funding models that effectively incentivise both provider and consumer to seek adequate care outside the secondary system.

The Review also heard numerous examples where integration and cooperation between the Health sector and the various other social sector ministries would enhance health outcomes and reduce inequalities. It is essential that a centrally led approach to this work is enhanced and progressed, to build on the existing initiatives being pursued by social sector executives.

APPENDIX SCHEDULE

APPENDIX I - Terms of Reference

APPENDIX II - Listing of Interviewees

APPENDIX III - Overview of section 11 committees

APPENDIX IV - Reviewer backgrounds

Terms of Reference
Capability and Capacity Review

Background

In 2009 the Government responded to the challenges facing New Zealand's public health and disability system by establishing a Ministerial Review Group (MRG). Its task was to provide advice on how best to improve the quality and performance of the system. The recommendations adopted by Government were focused on reducing duplication of capital expenditure decisions, workforce planning, information technology (IT) services, and consolidation of the 21 District Health Boards' back office functions. The Group recommended a review of the effectiveness of the adopted recommendations after three years.

Over the past five years the challenges to the clinical and financial viability of the public health and disability system have intensified. Performance has generally been sound through tough financial times but New Zealand continues to compete for a scarce workforce, and changing health needs and patterns of ill health (driven in part by demographics) mean that new models of care are needed. Balancing increasing costs with changing public expectations of service and a growing fiscal sustainability challenge while maintaining quality, is increasingly problematic. Across the supply chain of health provision, the system is also currently weighted in the areas of detection and treatment, rather than the prevention or rehabilitation elements that can best contribute to improved economic growth and social cohesion.

Capability and Capacity Review Purpose

The Government wants to build on the current progress of the New Zealand health and disability system and improve its adaptability and responsiveness to meet future needs. In order to achieve this, the Director-General has requested a review of the post-Ministerial Review Group (MRG) sector arrangements, with a particular focus on the *capability and*

capacity gaps that need to be addressed if the system is to be well placed to meet the medium term challenges before it.

For the purpose of this review "capability and capacity" is defined as human capability and capacity including governance (both corporate and clinical), leadership, management and delivery.

The review will consider and comment on infrastructure, technology and facilities capability and capacity as it relates to both structural and human resource dimensions.

Review Deliverables

The review will advise the Director-General on:

- how well placed the sector is in terms of the human resource capability and capacity if the sector landscape (using a four year excellence horizon) was to be all it could be to support the health and wellness of New Zealanders. The review will be informed by learning's following the MRG implementation as well as considering new insights/thinking not identified in the MRG review;
- the capability and capacity gaps that must be filled and developed, and the sector operating model enhancements that must be incorporated going forward to deliver the four year excellence horizon;
- areas, which may require further exploration to unlock the identified performance challenge.

In particular the review will address:

- Have the new constructs post the MRG, in relation to human resources capability and capacity, added value?
- Is the current quality of clinical and managerial governance and leadership consistent, adding value and supporting quality service delivery?
- Is the contracting environment, capacity and relationship management between the DHB sector and NGOs best placed to meet health system and users' needs?

The review will take as its starting point the decisions made by Cabinet following the recommendations of the 2009 Ministerial Review Group and:

- specifically look at the capability and capacity of national bodies within the health sector, such as, but not limited to, (and in no particular order) -

- National Health Board, National Health IT Board, Health Quality and Safety Commission, National Health Committee, Health Workforce New Zealand;
- Any other agencies or individuals that the panel considers will contribute information useful to their deliberations and is within review scope.

Progress reports will be provided to the Director-General fortnightly commencing 27 March 2015.

A final report will be provided to the Director-General by 30 June 2015.

Review Scope

The capability and capacity review will have two key foci:

a. an assessment of post MRG sector arrangements through consideration of the following questions from a capability and capacity perspective:
    i. are the resulting sector arrangements working and delivering the results as intended?
    ii. are these sector arrangements still setting the New Zealand health and disability system up well for the future?

b. as a result of changes in the post-MRG environment or due to fresh insights, is sufficient progress being made to ensure the health and disability sector has the appropriate capability and capacity, innovation and flexibility to respond to the challenges it is facing?

Process and Methodology

The panel for this review will comprise:

- Sue Suckling (chair)
- Andrew Connolly
- Jens Mueller
- David Russell.

Officials from the Ministry of Health will provide technical support and advice to the review, in addition to secretariat support.

The Review will be focused, qualitative and principally use targeted interview inquiry diagnostics (as is used in the SSC PIF review methodology). Key personnel in the health and

disability system, including the Chairs and CEOs of major national post-MRG bodies and leaders of other sector agencies e.g., NGOs and community groups, will be interviewed as a part of this review through a structured interview process. Panel members will undertake interviews. The Director-General will be consulted as to who will be interviewed but the panel will be free to talk to additional persons who it deems are relevant to deliver on its brief. The review may also request input from other bodies that intersect the health system or provide key infrastructural services. Interviews will be supplemented by relevant documentation as requested by the panel.

Interviews will be booked and carried out during April and May, and will be in person or by telephone.

Information obtained as part of the interview process will remain confidential to the review panel.

The review will take account of related work and work closely with the funding review and the Ministry team developing the New Zealand Health Strategy (Strategy).

Any communications about the review will be agreed between the Director-General and the review Chair.

Related Work

The Minister of Health has asked the Ministry to lead an update of the New Zealand Health Strategy to be delivered by the end of June 2015. The Capability and Capacity Review will need to reflect the high-level direction being developed in the Strategy – to achieve the timelines set for both projects close linkages between this review process and the development of the Strategy will be required.

The Director-General of Health has asked an independent review group led by Dr Murray Horn to assess what funding arrangements can best support the Government's high level outcomes for the health and disability system and how funding may best be allocated within the system. The capability and capacity review must work with Dr Horn to ensure alignment and relevance in findings and recommendations between the two reviews.

Where additional areas are identified during the work of the other reviews that could be included within this project scope, this is to be at the mutual agreement of the Director-General and the review Chair.

APPENDIX II - Listing of Interviewees

Interviewees

Organisation	Interviewee
Accident Compensation Corporation	Paula Rebstock, Chair
Accident Compensation Corporation	Scott Pickering, Chief Executive
Acurity Health Group	Ian England, Chief Executive
Association of Salaried Medical Specialists (ASMS)	Angela Belich, Deputy Executive Director
Association of Salaried Medical Specialists (ASMS)	Dr Hein Stander, National President
Association of Salaried Medical Specialists (ASMS)	Lyndon Keene, Researcher
Auckland DHB	Dr Richard Sullivan, Clinical Leader
Bay of Plenty DHB	Sally Webb, Chair
BUPA	Gráinne Moss, Managing Director
Canterbury & West Coast DHBs	Carolyn Gullery, General Manager Planning & Funding
Canterbury and West Coast DHBs	David Meates, Chief Executive
Capital and Coast DHB, Hutt DHB and Wairarapa DHB (3DHBs)	Dr Ashley Bloomfield, Director, Service Integration & Development
Capital Investment Committee, National Health Board	Evan Davies, Chair
Central TAS	Graham Smith, Chief Executive
Central TAS	Team members
College of Nurses Aotearoa	Professor Jenny Carryer, Executive Director
Council of Pacific Collectives	Tino Pereira and colleagues
Counties Manukau DHB	Associate Professor Peter Gow
Counties Manukau DHB	Dr Lee Mathias, Chair
Counties Manukau DHB	Geraint Martin, Chief Executive Officer
Counties Manukau DHB	Martin Chadwick, Director, Allied Health
Counties Manukau DHB	Professor Jonathon Gray, Director, Ko Awatea
Department of Corrections	Bronwyn Donaldson, Director, Offender Health
Department of Corrections	Vince Arbuckle, Deputy Chief Executive, Corporate Services
Department of the Prime Minister and Cabinet	Andrew Kibblewhite, Chief Executive
Department of the Prime Minister and Cabinet	Arati Waldegrave, Advisor, Policy Advisory Group – Health, ACC & State Sector
Directors of Nursing	Helen Pocknall, Chair
General Practice New Zealand	Fiona Thomson, Chief Executive Officer
Health and Disability Commissioner	Anthony Hill, Health and Disability Commissioner
Health and Disability Commissioner	Dr Lynne Lane, Mental Health Commissioner
Health Information Standards Organisation (HISO)	Zeeman Van Der Merwe, Chair
Health Promotion Agency	Clive Nelson, Chief Executive
Health Promotion Agency	Dr Lee Mathias, Chair
Health Quality and Safety Commission	Dr David Sage, Clinical Lead

Health Quality and Safety Commission	Dr Janice Wilson, Chief Executive Officer
Health Quality and Safety Commission	Professor Alan Merry, Chair
Health Research Council	Dr Matire Harwood, Deputy Chair
Health Workforce New Zealand	Dr Graeme Benny, Director
Health Workforce New Zealand	Professor Des Gorman, Executive Chair
Healthcare of NZ Ltd	Peter Hausmann, Chief Executive Officer and Executive Director
Hospice NZ	Mary Schumacher, Chief Executive Officer
Hospice NZ	Wilf Marley, President
Kowhai Health Associates	Cathy Cooney
Le Va Pacific Inc	Dr Monique Feleafa, Chief Executive
Medical Technology Association of New Zealand	Chandra Selvadurai, President
Medical Technology Association of New Zealand	Faye Sumner, Chief Executive Officer
Mental Health Foundation	Judi Clements, Chief Executive
MercyAscot	Dr Lloyd McCann, Director Medical Services
Metlifecare	Alan Edwards, Chief Executive Officer
MidCentral DHB	Barbara Robson , Board Member and Consumer Advocate
MidCentral DHB	Dr Ken Clark, Chief Medical Officer (and Chair, National CMO group)
Midlands Health Network	John Macaskill-Smith, Chief Executive Officer
Midwifery Council	Sharron Cole, Chief Executive/Registrar
Midwifery Council	Sue Calvert, Midwifery Advisor
Ministry of Health	Cathy O'Malley, Deputy Director-General, Sector Capability and Implementation
Ministry of Health	Chai Chuah, Director-General of Health
Ministry of Health	Dr Anna Ranta, Clinical Leader, Stroke
Ministry of Health	Dr Don Mackie, Chief Medical Officer
Ministry of Health	Executive Leadership Team
Ministry of Social Development	Brendan Boyle, Chief Executive
National Hauora Coalition	Simon Royal, Chief Executive
National Health Board	Board Members
National Health Board	Dr Margaret Wilsher, Board Member
National Health Board	Hayden Wano, Interim Chair
National Health Committee	Mrs Anne Kolbe, Chair
National Health Committee	Peter Guthrie, General Manager
National Health IT Board	Dr Murray Milner, Chair
National Health IT Board	Graeme Osborne, Director
National Health IT Consumer Panel	Stephanie Fletcher, Chair
Nelson Marlborough District Health Board	Chris Fleming, Chief Executive
Nelson Marlborough District Health Board	Jenny Black, Chair
New Zealand Disability Support Network	Dr Garth Bennie, Chief Executive
New Zealand Health Innovation Hub	Dr Frances Guyett, Chief Executive Officer
New Zealand Nurses Organisation	Kerri Nuku, Kaiwhakahaere
New Zealand Nurses Organisation	Marion Guy, President
New Zealand Nurses Organisation	Memo Musa, Chief Executive
New Zealand Police	Commissioner Mike Bush, Commissioner of Police
New Zealand Productivity Commission	Dr Graham Scott, Commissioner
New Zealand Public Service Association	Richard Wagstaff, National Secretary (and colleagues)

New Zealand Resident Doctors' Association	Dr Deborah Powell, National Secretary
New Zealand Resident Doctors' Association	Dr Sara Moeke, President
Nga Mataapuna Oranga	Janice Kuka, Chief Executive Officer
Ngati Hine Health Trust	Gwen Tepania-Palmer, Executive Chair
Ngati Porou Hauora	Rose Kahaki, Chair
Ngati Porou Hauora	Teepa Wawatai, Chief Executive
Nursing Council	Carolyn Reed, Chief Executive Officer
Nursing Council	Dr Deborah Rowe, Chair
NZ College of Midwives	Norma Campbell, Jacqui Anderson and Alison Eddy
NZ Health IT Cluster	Jodi Mitchell, Chair
NZ Health IT Cluster	Jodi Mitchell, Chair
NZ Health IT Cluster	Scott Arrol, Chief Executive
Ora Toa PHO	Matiu Rei, Chief Executive
Ora Toa PHO	Te Iringa Davies, Manager
Orion Health	Ian McCrae, Chief Executive Officer
Orion Health	Jerome Faury, Country Manager - New Zealand
Pegasus Health	Professor Les Toop, Chair
Pegasus Health	Vince Barry, Chief Executive
PHARMAC	Steffan Crusaz, Chair
PHARMAC	Stuart McLauchlan, Chief Executive Officer
Pharmacy Guild of New Zealand	Dr Lee Hohaia, Chief Executive
PHO Alliance	John Ayling, Chair
PHO Alliance	Philip Grant, Chief Executive
Platform Trust	Marion Blake, Chief Executive
Procare Health Limited	Dr Harley Aish, Chair
Procare Health Limited	Paul Roseman, Senior Manager - Strategic Development
Procare Health Limited	Steve Boomert, Chief Executive Officer
Progress to Health	Karen Covell, Chief Executive
PwC	Debbie Frances, Partner
Ryman Healthcare	Simon Challies, Managing Director
Sapere	David Moore, Chief Executive Officer and Director
Secretary for Education	Peter Hughes
Service Food Workers Union	John Ryall, President
State Services Commission	Iain Rennie, State Services Commission
State Services Commission	Mary Slater, Assistant Commissioner
The Treasury	Ben McBride, Manager Health
The Treasury	Gabriel Makhlouf, Chief Executive and Secretary
University of Auckland	Professor Ngaire Kerse, Head of School of Population Health and a Professor of General Practice and Primary Health Care
University of Otago	Professor Peter Crampton, Pro Vice Chancellor, Health Sciences and Dean, Faculty of Medicine
University of Otago	Associate Professor Jo Baxter, Associate Dean – Maori Health
Waitemata DHB	Dr Dale Bramley, Chief Executive Officer
Waitemata DHB	Dr Lester Levy, Chair
Walsh Trust	Rob Warriner, Chief Executive
Whitireia Polytechnic	Dr Kathryn Holloway, Dean of Faculty of Health

World Health Organization, Manila	Dr Mark Jacobs, Divisional Director, Combating Communicable Diseases
Also:	DHB Chairs and Chief Executives
	Directors of Nursing
	Dr Murray Horn, Chair, Funding Review
	Hon Bill English, Minister of Finance
	Hon Dr Jonathan Coleman, Minister of Health
	Murray Georgel, until recently, Chief Executive, MidCentral DHB
	Professor Nicholas Mays, Former Principal Health Advisor, New Zealand Treasury

Note: Some stakeholders represented multiple organisations.

APPENDIX III - Overview of Section 11 Committees

Overview of section 11 committees

National Health Board

The National Health Board is made up of a ministerial appointed board established under section 11 of the NZPHD Act, which is supported by a branded business unit within the Ministry of Health.

It was established in 2009 to advise the Minister of Health on the planning and funding of designated national services and DHB services. It is responsible for overseeing the NHB Business Unit's work programmeme and, along with its subcommittees and HWNZ, providing advice on how to bring together activities associated with planning and funding of future capacity (IT, facilities and workforce) in order to better integrate them for future service requirements.

The Board has nine members (including the chair), who are appointed by the Minister of Health.

A manager (the National Director) of the National Health Board is appointed by the Director-General of Health after first consulting with the Chair of the National Health Board. The Director-General is accountable for the performance of the NHB Business unit, and the National Director of the NHB is responsible to the DG for the performance of functions and powers delegated by the DG.

National Health IT Board

The National Health IT Board is established as a sub-committee of, and reports to, the NHB. It was established in 2009 and replaced the Health Information Strategy Advisory Committee.

The Board provides independent, strategic advice to the Minister of Health, NHB and Ministry of Health. It is responsible for strategic guidance for the sector on the best approach to develop a coherent ICT capability for the sector and endorsing specific investments in ICT to ensure alignment with strategy and implementation.

The National Health IT Board comprises up to eight members including the chair. The Minister of Health appoints the chair and board members.

The work of the National Health IT Board is supported by the Information Group which is part of the NHB Business unit. The Information Group is led by the Director, National Health IT Board & Director, Information Group. The Director is appointed by and accountable to the National Director, NHB (and ultimately the Director-General).

Capital Investment Committee

The CIC is a subcommittee of the NHB. It is responsible for a centrally-led process for the national prioritisation and allocation of health capital investment in the health sector.

The CIC comprises up to seven members including the chair. The NHB appoints the chair after consultation with the Minister of Health and the Minister of Finance. The Chair will appoint the members of the CIC, after consultation with the Ministers of Health and Finance.

The work of the CIC is supported by the National Health Board Business Unit.

National Health Committee

The NHC is established under both sections 11 and 13 of the NZ Public Health and Disability Act 2000. (Section 13 of the Act enables the Minister to appoint a committee (established under section 11) to be known as the national advisory committee on health and disability.)

The NHC was reconfigured in 2011 and is responsible for prioritising new and existing health technologies and making recommendations to the Minister of Health. The NHC also incorporates the Public Health Advisory Committee.

The NHC comprises up to 10 members (including the chair) who are appointed by the Minister of Health.

The NHC is supported in its work by an Executive which is resourced by the Ministry of Health but responsible to the NHC.

Health Workforce New Zealand

HWNZ is a branded business of the National Health Board and its work is overseen by an independent board appointed under section 11 of the NZPHD Act.

HWNZ was set up in 2009 to provide national leadership on the development of the health and disability workforce. It has overall responsibility for planning and development of the health workforce and ensuring that our healthcare workforce is fit for purpose.

HWNZ provides advice to both the Minister of Health and the DG of Health. It is accountable to the Minister of Health.

HWNZ comprises eight members including the Chair. The NHB Business Unit National Director (and the DG of Health) are accountable for the performance of the business unit via a Director, HWNZ. The National Director, NHB is responsible for appointing the Director after first consulting with the chair of HWNZ.

APPENDIX IV - Reviewer Background Information

Sue Suckling, OBE (Chair)

Sue Suckling has over 30 years' experience in corporate governance and leading strategic projects both in the public and private sector. She currently holds a number of senior governance roles including Chairing NZQA and Callaghan Innovation for the Crown. She holds a Masters in Biotechnology and an Honorary Doctorate in Science, is a Companion of the Royal Society, and has been awarded an OBE for her contribution to business.

Andrew Connolly, BHB, MBChB, FRACS (General Surgery)

Andrew Connolly is a general & colorectal surgeon and Head of Department of General and Vascular Surgery at Counties Manukau District Health Board. He is the Chair of the Medical Council of New Zealand. He holds a University of Auckland honorary Associate Professorship in Surgery.

Professor Jens Mueller, MNZM

Jens Mueller has led global health care enterprises for more than 30 years, in Europe, the USA and New Zealand. He now consults with governments and businesses on sustainable long-term corporate strategies. He teaches at Hamilton's Waikato Management School, Shantou University in China and Northern Illinois University in Chicago, and is a Director of PHARMAC and its Audit/Forecast Committee Chair. He is a Professional Member of the Royal Society, holds two doctorates and three Masters degrees in law and business and is a company director in NZ and overseas. He has authored/edited 7 books on leadership.

David Russell, QSO

David Russell is a consumer issues consultant with a particular interest in the health sector. He is the past chief executive of Consumer NZ and currently Chairs the Telecommunications Dispute Resolution Council. He holds a Massey University honorary doctorate in commerce.

APPENDIX V - Overview of New Zealand Health Strategy update

The current New Zealand Health Strategy was released in 2000. In the 15 years since then, our population has changed and the health sector is facing a range of pressures, including a growing ageing population and fiscal sustainability.

The Ministry is updating the New Zealand Health Strategy to reflect these changes and ensure we're achieving better health outcomes, and delivering quality health and disability services to the New Zealanders who need them the most.

The updated Strategy will include a roadmap for the sector, identifying the best way to achieve our priorities over the next 3–5 years.

Process for updating the strategy

The Ministry will develop the strategy using targeted engagement and consultation with key stakeholders.

Two external reviews of health sector funding arrangements, and sector capability and capacity will also inform the update of the strategy. These reviews will consider how the health sector can best support the delivery of government policy and ensure that the sector can meet future needs.

The draft strategy will be delivered to the Minister by the end of June. Consultation on the draft strategy will occur after the Minister has considered the draft.

Management of the update

The update of the New Zealand Health Strategy will be led by the Ministry of Health, supported by the expertise of an external advisory group.