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Appendix A: Terms of Reference

Purpose

The Government has established a review into the New Zealand Health and Disability System (the Review). This review will identify opportunities to improve the performance, structure, and sustainability of the system with a goal of achieving equity of outcomes, and contributing to wellness for all, particularly Māori and Pacific peoples.

Background

The New Zealand Health and Disability System has many strengths, and intersects the life of every New Zealander. It is looking after New Zealanders well, especially when we are acutely ill or injured.

Overall, New Zealanders are living longer and healthier lives. However, the way the current system is operating means that many people, particularly those on low incomes, wait until they are sick, instead of accessing the care they need to stay well. Disparities of outcomes exist across the system, especially for Māori and Pacific peoples. In reviewing the New Zealand Health and Disability System we can identify opportunities to do more, and to address these inequities.

The system is under pressure, facing significant contextual change, and will need to operate very differently if it is to continue to deliver for New Zealanders. The rapidly changing global, societal and technological context within which New Zealand's Health and Disability System operates makes a review timely.

The current devolved Health and Disability System has a complex mix of governance, ownership, business and accountability arrangements. This complexity can get in the way of ensuring public money is spent, and invested, in a manner that provides health care to the public in a coherent and smart way.

Scope of Review

All New Zealanders should be able to aspire to improving levels of health and wellbeing. The goal for the New Zealand Health and Disability System, as currently set out in legislation is that it is strong, effective and delivers equitable health outcomes for all New Zealanders. The Review will investigate where the system is not currently achieving this core equity goal, and understand the drivers of this (whether it be service delivery, or the broader social determinants of health). The Review will focus on the future needs of New Zealanders and make recommendations on changes to the Health and Disability system to ensure all New Zealanders have confidence that the system will assist them and their families to live well.

The Review will consider the overall function of the Health and Disability system to ensure the system is better balanced towards wellness, access, equity, and sustainability.

The Review will provide a report to the Government, including recommendations, on:

- ▶ A sustainable and forward-looking Health and Disability System that is well placed to respond to future needs of all New Zealanders and which:
 - Is designed to achieve better health and wellness outcomes for all New Zealanders
 - Ensures improvements in health outcomes of Māori and other population groups
 - Has reduced barriers to access to both health and disability services to achieve equitable outcomes for all parts of the population

- Improves the quality, effectiveness and efficiency of the Health and Disability System, including institutional, funding and governance arrangements.

▶ How the recommendations could be implemented.

In examining the points above, the Review will consider:

- ▶ Future needs of the population and how they may differ from the issues seen today (such as the impact of population change and growth, upon service demand, workforce availability and risks that may need to be managed)
- ▶ Importance of primary health care as the foundation of a person-centred Health and Disability system
- ▶ The role of public health and prevention in supporting health and wellness
- ▶ Contribution of and the interaction between health and other social sector agencies in supporting health and wellness
- ▶ Capacity of the Health and Disability system to deliver the appropriate level of care and ensure the care is safe and high-quality
- ▶ Distribution of services, including current investment practices and future infrastructure needs
- ▶ Optimising workforce (development, scopes of practice, inter-professional collaboration, retention, cultural competency, and distribution)
- ▶ The role of data and evidence in informing policy development, investment decisions, and provision of services
- ▶ Potential opportunities and risks associated with current and emerging technologies and the implications for, including but not limited to, delivery of services, clinical tools and settings, communication and transport
- ▶ The Government's overall Fiscal Strategy.

The Government expects that the Review will work alongside other reviews, and consider their outcomes and findings as appropriate in preparation of the recommendations of the Review.

The following areas are outside the scope of the Review:

- ▶ The ACC scheme itself (although the relationship between the Health and Disability system and the ACC scheme is within scope)
- ▶ PHARMAC (although the relationship between the Health and Disability system and PHARMAC is within scope)
- ▶ Private health insurance (although its interaction with demographic drivers of health care need is within scope)
- ▶ The MidCentral Prototype (for Disability service delivery) that is currently underway (however, learnings from this work will be considered during the development of the Review's recommendations).

Reviewers

The review will be undertaken by an expert review panel (the panel), comprising of a Chair and up to six Panel members. The expert review panel (the panel) will be supported by a secretariat of officials and it will be able to seek independent advice and analysis on any matter within the scope of its Terms of Reference.

Process and Timing

The panel will be expected to engage with stakeholders including DHBs, PHOs, other health providers, health professionals, and the public in developing its recommendations. Engagement with the public will enable consumers, family and whānau to be included and heard.

The panel should have its first meeting no later than August 2018, issue an interim report to the Minister of Health no later than 30 August 2019, and a final report to the Minister of Health no later than 31 March 2020. These dates may be varied with the consent of the Minister of Health.

Appendix B: Recent and ongoing initiatives

Recent and ongoing initiatives

The Review recognises a series of recently completed or ongoing initiatives that directly affect or work alongside its own work and that had extensive engagement and input from a wide variety of New Zealanders. In this interim report, the Panel does not revisit general recommendations from these earlier reports, but will respond to specific recommendations directed towards it in the final report.

Better Later Life / He Oranga Kaumātua 2019 to 2034: Strategy for an ageing population

This strategy identifies five areas to improve experiences of ageing: the need to prepare for financial and economic security, improve access to health and social services, provide housing options so people can age in the community, enhance opportunities for social connection and participation, and provide accessible built environments for community participation.

Child and Youth Wellbeing Strategy

As part of the development of the Child and Youth Wellbeing Strategy, the Office of the Children's Commissioner and Oranga Tamariki heard from 10,000 New Zealanders, including 6,000 children and young people, about what good wellbeing means to them, what gets in the way of wellbeing, and what we should do about it. This consultation concluded that health (in its broad definitions) plays a key role in children and young peoples' and in adults' perceptions of wellbeing and a good life. The engagement emphasised the importance of whānau and family relationships, the need for belonging and acceptance, a focus on community-based solutions, the need for cross-government integration, and key values of equity and fairness. The Child and Youth Wellbeing Strategy will be published in 2019.

Government Inquiry into Mental Health and Addiction

This inquiry delivered wide-ranging recommendations to improve the mental health and addiction system and services, setting the direction for the next 5–10 years. The Government has accepted, accepted in principle, or agreed to further consider 38 of 40 recommendations.

Our Schooling Futures: Stronger Together / Whiria Ngā Kura Tūātitini

Tomorrow's Schools Independent Taskforce covers the provision of compulsory schooling for children and young people (aged 5–19 or 21 with learners with high needs) and focuses on a system that promotes equity and excellence. Noted in its eight recommendations is that the health and disability support system in school needs a significant increase in resourcing and integration by the Ministry of Education. It also emphasises data moving with the student, particularly in terms of health and disability support, but also early intervention.

Pacific Health Action Plan

The Ministry of Health is developing a new plan for Pacific peoples and communities. This plan will have a strong focus on prevention and determinants of health, recognising areas outside health play a significant role in the health of Pacific peoples (in particular, income and employment, education, housing, and culture).

Public Service Act

The Government has decided to change the statutory framework governing New Zealand’s public service. A new Public Service Act will more effectively support the Wellbeing Budget approach and deliver better outcomes and services. Five important areas are a unified public service with cross-sector boards and accountabilities, strengthened Māori–Crown relationships, flexible employment and workforce deployment, joint leadership, and responsive organisational structure. The goal is a joined up, agile and adaptive public service for New Zealand.

Wai 2575 – Health Services and Outcomes Inquiry

This kaupapa inquiry commenced in October 2018 with two primary care–related claims. The claimants argued, among other things, that New Zealand’s system of providing primary care services has not, and does not, fully meet the needs of Māori. This fact, along with the resulting health inequities, represented a breach of the Crown’s Treaty obligations. Although each of these claims had its own distinct areas of focus and grounds for concern, their shared views included the contention that the way the Crown has designed and run primary health care services constitutes a breach of the principles of the Treaty. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (July 2019) reported a broad-ranging series of breaches by the Crown in terms of compliance with the Treaty, equity of health outcomes, oversight and accountability, and variability of funding arrangements that do not address Māori health needs or allow for kaupapa Māori models of care.

Wakamana Tāngata / Restoring Dignity to Social Security in New Zealand

The Welfare Expert Advisory Group recognised the current system is not delivering for the most vulnerable populations. The group’s report was informed by the voices of over 3,000 people. Wide-ranging recommendations to address imbalances in the system cover purpose, governance, and changes and increases to income support to restore trust and dignity so people can meaningfully participate in families and communities.

Whānau Ora Review / Tipu Matoro ki te Ao

This review evaluated the effectiveness and challenges of current whānau ora arrangements. It emphasised the need to expand cross-sector engagement and adequately fund and grow whānau-centred approaches, especially in rural and high deprivation areas.

Appendix C: Executive Summary Wānanga

Please see full wānanga report for in-depth overview – available from <https://www.systemreview.health.govt.nz/interim-report>

The MEAG hosted four wānanga to provide an opportunity for Māori to help shape what the future New Zealand health and disability system might look like. In particular, the wānanga were an opportunity to hear whakaaro Māori about the current issues impacting on Māori and the health system, as well ideas and inspiration about a future system that is designed to prioritise Māori health equity, outcomes and aspirations. Participants were asked to think about the system level changes that might be needed to drive improved Māori wellbeing in order for the benefits realised within the next 5-10 years.

The wānanga were held on the following dates and locations:

- ▶ 29 May 2019, Kaikohe
- ▶ 4 June 2019, Rotorua
- ▶ 18 June 2019, Dunedin
- ▶ 25 June 2019, Wellington

Some key issues raised by participants included frustration about the level of disruption and continuity that affects service provision with the changing of political parties in Government. A solution mooted was to gain cross-party support for a health system that resonated with all political parties.

Concern was also shared that the system was disjointed, bureaucratic, expensive, and largely inefficient. A common response from participants was that District Health Boards were a significant influencers in poor service design and delivery for Māori, with calls to get rid of them.

Participants from the Māori Deaf community shared their experiences and challenges with the lack of sign translation services, including extremely limited access to te reo Māori sign language, and the significant impact on their ability to access and receive quality health services. Māori with disabilities also commented that they found the system hard to navigate and that there were differences between rural and urban access, leading to a sense of isolation and not being heard.

Wānanga also heard about the experiences of people with neurological disabilities, on the autism spectrum, and with attention deficit hyperactivity disorder, including the challenges of delayed recognition, treatment, and support, and the compounding effects of racism.

All participants were passionate about their specific areas of work, and many felt that better intra-sectoral and inter-sectoral relationships would reduce bureaucratic and inefficient processes in the system. These relationships would also reduce the competitive nature of contracts and encourage collaborative working relationships. Many participants did not have a full understanding of how the whole of the health and disability system functioned but felt that some form of overarching Māori group could be responsible for monitoring the overall health outcomes of Māori in the future.

Wānanga participants engaged and, in the main, were positive in their efforts to imagine a future system better designed to meet Māori needs. The key themes raised across the wānanga reflected on the possibilities and opportunities in a system where Te Tiriti / the Treaty was firmly established in legislation and reflected across all aspects of the system. Iwi and Māori would be empowered to exercise their tino rangatiratanga (authority, ownership, leadership) and mana motuhake (self-determination, autonomy) for their whānau, and the system would deliver and be held accountable for delivering equity for Māori. Iwi

and Māori would take their place at the governance and decision-making tables and be able to create meaningful change in the way the system was funded, designed, delivered, and monitored. Further, core values and a commitment to Māori health would be supported at a parliamentary level and less subject to the changing priorities of successive governments.

This system would have strong and enduring relationships and strategic partnerships between the Crown and Māori, between health and disability providers, and with other sectors to deliver a joined-up approach for Māori whānau. New Zealand would have a representative and highly skilled Māori health workforce, and Māori providers would flourish and be treated equitably in the contracting process. Racism would not be tolerated at any level in the system, and Māori values would be embedded and affirmed in the delivery of health care and services. Mātauranga Māori would be supported and appropriately funded, and the health workforce would have the skills and competence to work effectively with mātauranga Māori approaches.

The system and services would be designed with whānau and their needs at the centre. Whānau rights and needs would be considered in the design and delivery of services, and whānau would be empowered to navigate and benefit from services that would offer choices according to their needs and preferences. Whānau would be technologically enabled and have access to the knowledge and support they need to take control of their health and wellbeing needs. Services would be of a high quality, accessible, and delivered in ways that were mana enhancing and effective for diverse whānau needs and realities. Services would be responsive to and appropriate for rangatahi Māori, and rangatahi Māori would be inspired and supported to be a part of a future health workforce.

Many wānanga participants felt strongly that it was time for iwi and Māori to take control of their own destiny in the system with the establishment of some form of independent Māori authority in which Māori had access to and control of the resources, decision making, design, and delivery of future health and disability services for Māori in Aotearoa. They also noted that Māori would still need, and expect to be able to access, high quality, responsive, and culturally relevant mainstream services that met their diverse health and wellbeing needs.

Appendix D: Health Services and Outcomes Kaupapa Inquiry (Wai 2575)

The Health Services and Outcomes Kaupapa Inquiry¹ (the Inquiry) was commenced on 30 November 2016 to inquire into nationally significant health issues for Māori. The Inquiry is being conducted in three stages. Stage One relates to ‘priority themes that demonstrate system issues’, in which the Tribunal has heard from two claims, the National Hauora Coalition, and the Māori Primary Health Organisations. These claims were prioritised because they:

- ▶ raised urgent and current issues that are significantly detrimental to Māori health
- ▶ raised concerns the exemplify system issues
- ▶ were brought by claimants who were ready to proceed.

The remaining claimants will be considered in stages two and three of the Inquiry. The Inquiry Report was prepared with some urgency to ensure that the analysis, findings, and recommendations could be considered by the Health and Disability System Review.

The Inquiry identified four thematic issues that needed to be addressed from the claimant submissions, these being:

1. the Treaty-compliance of the Public Health and Disability Act 2002 (*the Act*) and policy framework
2. funding arrangements for primary care
3. accountability arrangements for primary health care
4. the nature of Treaty partnership arrangements in the primary health sector.

Treaty-compliance of the Act and policy framework

The Tribunal considered the legislative and policy framework that underpins the primary health care system and its services and identified a number of key weaknesses in the Act and key health policies, including that:

- ▶ the Public Health and Disability Act 2002 does not identify health equity as a key driver of the health system but rather refers to reducing ‘health disparities’. The Tribunal asserted that equity of health outcomes is one of the expected benefits granted to Māori as citizens by the Treaty and that section 3(1)(b) of the Act does not satisfy the Crown’s Treaty obligations².
- ▶ the New Zealand Health Strategy – 2016 does not include a strong focus on equity and does not appropriately prioritise Māori health outcomes towards achieving equity for Māori.
- ▶ the Primary Care Strategy – 2001, makes reference to the need to ‘identify and remove health inequalities’ and identifies Māori as having poorer outcomes but has not been adequately implemented to achieve this goal. Further the Strategy contains a ‘watered down’ version of the Treaty principles, based on an old interpretation given by the Royal Commission on Social Policy in the 1980’s, ignoring three decades of scrutiny that have been applied to the principles by courts and the Tribunal since that time.

¹ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal

² Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal

- ▶ while He Korowai Oranga (2002 and 2014) contains the most visible commitment to achieving equity for Māori, it has not been fully implemented, and has ‘not been integrated into the primary health care framework as a whole’
- ▶ other accountability documents including: the Crown Funding Agreement and its appended Operational Policy Framework; the Services Agreement for Primary Care; the Minister’s Letter of Expectations; the Planning Guidelines; and the System Level Measures Framework are not able to guarantee consistent expectations of equity. Further, Crown witnesses noted that while developing plans for System Level Measures is mandatory, there is little monitoring against the framework, the measures do not distinguish between Māori and other populations, and incentive payments were being paid regardless of performance³.

The Tribunal has given its view that the Act has taken a reductionist view to the Treaty of Waitangi, and that while there is an expectation that part 3 of the Act will identify mechanisms for implementation, these mechanisms are only applied to DHBs and not to other Crown agents (including the Minister and the Ministry). The Tribunal concludes that the Treaty provisions in the Act:

- ▶ have proven ineffective in practice in regard to addressing inequities
- ▶ do not provide for Māori as Treaty partners to be fully involved in co-design, control or delivery of the primary care health system
- ▶ fail to provide for partnership, tino rangatiratanga, or mana motuhake
- ▶ only apply to part and not the whole of the health sector
- ▶ are a narrow reductionist version of the Treaty principles⁴

Māori Engagement in Governance

Section 29 of the Act includes the following statutory obligation in relation to district health boards:

(4) In making appointments to a board, the Minister must endeavour to ensure that—

(a) Maori membership of the board is proportional to the number of Maori in the DHB’s resident population (as estimated by Statistics New Zealand); and

(b) in any event, there are at least 2 Maori members of the board.

Claimants argued that, even where the conditions of this section of the Act met, this did not provide decision-making power given that Māori board members are almost always in the minority. They also noted that the Crown had not adequately monitored or ensured that DHBs met this requirement. Evidence to the Tribunal showed that the requirement for Māori representation had only been met on one occasion in 2001. In 2018 only 18 DHBs had met the minimum of two Māori members and 11 met the proportionality requirement, which was the lowest level of compliance of 4(a) of the Act since it came into force. Māori were more likely to be appointed to the boards rather than elected. Concerns were expressed by claimants and witnesses that Māori were a minority in the national decision making process to determine primary care contracting and that those ‘few Māori voices’ were ‘drowned out’ by being

³ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal

⁴ Ibid.

'outnumbered'. The Tribunal concluded that the DHB board representation model has failed to meet the proportionality provision, that there has been no accountability to meet this provision, and is therefore not a full reflection of the principle of partnership⁵.

Other partnership models aimed to meet the Operational Policy Framework requirement to 'establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Māori health improvement' include the establishment of Māori/iwi relationship boards. In contrast to statutory requirements of DHBs to establish community, public health and disability advisory boards, Māori partnership boards are not required by the Act. Having said this, all DHBs have some form of Māori advisory board currently. However, it was acknowledged by the Crown and witnesses that these partnership boards were regionally variable, were not always involved in decision making at the governance level, had less 'mana' than a statutory board, and had become a 'tokenistic' 'tick box' for DHBs. Further, a number of those on the partnership boards lacked the capacity and capability to contribute effectively, and as iwi/hapū representatives on a number of boards were not always able to regularly attend meetings. The Tribunal concluded that the failure to require Māori partnership boards in the statutes was a weakness of the framework, and cites the 2016 report of the Office of the Auditor, Principles for Effectively Co-governing Natural Resources as an example of what can happen for co-governance in practice⁶.

Funding Arrangements for Primary Health Care

The Ministry of Health (MoH) allocates more than three-quarters of the public funds it manages through Vote Health to DHBs, who use this funding to plan, purchase and provide health services, including the majority of public health services, within their areas. Most of the remaining public funding provided to MoH (approximately 19 percent) is used to fund important national services, including disability support, public health and Māori health services and postgraduate clinical education and training⁷.

The Tribunal acknowledged that the introduction of capitation was intended to shift the health system to focus on equity and that the capitation-based funding model has the potential to achieve this. However, Crown Counsel and witnesses noted that the funding arrangements currently in place had failed to direct funds to communities, including Māori, with the greatest health needs, and that they underfunded organisations serving high-needs patients. They concurred that the funding formulas for primary care needed to be reviewed. While Section 3 of the Act sets the objective that funding of primary health care should be directed to reducing inequalities '*to the extent reasonably achievable' within available funding*', further risk adjustment was required to ensure the funding reflected the need of the population accessing care⁸.

In funding the establishment of Māori Primary Health Organisations (PHOs), the Crown acknowledged that it had not appropriately determined adequate establishment funding, did not have a national formula or criteria in place, and that consequently establishment funding was variable. In particular, there was no

⁵ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal

⁶ Ibid.

⁷ Ministry of Health, *Funding*, [website], 2016., (accessed 17 May 2019).

⁸ Ibid.

distinction made between already established Independent Practitioner Associations (IPA), and newly forming Māori and community PHOs. There was also no consideration given to the existing resources, capability and infrastructure of the different organisations, the level of competition for enrollees and funding, or any substantial analysis of the nature and needs of the respective communities they would serve. This led to significant advantages being awarded to the IPA-based PHOs and significant disadvantages to Māori PHOs, and these have been seen to compound over time⁹.

Additional challenges identified were in the way that DHBs were funded and in particular for Māori. Census information provides the population data used to calculate the population-based funding formula (PBFF) used to decide capitation funding levels. Incomplete Census data on the Māori population in some regions means that there has been significant undercounting of Māori, consequently the apportioned funding has been insufficient to meet health needs. Evidence showed that in 2013 this undercount was 6.1 percent for Māori compared with 1.9 percent for non-Māori populations, further contributing to inequities in the distribution of funding for Māori health needs. A further finding of the Tribunal was that while the PBFF uses Māori ethnicity as a factor to decide funding, DHBs were not required to spend that funding on Māori health initiatives. They concluded that this is also inconsistent with Treaty principles for equity and active protection¹⁰.

First level services funding data used to identify the level of Māori health needs were calculated using service utilisation data by age and sex only, and came from a small sample in 1998-1999. This data source hasn't been updated since the funding formula was introduced. The Tribunal found that the data source was neither complete nor reliable and therefore not fit for calculating Māori health needs, particularly in dispersed or rural populations or those living in socio-economically deprived communities. While there are other funding mechanisms designed to compensate for flaws in the funding formula, the Tribunal found that these were insufficient to offset the low-level of first contact funding. Crown witnesses confirmed this finding and acknowledged that no work had been undertaken to ensure the level of funding was adequate to need. This was despite findings from an Expert Advisory Group in 2006 recommending significant changes, and internal recommendations to do so since 2013. Not only was there agreement that the capitated funding allocated to address differential Māori health needs was insufficient, the Crown conceded that PHO's were not required to spend that funding on Māori. The impact of this is that by the 1990s Māori and other groups were less likely to access primary health care due to cost and moved to access needed care from secondary services that were free. In 2016/17 over one third of Māori reported unmet health care needs due to cost¹¹.

Māori Primary Health Care Providers

The Wai 2575 Tribunal noted that combined with inadequate establishment funding, insufficient capitation funding to meet high-needs patients has had a significant impact on the sustainability of primary health organisations and providers, and in particular for Māori PHOs. The primary health funding model was based on an assumption that practices would have a mix of patients and that populations with high health-care needs would be subsidised by co-payments of those who could afford to pay. This significantly

⁹ Ibid.

¹⁰ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal

¹¹ Ibid.

advantaged larger more established PHOs with healthier patients. Māori PHOs, many of which have a vast majority of Māori with high social deprivation and health care needs, had to provide more complex care with significantly less funding¹².

The funding arrangements also constrained the extent to which Māori providers were able to provide services within kaupapa Māori approaches and frameworks. Claimants noted that kaupapa approaches to care often required additional time and resource in addition to the more complex health needs experienced by many Māori, and that the funding allocated did not provide for this. The impact of this was that Māori providers were likely to offer lower staff salaries, have an increased reliance on unpaid volunteers, and a higher level of unmet needs within their communities. Staff working in Māori PHOs also experience higher levels of stress related to this¹³.

Reports commissioned by the Ministry and undertaken by Deloitte in 2007, and in 2010 both concluded that there was substantial underfunding of PHOs that were serving predominantly Māori communities and Māori PHOs in particular. The 2010 Deloitte report was never released by the Ministry and further planned work was not undertaken. A summary of the draft 2010 Deloitte report concluded that:

- ▶ high needs providers have a significantly different patient mix in terms of both age and ethnicity, much higher than average fee for service deductions, much higher than average patient turnover, and a smaller percentage of their income generated by patient co-payments. They also had more patients with chronic and long-term illness.

In addressing the Tribunal, the Crown noted the following:

- ▶ primary health organisations and providers serving predominantly high-needs communities were underfunded at the point of establishment and throughout their operation (p110)
- ▶ the Crown's response to the inadequacy of the formulas has been insufficient 'in that there are still obviously quite significant barriers to access to primary care and ...some PHOs and practices serving high needs populations have continued to really struggle' (p111)
- ▶ while some districts underfunded Māori non-governmental organisations in primary care, other district health boards have recognised the inefficacy of the base funding provided under the primary health care framework and have reprioritised their discretionary funding accordingly (p111)
- ▶ the Global Financial Crisis seriously affected the way that district health boards used their discretionary funding (p112)¹⁴

Expert witnesses noted an '*inherent conflict of interest*' in that DHBs were more likely to direct funding to protect their secondary care provider arm than to use discretionary funding for primary care and external

¹² Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal.

¹³ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal.

¹⁴ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal.

providers, and that DHBs had been poorly resourced and supported to undertake their key role in primary health care¹⁵.

The Tribunal findings (p116-117) were that:

- ▶ the Crown broadly allowed variability of establishment funding for primary health organisations, with no consistent recognition of the existing capital they may have had or the needs of the populations they would serve. This disadvantaged many Māori organisations seeking to become a Māori primary health organisation, and as a result, Māori patients with high needs who enrolled with these organisations. The failure to implement a system to allocate equitably establishment funding is a breach of the Treaty principles of partnership, options, active protection and equity.
- ▶ both the population-based funding formula for district health boards and the funding arrangements for the primary health care system have not worked to address Māori health needs
- ▶ the funding arrangements for the primary health care system particularly disadvantage primary health organisations and providers that predominantly service high-needs populations, and particularly impact on Māori-led primary health organisations and providers in that category
- ▶ the funding arrangements for the primary health care system do not adequately provide for kaupapa Māori models of care
- ▶ both individually and when taken together, these Crown failures constitute a breach of the Treaty principles of partnership, active protection, equity and options.
- ▶ the Crown's failure to amend or replace these funding arrangements for over a decade adequately, in the face of both consistent advice to do so and persisting Māori health inequity, is inconsistent with the duty of good faith, and a breach of the Treaty principles of partnership, options, active protection and equity.

Accountability Mechanisms for DHBs and Primary Health Care

The Tribunal noted the Crown's ultimate responsibility for the provision of health care and the performance of the health system. Through the Inquiry, the Tribunal sought to understand the planning and accountability documents that give effect to this, and the extent to which the sector was meeting its statutory requirements to address equity for Māori in particular. The Tribunal noted that health entities were held accountable through three specific processes: planning; measuring; and reporting.

Planning

In 2008-09 the Ministry required DHB boards to submit a Māori Health Plan in response to a report of the Auditor-General that found that boards '*did not provide detailed information on the level of disparity in their district and did not report consistently on Maori health disparities in their annual reports*' (p123). These plans were only made public at the discretion of each individual board. In 2016 the Ministry rescinded the requirement for DHB boards to prepare Māori Health Plans, despite stating in the previous year that they were '*fundamental planning, reporting and monitoring documents, that underpin the DHB's efforts to achieve health equity and improve health outcomes for Maori.*' and '*to achieve indicator targets set nationally and locally*' (p123). From 2017, there was an expectation that Māori health planning would be incorporated into the wider DHB plans. It was noted that a number of DHBs, and in particular Te Tumu

¹⁵ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal

Whakararae – a representative group of Māori DHB General Managers, were resistant to the removal of Māori Health Plans.

While the Ministry argued that the purpose of removing the requirement for Māori Health Plans was to give equal status to Māori health alongside other priorities in the DHB planning documents, in giving evidence to the Tribunal the Crown concedes that *'in practice, amalgamation has achieved the opposite'* (p125). Other, and perhaps more fundamental, criticisms of DHB planning process has been in the failure of DHBs to undertake their planning processes in consultation with the rest of the sector, the wider public, and in particular with Māori¹⁶.

Primary health organisations were also required to produce Māori Health Plans but there was a high level of resistance among some PHOs. It was suggested that the resistance may have stemmed from a reluctance to publish persistent inequities in Māori health outcomes. The requirement for PHOs to provide Māori Health Plans was removed in 2013, from that point PHOs were required to contribute to DHB plans. Ongoing PHO resistance was posed as one possible reason why Māori Health Plans were scrapped altogether in 2016.

Measuring

Witnesses to the Tribunal agreed that measures for Māori health needed to be visible and easily understood by the sector and the public, and that DHBs needed to report against these measures. It was also noted that the visibility of Māori health measures was an important accountability mechanism, and trigger to motivate improved performance of providers and clinicians alike. An example was given by one DHB witness:

- ▶ 'last year we had 30% of Māori kids enrolled in our dental health service so 70% weren't and our board, literally, pointed a big finger at the clinical director of our community dental services and said, 'Sort that out.' [.....]..what I find with clinicians is they don't like looking at data which makes them look bad. (p126)'

The Tribunal concurred with witnesses that dispersing Māori health measures through the DHB district annual plans led to a lack of visibility and specificity, and little clarity about what actions a DHB might take to ensure inequities would be addressed¹⁷.

Reporting

DHB reporting frameworks were also identified as being weak or flawed. The System Level Measures Framework does not provide information by population groups, and the annual Health and Independence Report, which is the accountability mechanism between the Ministry and its Minister, does not always report on key issues consistently over time, or report on trends, it does not break information down by DHB, and does not always report on inequities' (p126). DHBs have not been required to report publicly on health outcomes for Māori or any other ethnic group since 2009. Further, despite a contractual requirement for boards to provide information, including ethnicity data to Māori, there has been inconsistent compliance with this requirement and the Ministry has not held DHBs accountable for this.

¹⁶ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-Publication Version). Wellington: Waitangi Tribunal

¹⁷ Ibid.

Claimants acknowledged the discomfort of reporting on data that showed insufficient progress, but that this was the point of accountability and that such discomfort was necessary to stimulate action to do better¹⁸.

Public reporting of primary care utilisation and outcomes is seen as an important mechanism of public accountability for the investment in primary health care services. Evidence presented to the Tribunal showed that only limited data was provided to DHBs by PHOs and that this was often incomplete. It was also noted that the 'paucity of publicly available data limits opportunities to monitor and evaluate the performance of the health sector' and that the lack of Māori specific outcomes and indicators called into question the Crown's commitment to Māori health. Witnesses noted that a number of reports and mechanisms that had previously reported on a comprehensive range of Māori health indicators and levels of funding to Māori health providers had not been produced since 2016.

- ▶ 'It is difficult to know how the Ministry of Health and DHBs work to hold PHOs to account, including in relation to Māori health, as such research does not, to my knowledge, currently exist.' (p132)¹⁹

Accountability frameworks for Primary Health

There was firm agreement between the Crown and other witnesses that the implementation of the primary care framework had failed to ensure appropriate accountability measures or levers, and as such performance and commitment to Māori health was varied across the country. There is no agreed performance framework in place between DHBs and PHOs, and there are few, if any, consequences for failure to provide appropriate care to their populations. Further, there is evidence to suggest that there were few measures in place for PHOs to account for how funding from the System Level Measures Framework and the Flexible Funding Pool was applied. Conversely, Māori PHOs argued that they were subject to a high level of scrutiny and '*compliance monitoring and auditing*'²⁰.

The 'permissive' and 'semi-devolved' policy environment for primary health care has been criticised because it has allowed a high degree of variability, and while it was intended to provide for local solutions and community ownership, it has made it difficult to implement nationally consistent approaches. Witnesses noted that the challenges and risks associated with implementation of the primary health care system have been identified, well described, and commented on for 17 years, but a lack of monitoring and necessary adjustments have led to failures in meeting the health needs of those most in need²¹.

Monitoring of the Crown

The role of Te Puni Kōkiri (TPK) under Section 5 of the Ministry of Māori Development Act 1991 includes specific responsibility for:

- ▶ promoting increases in the level of achievement attained by Māori with respect to health
- ▶ monitoring, and liaising with, each department and agency that provides or has a responsibility to provide services to or for Maori for the purpose of ensuring the adequacy of those services.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid.

Witnesses noted the failure of TPK to fulfil its responsibility as ‘A critical monitoring and accountability opportunity to improve performance in Māori primary health services which has been lost because it has simply not been implemented’ (p134). In its response, TPK noted that since 2004 the agency had moved away from a focus on monitoring. This in turn led to the discontinuation of agency reviews and effectiveness audits and a greater focus on policy and programme development. The Tribunal determined that failure to monitor the health sector in delivering improved health outcomes was a distinct breach of TPKs requirements under section 56 of its Act²².

The Tribunal notes that the Ministry of Health has failed in its role as a steward of the health system to apply appropriate accountability mechanisms, to monitor performance, and to communicate a commitment to achieving equitable Māori health outcomes. The Tribunal findings were that:

- ▶ The ways health entities are held to account does not support the pursuit of equitable Māori health outcomes, and that this is a breach of the Treaty principles of active protection and equity.
- ▶ The Crown does not collect sufficient qualitative or quantitative data to fully inform itself how the primary health care sector is performing in relation to Māori health and this is a breach of the Treaty principles of active protection and equity.
- ▶ The Crown also does not use the data it does collect effectively, including by making it accessible to, and understandable by, the public. This failure, similarly, has acute repercussions for Māori health, which is not systematically separately measured and reported on. The ineffective use of data, particularly the failure to measure and report separately on Māori health outcomes, is a breach of the Treaty principles of active protection, equity and partnership.
- ▶ Te Puni Kōkiri’s failure to carry out its statutory duty to monitor the health sector through conducting agency reviews, under section 5 of the Ministry of Māori Development Act 1991, is a breach of the Treaty principle of active protection and the duty of good governance. (p138)

Treaty partnership arrangements in the primary health sector

The Crown agreed in its submission to the Tribunal that ‘ensuring Māori influence decision making on health is a Treaty guarantee’ (p139) and while they noted the permissive framework was supposed to facilitate this, the stated that there were weaknesses in recognition and support for tino rangatiratanga.

Both Crown and claimant witnesses noted concerns were raised by Māori during the design of the primary health care framework that the discussion document did not show true commitment to partnership and they felt they had not been appropriately consulted in the early development of the primary health strategy.

Māori were not involved in policy development nor in the implementation design for the strategy. It was only once decisions were made that Māori providers and organisations were let in to execute the policy. Māori advice, input and structures were not considered. In this way, Māori were treated as a marginal part of the health sector, rather than central to government success. (p141)

Based on the evidence presented and the high level of agreement among claimants, the Crown and their witnesses, the Tribunal concluded that the development of the Primary Care Strategy and framework did not provide a robust co-design process and was symptomatic of a failure to give due regard to the expression of the Treaty.

²² Ibid.

Māori experiences of working in the primary health care sector

The Tribunal noted that Māori are significantly under-represented across all health professions, which contributed to the relatively low-level of influence of Māori working in the health sector. The Tribunal also made note of the small proportion of Maori working within the Ministry of Health (8.25% of Ministry staff identified as Māori in 2018).

The Crown's stated intention for the disestablishment of Te Kete Hauora (The Ministry of Health's dedicated Māori policy unit) in 2016 was to improve the capacity of whole Ministry to address health inequities for Māori. Claimants noted the challenges they experienced in recruiting and maintaining qualified and experienced staff. In particular, chronic underfunding had contributed to lower salaries being paid in Māori PHOs, which in turn led to staff seeking less stressful and more financially rewarding roles in DHBs. In some cases Māori PHOs experienced deliberate recruitment from DHBs looking to entice Māori staff into their workforce. This left the burden for Māori PHOs to find, recruit and develop staff that they were then unable to retain because they were not able to compete with DHB funded services.

Institutional racism in the health system was described as persistent inaction in the face of identified need, and was reinforced by decades of decisions and strategies that continued to systematically disadvantage those working with high-needs Māori communities.

- ▶ *institutional racism doesn't have to be deliberate. It can be the unintended outcome of well-intentioned people.....But it's a failure in imagination, it's a failure in monitoring, it's a failure in reporting and it's a failure for consequences for poor performance (p152).*

It was acknowledged that racism is also observable in the deficit-focused discourse in the health system that serves to maintain and justify inequities for Māori. Such language included the use of statements like 'Māori are hard to reach' or 'not compliant', which serve to paint Māori as in being responsible for their own poor health and allows the system to turn attention away from its own failings. Further, there is evidence that poorer outcomes are not just a symptom of the system structure and design but also relate to the quality of care. It was noted by an expert witness that nationally Māori children access primary care at the same rate as non-Māori children, and Māori adults at a higher rate than non-Māori, but that 'on average they still have the highest unmet need of any population group' (p154).

Racism also extends beyond the experiences of patients and was identified within the Māori workforce. Claimants and witnesses described experiences where their advice and expertise was seen as less valuable and credible than other professionals and experts in the system. Māori nurses will be specifically pursuing a claim in the next stage of the WAI 2575, but in their submission to Stage One they noted that Māori nurses were often actively discriminated against within the system. They argue that although Māori nurses had met the same training standards and requirements to become a nurse, they were seen as less qualified than other nurses in non-Māori organisations. Māori nurses also noted an additional expectation by their organisations and colleagues to undertake cultural roles and tasks outside of their job description, but that this was not recognised or financially rewarded.

As noted in earlier sections of this report, the impact of racism is a determinant of poor outcomes and Māori have preponderantly experienced this in the health system. The WAI2575 findings reinforce and support the evidence that racism continues to be a significant factor in the failures of the health system to achieve equity for Māori.

Culturally Appropriate Services

- ▶ Cultural safety intends to recognise that sociocultural difference manifests, in part, as a power imbalance between different ethnicities (p155).

The Crown has an obligation under the Treaty to ensure services for Māori are culturally appropriate. Further, it has been identified that where services are delivered in ways that are not culturally appropriate this becomes an important determinant and leads to poorer health outcomes.

At the establishment of PHOs there were 14 Māori PHOs, but they were '*actively disadvantaged*' and most were unable to be sustained in the constrained funding environment. Crown witnesses acknowledged that there had been a failure to support Māori PHOs and as a result, many had to close.

The Crown also noted that Māori PHOs had contributed to significant improvements in Māori health outcomes and as such, should be considered as exemplars for the performance of the rest of the primary health care sector. Claimants noted the enthusiasm with which they embraced the new primary health care framework as a way of delivering high quality care in ways that were appropriate for, and preferred by, their communities. Further, they noted that working in this way provided an opportunity for expression of tino rangatiratanga and mana motuhake. They conclude that '*tino rangatiratanga over hauora Māori should be an intrinsic facet of a Treaty-compliant primary health system* (p158), and further that '*it is unacceptable that the health of the most vulnerable whānau are under threat because of the way that the primary health system is organised and monitored* (p159)'.

In response, the Tribunal findings were that:

- ▶ the Crown did not design the primary health care framework in partnership with Māori
- ▶ the disestablishment of Te Kete Hauora, and the failure to replace it at the time, is a breach of the Treaty principles of equity and active protection
- ▶ the primary health care framework does not recognise and properly provide for the tino rangatiratanga and mana motuhake of hauora Māori. This is a breach of the Treaty's active protection of tino rangatiratanga, as well as a breach of the principles of partnership, active protection, equity, and options.

Tribunal Summary and Recommendations

In its summation, the Tribunal made the following judgements and observations:

- ▶ The Crown's failures prejudicially affect the ability of Māori to sustain their health and wellbeing. The prejudice suffered by Māori because of these Crown failures is extensive. The legislative and policy framework is insufficient in and of itself, and the Crown's renewed, specific commitments to improve Māori health are not enough to negate this insufficiency on their own. This is unacceptable. We reiterate that the depth of inequity suffered by Māori, and particularly the fact that it has not measurably improved in the two decades since the framework was put in place, mean that the Crown's failures are very serious. (p161).

Tribunal Recommendations

The Tribunal made two overarching recommendations (Pxxv):

(a) That the legislative and policy framework of the New Zealand primary health care system recognises and provides for the Treaty of Waitangi and its principles. To that end, we recommend an amendment to

the New Zealand Health and Public Disability Act 2000 to include a new Treaty of Waitangi clause. We have also gone on to recommend several principles for adoption and use in the primary health care sector.

(b) That the Crown commit itself and the health sector to achieve equitable health outcomes for Māori. To that end, we recommend an amendment to section 3(1)(b) of the New Zealand Public Health and Disability Act 2000.

In relation to structural reform of the primary health care system, we made an interim recommendation that the Crown commit to exploring the concept of a stand-alone Māori Primary Health Authority. Furthermore, we recommend that the Crown and the stage one claimants design a draft term of reference to explore that possibility. We have directed the parties to report back to us by 20 January 2020 on progress.

In relation to funding, we have made an interim recommendation that the Crown and stage one claimants agree upon a methodology for the assessment of underfunding of Māori primary health organisations and health providers. The methodology should include an assessment of establishment and ongoing underfunding since the commencement of the Act. We have directed the parties to report back to us by 20 January 2020 on progress.

On the broader question of funding generally for the primary health care system, we recommend that the Crown conduct an urgent and thorough review of funding for primary health care, to better align it with the aim of achieving equitable health outcomes for Māori.

Appendix E: Key international conventions

International conventions

In addition to legislation, New Zealand is party to international conventions that relate to health and disability, including the:

- ▶ Convention against Torture
- ▶ Convention on the Rights of the Child
- ▶ Convention of the Elimination of all Forms of Discrimination against Women
- ▶ Convention on the Rights of Persons with Disabilities
- ▶ Declaration on the Rights of Indigenous People (which, in addition to the right to the highest attainable standard of physical and mental health, includes the right to traditional medicines)
- ▶ International Convention on the Elimination of All Forms of Racial Discrimination
- ▶ International Covenant on Economic, Social and Cultural Rights
- ▶ World Health Organization Framework Convention on Tobacco Control.

Also relevant are the:

- ▶ International Health Regulations 2005
- ▶ Universal Periodic Review.

Appendix F: International system values and principles

Introduction

As part of the Review's consideration of values and infying principles, a range on international healths systems principles and values were reviewed. The system level principles and vlues that drive leadership, culture and behaviour in four well resepected health organisations/systems are summarised below.

1. First Nations

SHARED VALUES: FNHA, FNHC, FNHDA Share Vision – Healthy, Self-determining and vibrant BC first nations children, families and communities

RESPECT: We believe that maintaining respectful relationships is fundamental to the achievement of our shared vision. Respectful relationships are built upon the recognition that we all have something to contribute as individuals and participants in the First Nations Health Governance Structure. Therefore, we commit to treating each other with dignity and generosity, being responsive to one another and acknowledging that each entity has their own respective processes and practices. wE are also committed to respectful interactions with First Nations, tripartite partners and other collaborators.

DISCIPLINE: We have the historic opportunity to achieve transformative change in First Nations health and wellness, and an obligation to make the most of this opportunity. This will require discipline amongst us, including through; loyalty to one another and our shared vision; upholding and supporting our roles, responsibilities, decision, and processes; maintaining and nurturing unity and unity front; integrity and reliability in fulfilling our commitments and accountability to one another for these commitments and contributions; and, solutions- oriented active participation

RELATIONSHIPS: We believe that effective working relationships with First Nations, tripartite partners and with one another are the foundation for achieving our vision and implementing our health plans and agreements. We commit to fostering effective working relationship and camaraderie underpinned by trust, honesty, understanding, teamwork and mutual support. We also acknowledge that humour and laughter are both good medicine, and a good way to build relationships.

CULTURE: We are here because of those that came before us, and to work on behalf of First Nations. We draw upon the diverse and unique cultures, ceremonies, customs and teaching of First Nations for strength, wisdom and guidance. We uphold traditional and holistic approaches to health and self-care and strive to achieve a balance in our mental, spiritual, emotional and physical wellness.

EXCELLENCE: We are humbled and honoured to have been asked by First Nations to work on their behalf to improve health and wellness, and have a moral and personal responsibility to strive for excellence. Excellence means that our outcomes are sustainable, that our processes are sustainable, that our processes are professional and transparent, and that we commit to learn continuously – through capacity development opportunities, from each other and from new, different and innovative models worldwide.

FAIRNESS: We work to improve the health and wellness of all First Nations in BC. Our decision-making reflects the best interests of all First Nations, and leads to just and equitable treatment amongst all First Nation communities, First Nations organisations, and across all regions of British Columbia. We are committed to make room for everyone, and are inclusive in our communications, information sharing, and discussions.

2. Nuka – South Central Foundation

Core Concepts; (WELLNESS) (Values)

Work together in relationship to learn and grow

Encourage understanding

Listen with an open mind

Laugh and enjoy humour throughout the day

Notice the dignity and value of ourselves and others

Engage others with compassion

Share our stories and our hearts

Strive to honour and respect ourselves and others

Leadership Principles; (OWNERSHIP)

Operate from the strength of Alaska Native cultures and traditions of leadership

Will stand in the gap to align and achieve the mission and vision

Nurture an environment of trust that encourages buy-in, systematic growth and change

Encourage ownership of responsible, calculated risk taking

Respect and grow the skills of future generations to drive initiatives and improvements

Share and listen to personal life stories in order to be transparent and accountable

Hedge people in by creating a safe environment where spiritual, ethical and personal beliefs are honoured

Improve for the future by learning from the past, giving away credit and celebrating achievements

Practice and encourage self-improvement believing there is good in every person

Operational Principles; (RELATIONSHIPS)

Relationships between customer-owner, family and provider must be fostered and supported

Emphasis on wellness of the whole person, family and community (physical, mental, emotional and spiritual wellness)

Locations convenient for customer-owners with minimal stops to get all their needs addressed

Access optimized and waiting times limited

Together with the customer-owner as an active partner

International whole-system design to maximize coordination and minimize duplication

Outcome and process measures continuously evaluated and improved

Not complicated but simple and easy to use

Services financially sustainable and viable

Hub of the system is the family

Interests of customer-owners drive the system to determine what we do and how we do it

Population-based systems and services

3. National Health Service

Principles

- ▶ The NHS provides a comprehensive service, available to all
- ▶ Access to NHS services is based on clinical need, not an individual's ability to pay
- ▶ The NHS aspires to the highest standards of excellence and professionalism
- ▶ The patient will be at the heart of everything the NHS does
- ▶ The NHS works across organisational boundaries
- ▶ The NHS is committed to providing best value for taxpayers' money
- ▶ The NHS is accountable to the public, communities and patients that it serves

Values

- ▶ **Working together for patients** - Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.
- ▶ **Compassion** - We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.
- ▶ **Respect and dignity** - We value every person - whether patient, their families or carers, or staff - as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.
- ▶ **We value every person** - whether patient, their families or carers, or staff - as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.
- ▶ **Improving lives** - We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.
- ▶ **Commitment to quality of care** - We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care - safety, effectiveness and patient experience - right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.
- ▶ **Everyone counts** - We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken - and that when we waste resources we waste opportunities for others.

4. Intermountain

Our Fundamentals of Extraordinary Care

- ▶ **Safety:** Patients and caregivers experience Zero Harm
- ▶ **Quality:** Always deliver evidence – based care that meets each individual’s healthcare goals and leads to top performance nationally
- ▶ **Patient Experience:** Patients and customers have an Intermountain experience that leads to lasting loyalty
- ▶ **Access:** All customers receive the care and information where, when and how they want it, with seamless coordination across the system
- ▶ **Stewardship:** Be an indispensable community partner, achieving the healthiest communities with the lowest cost per person in the nation. Be recognized globally as a financially sound, forever organisation.
- ▶ **Engaged Caregivers:** Caregivers have an unparalleled work experience that supports them delivering the fundamentals of extraordinary care.

Our Values

- ▶ **Integrity:** We are principled, honest and ethical, and we do the right thing for those we serve
- ▶ **Trust:** We count on and support one another individually and as team members
- ▶ **Excellence:** We perform at the highest level, always learning and looking for ways to improve
- ▶ **Accountability:** We accept responsibility for our actions, attitudes and health
- ▶ **Mutual Respect:** We embrace diversity and treat one another with dignity and empathy

Appendix G: General Practice and PHO Services

Introduction

This appendix should be read in conjunction with Chapter 7 of the Interim Report. It provides additional information on the analysis performed by the Review to better understand general practice.

Why general practice is important

General practice is often the first contact people have with the health and disability system. General practice provides a wide range of services to patients including advice, treatment, prescribing medication, and referring patients on to other specialists or services. There are around 3,600 general practitioners, 7,500 nurses and many allied health and other workforces working in around 1,000 practices across the country.^{1,2,3}

There is evidence that how we empower and engage patients and deliver services in primary care settings is key to achieving more equitable health outcomes and improving wellbeing. A recent World Health Organization review concluded that there is powerful evidence to suggest that primary care can produce a range of economic benefits including:

- ▶ Health outcomes - primary care can improve population health in terms of life expectancy, all-cause mortality, maternal, infant and neonatal mortality as well as mental health outcomes.
- ▶ Health system efficiency - primary care can reduce total hospitalisations, avoidable admissions, and emergency admissions and hospitalisations.
- ▶ Health equity - primary care improves equitable access to health care and equitable health outcomes.⁴

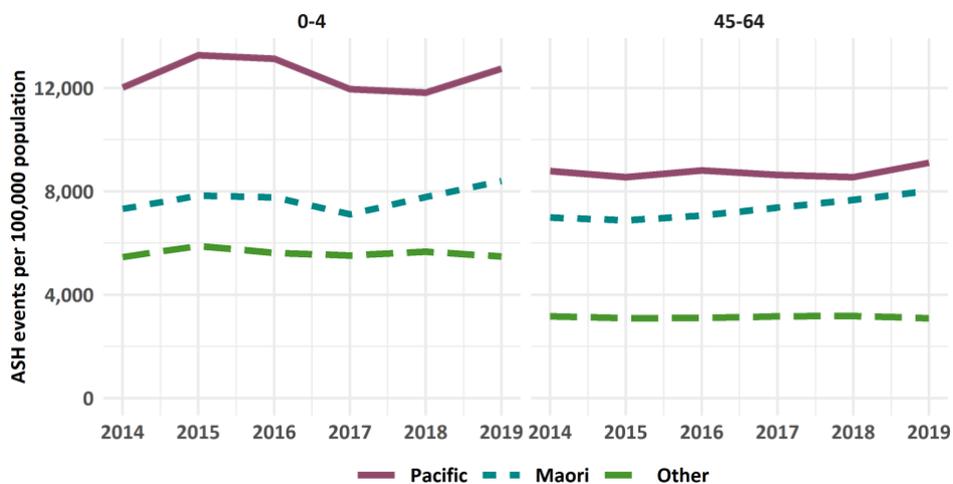
Inequities in health outcomes

There are clear inequities in health outcomes for key population groups including Māori, Pacific and disabled peoples.

On average, Māori live seven years less than non-Māori non-Pacific people, and this life expectancy gap is largest in areas with higher levels of socioeconomic deprivation. Māori have lower rates of childhood immunisation, are more likely to smoke, and are more likely to have to wait longer than three months to see a specialist. Pacific peoples live on average six years less than non-Māori non-Pacific people. Pacific people have higher rates of obesity and diabetes, and Pacific children have much higher than average rates of rheumatic fever. People with intellectual disabilities live on average 20 years less than the overall population, and are more likely to have chronic health conditions including heart disease, chronic respiratory disease and cancer.

These inequities are driven in part by differences in the social and economic determinants of health. However, health services including general practice can play a significant role in reducing these inequities. For example, Figure 1 shows ambulatory sensitive hospitalisation (ASH) rates for different ethnic groups. ASH rates are used as a proxy for what hospital admissions could be avoided if Tier 1 services were working more effectively. These rates are consistently higher for Māori and Pacific peoples, with Pacific ASH rates being around double that of non-Māori non-Pacific.

FIGURE 1: AMBULATORY SENSITIVE HOSPITALISATION (ASH) RATES BY AGE GROUPS AND ETHNICITY, 2014–2019



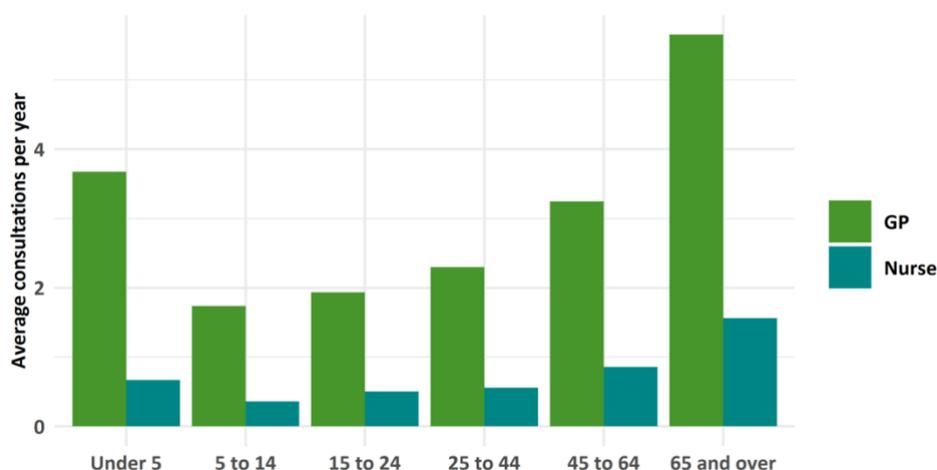
SOURCE: MINISTRY OF HEALTH, PHO REPORTING.

Service use

In 2018, around 17 million GP and nurse consultations were delivered in primary care and it is estimate that around 78% of all New Zealanders visited a GP at least once during the year^{5,6}. Between 2008 and 2016, the number of GP consultations increased nearly 12%, slightly above population growth (10.2%).⁷

Figure 2 shows that children under 5 and people over 65 are the most frequent users of primary care services. As the New Zealand population continues to age, demand for these services are likely to increase.

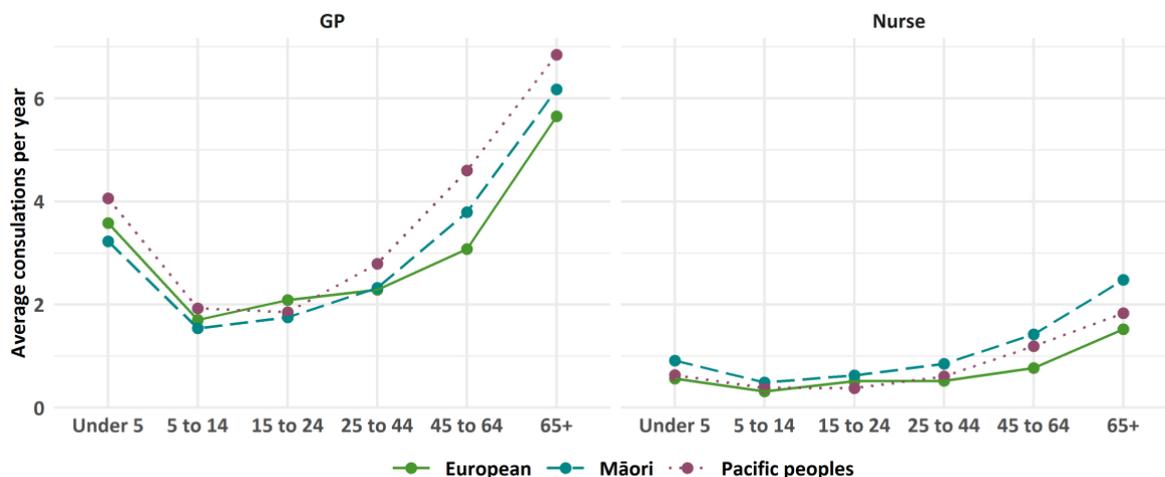
FIGURE 2: AVERAGE NUMBER OF GP AND NURSE CONSULTATIONS PER PERSON PER YEAR BY AGE GROUP, 2018



SOURCE: MINISTRY OF HEALTH, PHO REPORTING.

Figure 3 shows that Pacific peoples visit GPs most frequently across most age groups. Māori tend to visit a GP less frequently than Europeans for age groups under 45. In contrast, Māori are the most frequent users of nurse consultations across all age groups.

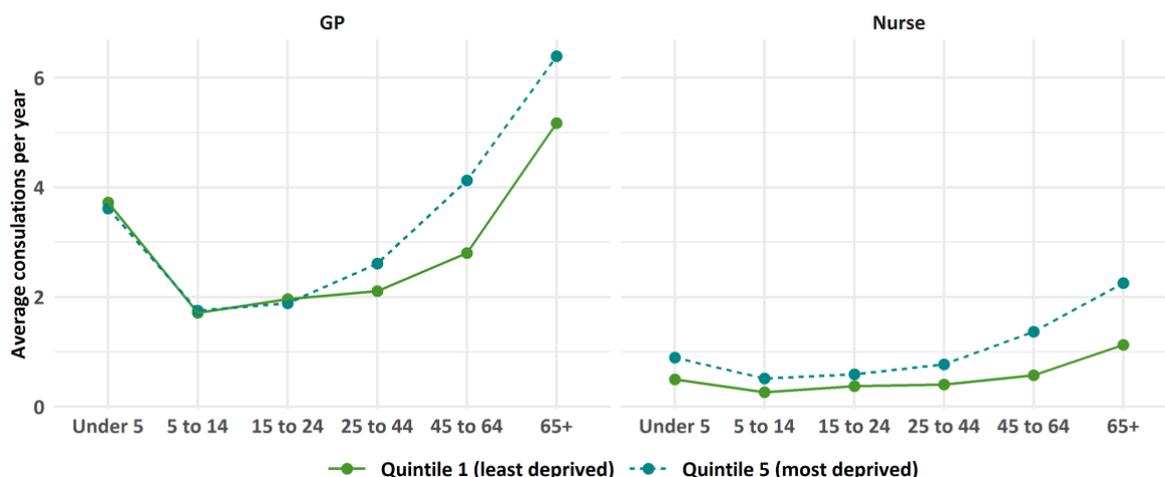
FIGURE 3: NUMBER OF GP AND NURSE CONSULTATIONS PER PERSON BY AGE GROUP AND ETHNICITY, 2018



SOURCE: MINISTRY OF HEALTH, PHO REPORTING.

For those under 25, those living high deprivation and low deprivation areas visit GPs equally frequently. Only above 25 do those living in high deprivation areas use more services. In contrast, those living in high deprivation areas are more likely to use nurse consultations in all age groups.

FIGURE 4: NUMBER OF GP AND NURSE CONSULTATIONS PER PERSON BY AGE GROUP AND DEPRIVATION, 2018

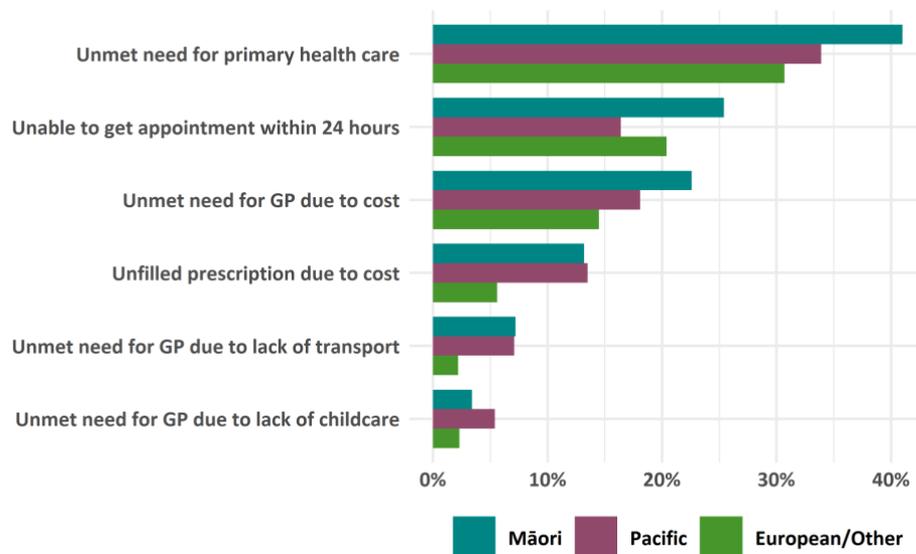


SOURCE: MINISTRY OF HEALTH, PHO REPORTING.

Barriers to access

Around 40% of Māori report unmet health need due to these barriers, compared with 34% of Pacific peoples and 31% of Europeans. Figure 5 shows that the availability of appointments is the most common barrier, followed by the cost of GP consultations. The cost of filling a prescription is a barrier for nearly 15% of Māori and Pacific peoples, and lack of transport and childcare are also reported as barriers.

FIGURE 5: BARRIERS TO ACCESS OF PRIMARY HEALTH CARE BY ETHNICITY, 2017/18

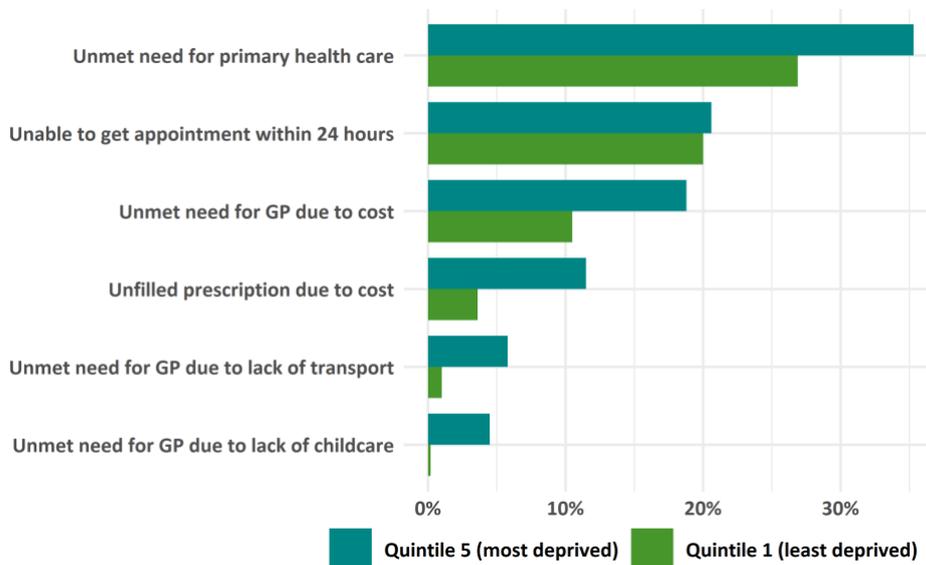


SOURCE: MINISTRY OF HEALTH, NEW ZEALAND HEALTH SURVEY 2017/18

Over time, the share of people reporting any unmet need for primary care has increased from 27% to 31% between 2011/12 and 2017/18. The share unable to get an appointment within 24 hours increased from 15.5% to 20%.

Figure 6 shows that those living in high deprivation areas are more likely to report barriers to access and have higher overall unmet need.

FIGURE 6: BARRIERS TO ACCESS OF PRIMARY HEALTH CARE BY SOCIOECONOMIC DEPRIVATION QUINTILE, 2017/18



SOURCE: MINISTRY OF HEALTH, NEW ZEALAND HEALTH SURVEY 2017/18

Health literacy and cultural factors are also barriers to access. Some people do not visit general practice because they don't feel culturally safe, and many services are not designed to be welcoming to these groups.

Primary care receives funding from a variety of sources

Around 68% of funding for PHOs and general practice comes from Vote Health (\$1,164 million). The remaining funding comes through ACC (\$150 million or 9%), private insurance (\$31 million or 2%), and patient copayments (around \$395 million or 23%).

The vast majority of government funding for general practice goes through the PHO Services Agreement⁸. This agreement is negotiated nationally by the PHO Service Agreement Amendment Protocol group (PSAAP), which includes representatives from DHBs, PHOs, general practice and the Ministry of Health.

DHBs are required to contract with PHOs for primary care services. This requirement was set in the Cabinet decision which devolved funding to DHBs for the purpose of purchasing primary health care from PHOs. In addition, the annual Crown Funding Agreement variations require funding to be paid to PHOs for services specified in the PHO Services Agreement. The majority of funding is from each DHB's devolved funding, with a further \$200 million coming from a Ministry of Health appropriation in 2017/18.

Public funding of primary care comes through a variety of funding streams described in Table 1.

TABLE 1: FUNDING FLOWS TO GENERAL PRACTICE AND PHOS

	2017/18 funding		Variables used in capitation
First Contact	\$655m	Pass-through	Age, gender, HUHC
Very Low Cost Access	\$56m	Pass-through	Age, gender, CSC
Zero Fees for Under 6s/13s	\$34m	Pass-through	Age, gender
Care Plus	\$69m	Flexible funding pool	Age, gender, ethnicity, deprivation
Services to Improve Access	\$52m	Flexible funding pool	Age, gender, ethnicity, deprivation
Management Fees	\$31m	Flexible funding pool	
Health Promotion	\$11m	Flexible funding pool	Age, gender, ethnicity, deprivation
Community service card scheme		Pass-through	Age, gender, CSC
Other funding	\$257m		

Note: VLCA funding was increase in December 2018, and now amount to annual funding of around \$90 million. The CSC scheme was introduced in the 2018/19 financial year, and amounts to annual funding of around \$60 million.

SOURCE: MINISTRY OF HEALTH

Most funding streams are paid on a capitation basis – payments based on the enrolled population in a PHO or a practice, regardless of the level of service provided.

Around \$750 million of funding is passed through to individual practices, as required by the PHO Services Agreement. Funding is paid through to practices using the exact formulas used to pay PHOs.

Four funding streams amounting to \$160 million of funding is kept in a flexible funding pool. The PHO services agreement requires this funding to be spent either on ‘alliance services’ agreed to by the local district alliance, or on services related to individual funding streams. For health promotion, services to improve access and Care Plus funding, the Agreement requires the PHO to submit a plan to the DHB on how it proposes to use this funding. There is little information or reporting on how flexible funding pool funding is used, and there is variation across the country.

PHOs and practices also receive funding for immunisations, rural sustainability, after hours services, and a variety of other services contracted for by individual DHBs. Funding through these other streams amounts to around \$260 million.

ACC funding to general practice was around \$150 million in 2017/18. This funding is paid directly to individual practices, not through PHOs. Around \$95 million was paid through contract to urgent care clinics and rural GPs, and around \$55 million was paid through cost of treatment regulations to individual practices. ACC payments are made on a fee for service basis, rather than by capitation.

Though most government funding is paid on a capitation basis, many practices earn the majority of revenue from fee for service payments. Considering only funding passed through to individual practices (\$745 million), around 40% of funding comes from fee for service payments from ACC, private insurance and out of pocket payments. This share is likely higher still for non-VLCA practices that charge higher than average fees.

Copayment regulation

The PHO Services Agreement allows practices to charge copayments to service users⁹. The Agreement states that PHOs will ensure that payments to providers will result in low or reduced fees charged to enrolled patients.¹⁰

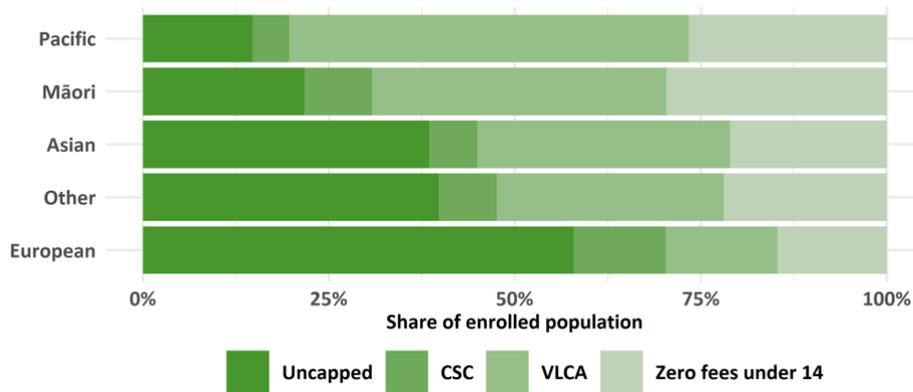
Copayment increases are restricted by the Agreement to a “reasonable” increase, which is calculated each year based on government funding and cost growth. Copayment increases above this reasonable level can be referred to a Fees Review Committee, which assesses whether fee increases are fair and reasonable to patients and providers.

In addition, a number of schemes have been introduced to reduce fees for particular populations. Individual practice can choose to join these schemes, and receive additional capitation funding if they do.

- ▶ Practices in the Very Low Cost Access (VLCA) scheme are required to charge adult patients no more than \$19 for a standard consultation, \$13 for 14 to 17 year olds, and no charge for under 14 year olds. Around one third of practices are in this scheme, and for a practice to join over 50% of their population must be Māori, Pacific or living in a high socioeconomic deprivation area.
- ▶ Practices in the free under 14s scheme are required to not charge fees for standard consultation with children under 14. Coverage of this scheme is very high, covering around 98% of children under 14.¹¹
- ▶ Practices in the community services card (CSC) scheme are required to charge CSC holders no more than \$19 for a standard consultation (\$13 for 14 to 17 year olds). Coverage of this scheme is high, covering 93% of CSC holders.¹²

Figure 7 shows how these fee reduction scheme affect different ethnic groups. For all ethnic groups other than European, over 50% of the population have access to consultations that are free or up to \$19. For Pacific peoples, 15% of the population are charged uncapped fees, over 50% are charged up to \$19 through VLCA practices and the CSC scheme, and around a quarter are eligible for free fees through the under 14 scheme. For Maori, around 21% are charged uncapped fees, just under half are charged up to \$19, and around 30% are under 14 and eligible for free fees.

FIGURE 7: GENERAL PRACTICE FEES BASED ON ETHNICITY, 2019

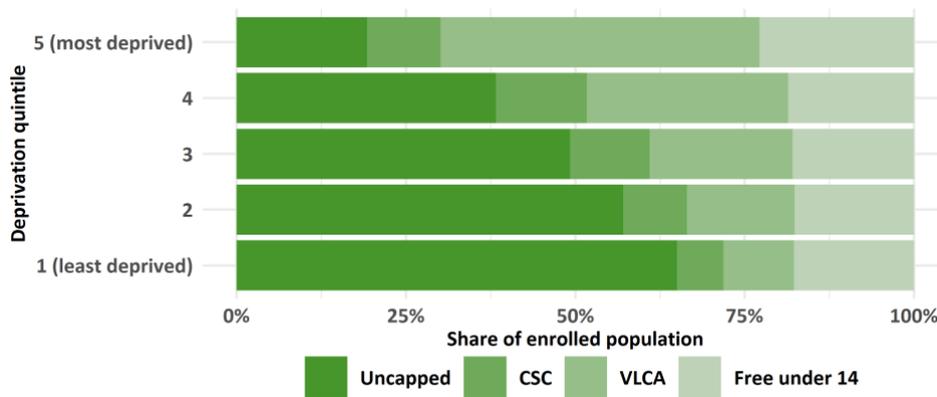


Note: For simplicity, this analysis assumes that all practices are covered by the under 14s free and CSC scheme.

SOURCE: MINISTRY OF HEALTH PHO REPORTING, INTERNAL CALCULATIONS

Figure 8 shows the same breakdown but by deprivation quintile. Around 20% of those living in the most deprived quintile are charged uncapped fees.

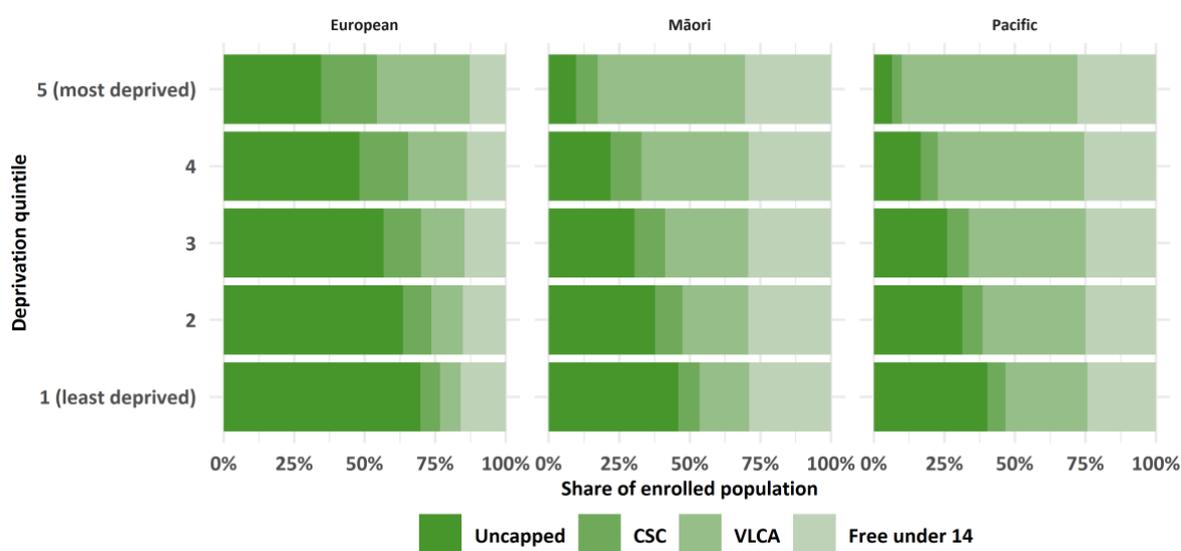
FIGURE 8: GENERAL PRACTICE FEES BY DEPRIVATION QUINTILE, 2019



SOURCE: MINISTRY OF HEALTH PHO REPORTING, INTERNAL CALCULATIONS

Figure 9 shows the copayments faced by people, broken down by both deprivation quintile and ethnicity (Asian and Other not shown). For Māori and Pacific living in high deprivation areas, under 10% are charged uncapped fees. In contrast, over a third of Europeans living in high deprivation areas are charged uncapped fees.

FIGURE 9: GENERAL PRACTICE FEES BY ETHNICITY AND DEPRIVATION QUINTILE, 2019



SOURCE: MINISTRY OF HEALTH PHO REPORTING, INTERNAL CALCULATIONS

This analysis suggests that:

- ▶ The current copayment reduction schemes have been effective in reducing copayments for Māori, Pacific peoples, and people in high socioeconomic deprivation areas.
- ▶ Further efforts to reduce uncapped copayments are likely to predominantly benefit non-Māori and non-Pacific peoples.
- ▶ Reducing copayments within Very Low Cost Access practices or through the CSC scheme may be more effective at targeting Māori, Pacific peoples, and people in high socioeconomic deprivation areas.

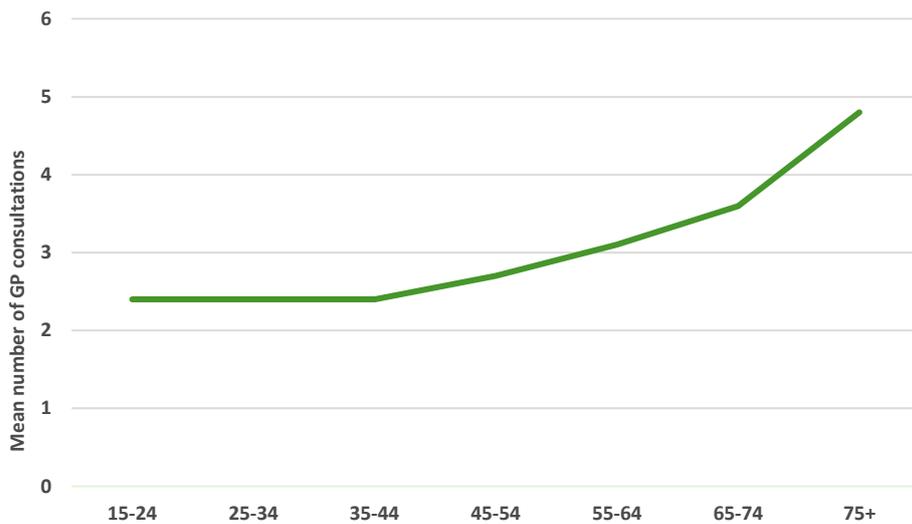
Equity of general practice funding

We have heard that the funding provided to Māori PHOs and practices with predominantly Māori populations is insufficient to meet the higher needs of Māori. This is echoed strongly in the Waitangi Tribunal’s ‘Hāuora’ report, which cites analysis performed by Deloitte and commissioned by the Ministry of Health. A particular concern is that first contact capitation payments, the largest PHO funding stream, are not adjusted for ethnicity or socioeconomic deprivation.

In addition, we have heard that the current capitation formula does not accurately account for enrolees with high and complex needs. In particular, while capitation is based on age, it contains only one age band for all those above 65.

Figure 10 shows that those over 75 on average see a GP 4.8 times per year. This is around a third more frequently than those aged 65-74. This suggests that the current capitation formula is not sufficiently granular to account for differences in need among older people.

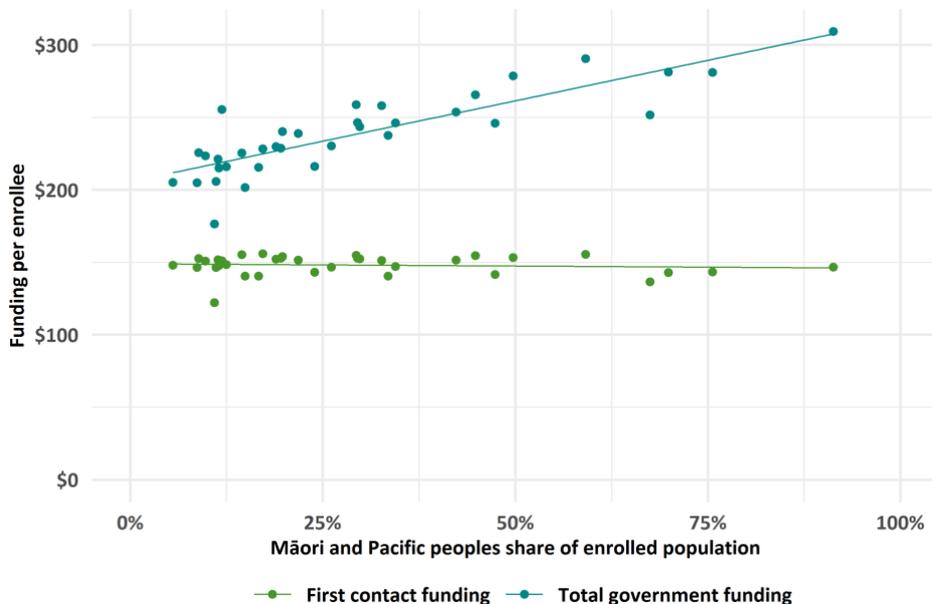
FIGURE 10: MEAN NUMBER OF GP CONSULTATIONS BY AGE GROUP



SOURCE: MINISTRY OF HEALTH, NEW ZEALAND HEALTH SURVEY 2017/18

Figure 11 shows funding per enrollee for each PHO compared with the Māori and Pacific share of each PHO’s enrolled population. First contact funding is shown in green, and total government funding is shown in blue.

FIGURE 11: FIRST CONTACT AND TOTAL GOVERNMENT FUNDING PER ENROLLEE BY PHO, 2019



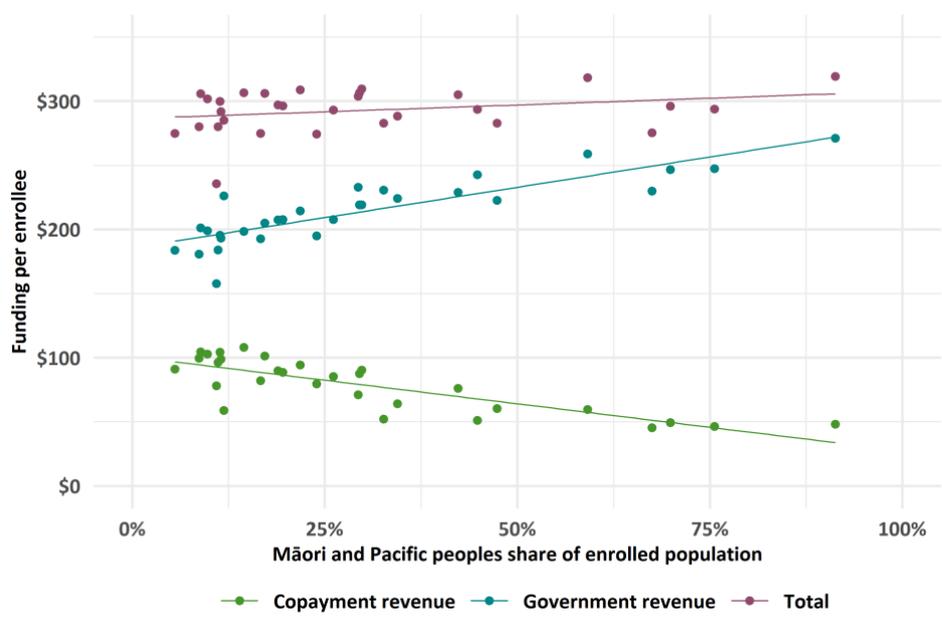
SOURCE: MINISTRY OF HEALTH PHO REPORTING, INTERNAL CALCULATIONS

As expected, first contact funding shows not correlation with the share of Māori and Pacific peoples enrolled, because ethnicity is not included in the first contact funding capitation formula. However, total

PHO funding shows a positive correlation. Some PHO funding streams are explicitly adjusted for ethnicity, such as services to improve access funding. Other funding streams are adjusted for factors correlated with ethnicity, including free fees for under 14 year olds, and VLCA funding.

Figure 12 shows government funding, an estimate of copayment revenue, and total revenue per enrollee. As shown above, PHOs with greater Māori and Pacific populations receive more government funding. However, practices in these PHOs also have lower estimated copayment revenue per enrollee. Adding these revenue sources together, total revenue is roughly even across PHOs regardless of their Māori or Pacific enrolment share.

FIGURE 12: COPAYMENT, GOVERNMENT AND TOTAL REVENUE PER ENROLLEE BY PHO, 2019

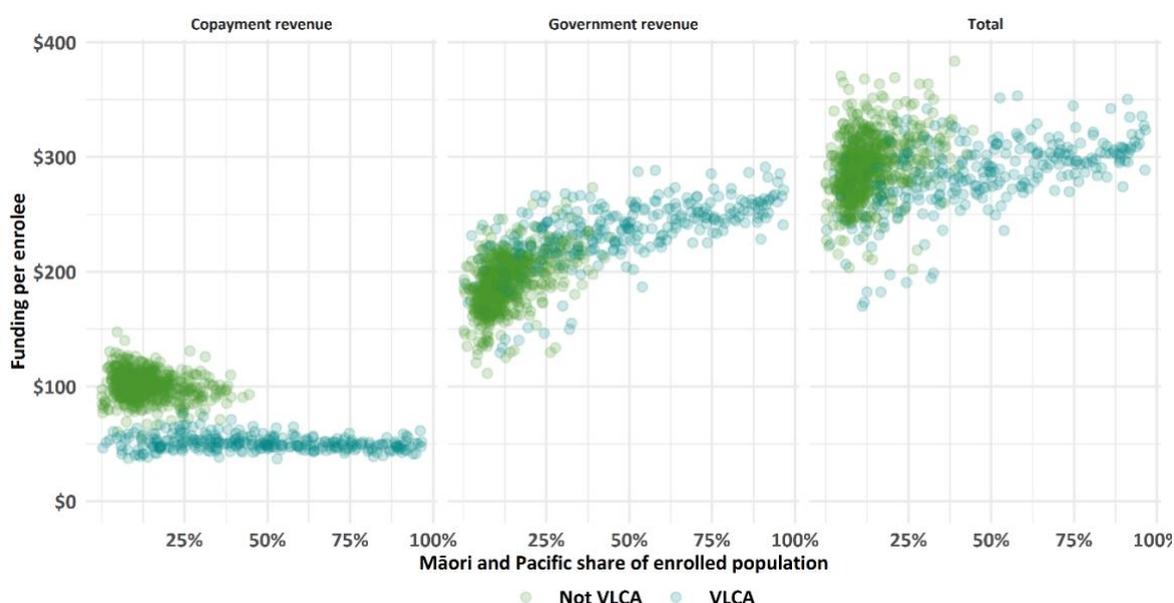


Note: Copayment revenue is estimated by multiplying estimated utilisation per year by estimated copayment charge. Estimated utilisation is the average general practitioner consultations for each age, gender, deprivation quintile and CSC status group in the 2018 calendar year. The estimated copayment charge is zero for under 14s, \$19 for those with CSCs and those in VLCA clinics, and \$45 for all other groups. These estimates do not account for practices voluntarily charging lower or zero fees based on patient need, for other sources of practice revenue, or differences in cost between practices.

SOURCE: MINISTRY OF HEALTH PHO REPORTING, INTERNAL CALCULATIONS

Figure 13 shows the same data (copayment, government and total revenue per enrollee) at the practice level. Copayment revenue tends to be lower for practices that serve Māori and Pacific populations, primarily driven by VLCA status. VLCA practices tend to have lower copayment revenue due to the limit on charging more than \$19. As with the PHO level, total practice revenue per enrollee is roughly even regardless of Māori or Pacific enrolment share.

FIGURE 13: COPAYMENT, GOVERNMENT AND TOTAL REVENUE PER ENROLLEE BY PRACTICE, 2019



SOURCE: MINISTRY OF HEALTH PHO REPORTING, INTERNAL CALCULATIONS

This analysis suggests that:

- ▶ PHOs serving Māori and Pacific populations receive more government funding on average.
- ▶ This funding is only enough to counteract the lower copayment revenue received by practices in these PHOs. This is partly due to copayment reduction schemes such as VLCA.
- ▶ Total revenue per enrollee appears to be no higher in practices serving Māori and Pacific populations.
- ▶ The level of services provided is likely to be no higher in practices serving Māori and Pacific populations, as they are funding from these revenues.

Given that Māori and Pacific populations have higher levels of need, this suggests that service delivery is not matching need.

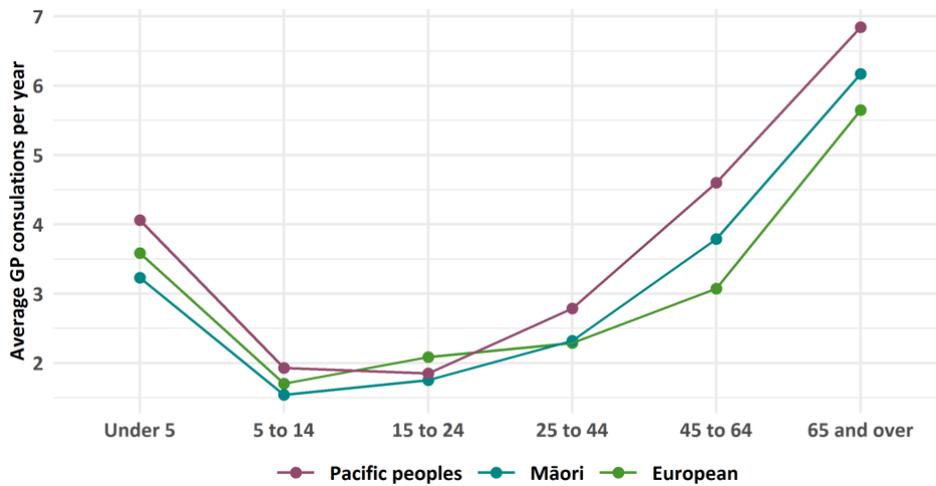
Adjustments to the capitation formula

Some have suggested including ethnicity and deprivation in the first contact funding formula. However, given the current method for constructing the capitation formula, there is no guarantee that this would result in a more equitable distribution of funding.

Capitation funding rates are currently based on historic service utilisation. Including ethnicity and socioeconomic deprivation as factors would allocate more funding to high needs groups only if they have higher historical utilisation. However, for many age groups this is not the case.

Figure 14 shows that for groups aged under 45, Māori have the same or lower levels of GP utilisation than Europeans. This is concerning given that the median age for Māori is around 24. Including ethnicity as a factor could actually reduce the funding allocated for Māori, effectively embedding existing inequities into funding arrangements.

FIGURE 14 AVERAGE GP CONSULTATIONS PER YEAR, BY AGE AND ETHNICITY



SOURCE: MINISTRY OF HEALTH, PHO REPORTING.

The more fundamental problem is that historic use of GP services is a poor proxy for need because it:

- ▶ does not account for the fact that copayments are a barrier to access
- ▶ does not account for other barriers to access, such as lack of transportation and lack of culturally appropriate services
- ▶ is based on only one service type, a standard GP consultation, rather than the more holistic range of services that primary care funding is intended to support.

Appendix H: Tier 2

Introduction

This appendix should be read in conjunction with Chapter 9 (Tier 2) of the Interim Report. It provides additional information on the analysis on current hospital and specialist services utilisation and service delivery arrangements.

Overview of current hospital and specialist services

Most hospital services in New Zealand are provided by the public sector through DHBs.

There are 82 certified public hospital facilities in New Zealand¹³. Some of these facilities are located within the same campus, for example, a separately certified mental health facility within the grounds of a general hospital; and are often considered as one 'hospital'. Hospitals are certified to provide some or all of the following services: medical services (including emergency medicine), surgical services, maternity and neonatal services, paediatric (child health) services, geriatric (health of older people) services, mental health services, and psychogeriatric services (mental health of older people). Some small community hospitals may also have aged residential care beds. Considerable variation exists in the size of hospitals and in the complexity and range of services delivered.

- ▶ Our public hospitals vary in size (as measured by the number of beds). For instance, according to the Ministry of Health data as at 8 March 2019 Auckland City Hospital has 1124 beds, Middlemore Hospital has 745 beds, Waikato Hospital has 673 beds and Christchurch Hospital 833 beds. A number of our provincial hospitals are moderately sized. For example Taranaki Base Hospital has 194 beds, Rotorua Hospital as 233 beds and Palmerston North Hospital has 354 beds. Our smaller community hospitals on the other hand have fewer than
- ▶ 100 beds and a number of hospitals that have under 100 beds are stand alone mental health facilities.
- ▶ Some hospitals provide more complex services than others. This delineation of complexity is described by a Role Delineation Model (RDM) that was developed in 2010 to replace the tertiary matrix DHBs used to self-identify tertiary services to access the tertiary adjustor funding pool. This RDM categorises service on a range of 1 from community services progressively to 6 for supra-complex services. Acute and elective services are level 3. Complex services at level 4 and above are generally grouped together because of the complex infrastructure needed to support them.
- ▶ Hospitals that provide services at levels 5 and 6 include Auckland, Waikato, Wellington, Christchurch and Dunedin hospitals. Based on the 2010 RDM other hospitals provide some complex services (e.g., Palmerston North Hospital's level 5 Oncology service) and some provide regional services that are designated a lower RDM level due to the level of support services available within that facility (e.g. Hutt Hospital's level 4 Plastics Service). While the RDM has not been updated on a national basis, some DHBs since have applied a similar process to describe the level of complexity in service they provide.

TABLE 2: LIST OF CERTIFIED PUBLIC HOSPITALS IN NEW ZEALAND, NORTHERN AND MIDLANDS REGION

DHB	Facility name	Beds	Services
Northland	Whangarei Hospital	249	Paediatric, Surgical, Mental health, Maternity, Medical, Psychiatric
	Kaitaia Hospital	32	Mental health, Maternity, Medical, Paediatric, Surgical
	Bay of Islands Hospital	20	Medical, Paediatric, Maternity, Surgical
	Dargaville Hospital	19	Paediatric, Surgical, Mental health, Maternity, Medical
Waitemata	North Shore Hospital	670	Geriatric, Paediatric, Surgical, Psychogeriatric, Mental health, Maternity, Medical
	Waitakere Hospital	283	Mental health, Maternity, Surgical, Geriatric, Paediatric, Medical
	Mason Clinic	109	Mental health
	He Puna Waiora	39	Mental health
	Elective Surgery Centre	30	Surgical
	Wilson Centre	26	Physical, Paediatric
	Pitman House	10	Mental health
Auckland	Auckland City Hospital	1124	Maternity, Surgical, Medical, Paediatric
	Auckland DHB X 3 Units - Mental Health	96	Mental health
	Buchanan Rehabilitation Centre	40	Mental health
	Greenlane Clinical Centre	31	Surgical, Medical
Counties Manukau	Middlemore Hospital	745	Surgical, Medical, Psychogeriatric, Geriatric, Mental health, Paediatric, Maternity
	Manukau Surgery Centre	78	Surgical
	Pukekohe Hospital	34	Geriatric, Maternity
	Tamaki Oranga	20	Physical, Mental health
	Auckland Spinal Rehabilitation	20	Medical
	Franklin Memorial Hospital	18	Geriatric
	Botany Downs Hospital	12	Maternity
	Papakura Obstetric Hospital	10	Maternity
Waikato	Waikato Hospital	673	Geriatric, Paediatric, Maternity, Surgical, Medical
	Henry Rongomau Bennett Centre	97	Mental health
	Thames Hospital	52	Medical, Maternity, Surgical
	Matariki Hospital	32	Geriatric, Medical
	Rhoda Read Hospital	32	Geriatric, Medical
	Tokoroa Hospital	21	Maternity, Medical
	Te Kuiti Hospital	16	Maternity, Medical
	Ward OPR1	15	Mental health
	Taumarunui Hospital and Family Health Team	14	Maternity, Medical
Puna Whiti	5	Mental health	
Bay of Plenty	Tauranga Hospital	360	Maternity, Surgical, Medical, Psychogeriatric, Geriatric, Mental health, Paediatric
	Whakatane Hospital	96	Mental health, Paediatric, Maternity, Surgical, Medical
	Opotiki Health Care Centre	6	Maternity, Surgical, Medical
Lakes	Rotorua Hospital	233	Paediatric, Maternity, Surgical, Medical, Geriatric, Mental health
	Taupo Hospital	36	Medical, Maternity, Surgical
Tairāwhiti	Gisborne Hospital	115	Mental health, Paediatric, Maternity, Surgical, Medical
Taranaki	Taranaki Base Hospital	194	Mental health, Paediatric, Maternity, Surgical, Medical
	Hawera Hospital	14	Maternity, Medical

SOURCE: MINISTRY OF HEALTH

TABLE 3: LIST OF CERTIFIED PUBLIC HOSPITALS IN NEW ZEALAND, CENTRAL AND SOUTHERN REGION

DHB	Facility name	Beds	Services
Hawke's Bay	Hawke's Bay Hospital	364	Paediatric, Maternity, Surgical, Medical, Mental health
	Wairoa Hospital & Health Centre	12	Maternity, Medical
	Central Hawkes Bay Health Centre	8	Medical
Whanganui	Whanganui Hospital	172	Paediatric, Maternity, Surgical, Medical, Geriatric, Mental health
MidCentral	Palmerston North Hospital	354	Psychogeriatric, Geriatric, Mental health, Paediatric, Maternity, Surgical, Medical
	Horowhenua Health Centre	28	Geriatric, Maternity, Medical
Wairarapa	Wairarapa Hospital	89	Psychiatric, Paediatric, Maternity, Surgical, Medical
Hutt Valley	Hutt Valley Hospital	322	Surgical, Psychogeriatric, Medical, Geriatric, Mental health, Paediatric, Maternity
Capital and Coast	Wellington Hospital	484	Paediatric, Surgical, Maternity, Medical
	Kenepuru Hospital	131	Medical, Psychogeriatric, Maternity, Surgical, Mental health
	Te Korowai Whariki	118	Mental health
	Wellington Hospital (Mental Health Services)	29	Mental health
	Kapiti Health Centre	2	Maternity
Nelson Marlborough	Nelson Hospital	191	Medical, Surgical, Maternity, Paediatric, Mental health
	Wairau Hospital	100	Maternity, Medical, Paediatric, Surgical
	Mental Health Admissions Unit	26	Mental health
	Tipahi Street Mental Health	13	Mental health
	Alexandra Hospital	12	Psychogeriatric
	Murchison Hospital and Health Centre	8	Medical, Rest home care
	Nelson Bays Maternity Unit (Te Whare Whanau)	5	Maternity
West Coast	Grey Base Hospital	114	Paediatric, Surgical, Mental health, Maternity, Medical, Dementia, Geriatric
	Buller Health	32	Maternity, Surgical, Medical, Geriatric, Paediatric, Rest home care, Mental health
Canterbury	Christchurch Hospital	833	Paediatric, Medical, Surgical, Maternity
	Burwood Hospital	229	Medical, Surgical, Mental health, Geriatric
	Hillmorton Hospital	195	Mental health
	Ashburton Hospital	54	Surgical, Maternity, Medical
	The Princess Margaret Hospital	53	Psychogeriatric, Medical, Mental health
	Tuarangi Home	37	Medical, Geriatric, Psychogeriatric, Rest home care, Dementia
	Kaikoura Hospital	21	Medical, Maternity, Geriatric
	Rangiora Hospital	16	Maternity, Medical
	Oxford Hospital	15	Medical, Geriatric
	Ellesmere Hospital	10	Medical, Geriatric
	Waikari Hospital	10	Geriatric, Medical, Maternity
	Darfield Hospital	9	Medical, Maternity, Geriatric
	Lincoln Maternity Hospital	7	Maternity
Chatham Island Health Centre	3	Medical	
South Canterbury	Timaru Hospital	132	Mental health, Paediatric, Maternity, Surgical, Medical
Southern	Dunedin Hospital	400	Mental health, Paediatric, Maternity, Surgical, Psychogeriatric, Medical, Geriatric
	Southland Hospital	176	Mental health, Surgical, Geriatric, Paediatric, Maternity, Medical, Psychogeriatric
	Wakari Hospital	120	Mental health, Intellectual, Medical
	Lakes District Hospital	14	Maternity, Medical

SOURCE: MINISTRY OF HEALTH

TABLE 4: DHB HOSPITALS WITH SERVICE CATEGORIES AT RDM LEVELS 2-6 IN 2010

District Health Board	Facility name	Emergency Medicine	Medical service	Oncology & Haematology	Surgical services	Maternity & Neonatal	Paediatric services	HOP	Rehab	Psychogeriatric
Northland	Whangarei Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Waitemata	North Shore Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Waitakere Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Wilson Centre	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Auckland	Auckland City Hospital	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	
Counties Manukau	Middlemore Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Manukau Surgery Centre	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Waikato	Waikato Hospital	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6
	Thames Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Matariki Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Rhoda Read Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Tokoroa Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Te Kuiti Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Taumarunui Hospital and Family Health Team	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Bay of Plenty	Tauranga Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Whakatane Hospital	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3
Lakes	Rotorua Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Taupo Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Tairāwhiti	Gisborne Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	
Hawke's Bay	Hawke's Bay Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Wairoa Hospital & Health Centre	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Central Hawkes Bay Health Centre	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Taranaki	Taranaki Base Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Hawera Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Whanganui	Whanganui Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	
MidCentral	Palmerston North Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Horowhenua Health Centre	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Wairarapa	Wairarapa Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Hutt Valley Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
Capital and Coast	Wellington Hospital	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6
	Kenepuru Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Nelson Marlborough	Nelson Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Wairau Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
West Coast	Grey Base Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Buller Health	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Reefton Health Services	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Canterbury	Christchurch Hospital	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6
	Burwood Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Ashburton Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	The Princess Margaret Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Kaikoura Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Rangiora Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Oxford Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
	Ellesmere Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Waikari Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	
South Canterbury	Timaru Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	
Southern	Dunedin Hospital	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6	Level 6
	Southland Hospital	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4	Level 4
	Lakes District Hospital	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2



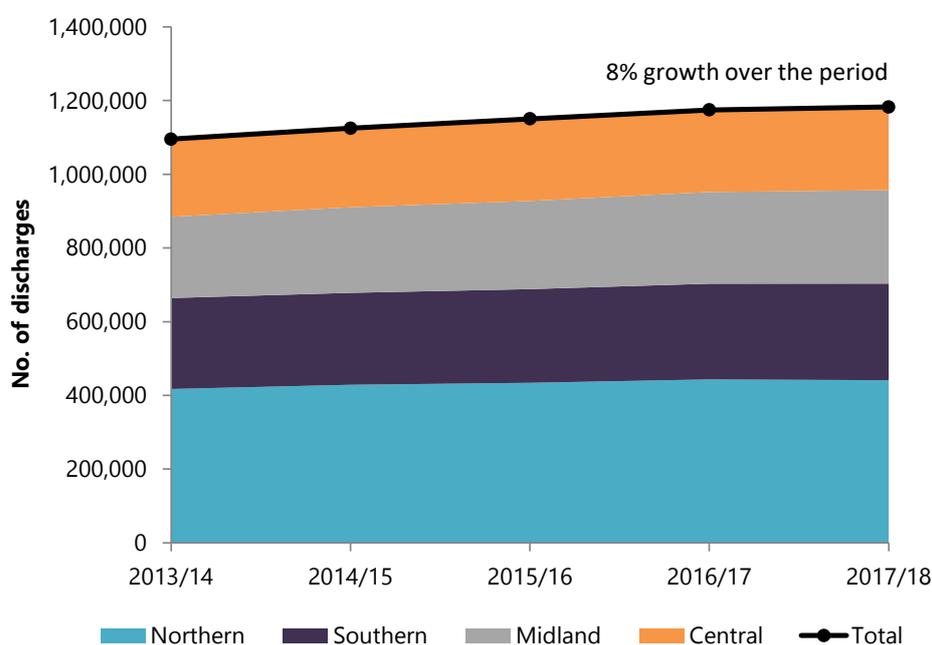
SOURCE: MINISTRY OF HEALTH, UPDATE OF NZ ROLE DELINEATION MODEL MAY 2010

Demand growth is driven by ageing and patients with increasingly comorbid and complex needs

Hospital discharges are events where a patient is admitted to hospital as an inpatient. This includes overnight, or multi-day stays, as well as day case events where the patient is admitted and discharged on the same day. Figure 15 shows the number of publicly funded discharges over the last five financial years. Publicly funded events are funded by the Ministry of Health, DHBs, or ACC; and include events for eligible overseas residents and events outsourced to private hospitals.

Figure 15 present the growth in hospital discharges by Region. It shows that hospital discharges have grown by 8 percent over the five-year period 2013 to 2018—from 1.10 million in 2013/14 to 1.18 million in 2017/18.

FIGURE 15: PUBLICLY FUNDED DISCHARGES BY REGION OF PROVIDER AGENCY



Northern Region = Northland, Waitemata, Auckland, Counties Manukau DHBs;
 Midland Region = Waikato, Bay of Plenty, Lakes, Tairāwhiti, Taranaki DHBs;
 Central Region = Hawke's Bay, Whanganui, MidCentral, Capital & Coast, Hutt Valley, Wairarapa DHBs;
 Southern Region = Nelson Marlborough, West Coast, Canterbury, South Canterbury, Southern DHBs.

SOURCE: MINISTRY OF HEALTH (NATIONAL MINIMUM DATA SET)

Table 5 shows the number of discharges by major service grouping. Medicine accounts for almost half of discharges, surgery for just over one-third, and maternity for around 12%. Every night in 2017/18, an average 8,800 people were in a publicly funded hospital bed.

TABLE 5: PUBLICLY FUNDED HOSPITAL DISCHARGES BY SERVICE GROUPING, 2013/14 TO 2017/18

Service	2013/14	2014/15	2015/16	2016/17	2017/18	Growth
Medicine	498,345	513,401	527,228	543,800	561,390	13%
Surgery	391,326	405,514	415,666	419,654	414,343	6%
Maternity	140,362	140,327	141,435	144,546	140,833	0%
HOP and DSS	22,891	22,683	23,562	23,058	22,746	-1%
Mental health	17,272	18,025	18,513	19,650	19,588	13%
Paediatrics	15,046	15,083	14,177	14,720	14,292	-5%
Neonatal	9,981	9,899	9,697	9,406	9,331	-7%
Total	1,095,223	1,124,932	1,150,278	1,174,834	1,182,523	8%

Note: DSS = disability support services; HOP = Health of Older People services.

SOURCE: MINISTRY OF HEALTH, NATIONAL MINIMUM DATA SET.

There are several points to make about this pattern of activity:

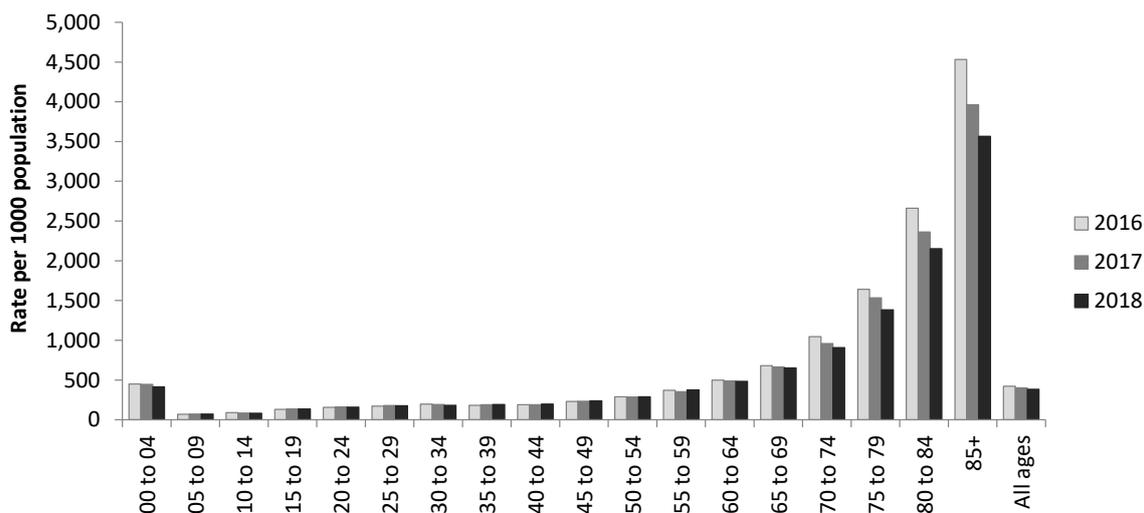
- ▶ Nearly 37 percent are admitted to a hospital in the Northern Region, with around one-in-five inpatients (the remaining 63 percent) admitted to a hospital in each of the three other regions respectively.
- ▶ The largest growth in discharges is in medicine and mental health discharges (13 percent or an average of 3 percent per year). Population growth over the same period was estimated at around 8 percent.¹⁴
- ▶ Growth in medicine is driven by population ageing and increasing co-morbidity; whereas growth in mental health may reflect existing unmet need driving an increase in throughput as inpatient units reduce length of stay.
- ▶ Bed days have not grown as fast as discharges—only a 1 percent increase from 3.17 million bed days in 2013/14 to 3.21 million in 2017/18, reflecting more recent efforts to reduce the length of time patients stay in hospital. Hospitals are seeking to improve flow within their walls as well as provide better and quicker access to community rehabilitation options; and to implement surgical productivity initiatives and programmes to enhance recovery after theatre.
- ▶ Neonatal average length of stay (ALOS) has increased in the last five years. This may reflect increasing complexity, for example, as babies survive birth at earlier gestation.
- ▶ Readmission rates are a balancing quality measure for reduced length of stay. Standardised readmission rates have remained static over the last three years (12.1 percent in the year to September 2016, 12.2 percent in the year to September 2017, and 12.1 percent in the year to September 2018).¹⁵ This static readmission rate suggests ALOS reductions have not been at the cost of quality of hospital service.

Population ageing has a significant impact across all services, including hospital services. People are living longer than previous generations, and they are living longer in poor health. Ageing is associated with an increase in long-term health conditions and multi-morbidities. This is particularly so for Māori, Pacific peoples, refugees, disabled people, and people living with a mental illness. As the proportion of the population ages, so too will the demands on the health and social system. Ministry of Health data shows

that people aged 65 and older are more likely than younger people to be diagnosed with cancer or have a stroke, diabetes, heart disease, chronic pain, or arthritis.

The growth in demand for hospital and specialist services over the next 25 years as the population ages is dramatic. People aged over 65 are more likely to be admitted to a hospital, and to stay longer in hospital, than the total adult population. In 2018, people aged over 65 accounted for 15.8% of the total population, 34.5% of all acute hospital admissions, and 53.0% of acute bed days. Most DHBs are planning for future service delivery within hospitals to be oriented to the frail elderly.

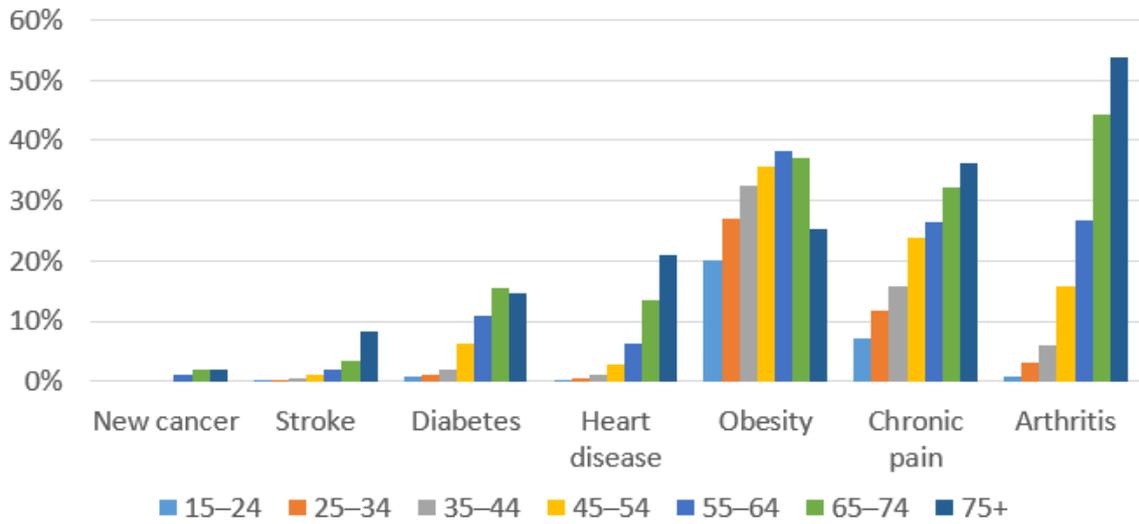
FIGURE 16 STANDARDISED ACUTE BED DAYS PER CAPITA BY AGE



SOURCE: MINISTRY OF HEALTH

Ministry of Health data show that people aged 65 years and older are more likely to be diagnosed with new cancer, suffer a stroke, have diabetes, heart disease, chronic pain and arthritis.

FIGURE 17 PREVALENCE OF CERTAIN CONDITIONS BY AGE



SOURCE: MINISTRY OF HEALTH (ANNUAL UPDATE OF KEY RESULTS 2014/15: NEW ZEALAND HEALTH SURVEY AND CANCER: NEW REGISTRATIONS AND DEATHS 2012)

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 - 3 Ministry of Health (2019) CBF data.
 - 4 World Health Organization, 2018. *Building the economic case for primary health care: a scoping review*. (Available at: https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf?sfvrsn=8d0105b8_2)
 - 5 Ministry of Health (2019) CBF data.
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 - 7 L Middleton, Dunn, P, O'Loughlin, C, and Cumming, J. 2018. Taking Stock: Primary care Innovation. Report for the New Zealand Productivity Commission. Victoria University of Wellington. https://www.productivity.govt.nz/sites/default/files/Taking%20Stock%20Primary%20Care%20Innovation_Victoria%20University%20Wellington.pdf
 - 8 PHO Services Agreement (version 6), 1 December 2018. <https://tas.health.nz/assets/Primary-psaap-u14/PHO-Services-Agreement-Version-6.0-1-December-2018-58445514-PDF.pdf>
 - 9 PHO Services Agreement (version 6), 1 December 2018. Clause F.1 (1).
 - 10 PHO Services Agreement (version 6), 1 December 2018. Clause F.22 (5d).
 - 11 Treasury, 2019. Estimates of Appropriations 2019/20 Vote Health. Accessed August 2019: <https://treasury.govt.nz/sites/default/files/2019-05/est19-v6-health.pdf>
 - 12 Treasury, 2019. Estimates of Appropriations 2019/20 Vote Health. Accessed August 2019: <https://treasury.govt.nz/sites/default/files/2019-05/est19-v6-health.pdf>
 - 13 <https://www.health.govt.nz/your-health/certified-providers/public-hospital>
 - 14 Projections produced by Statistics New Zealand according to assumptions specified by the Ministry of Health.
 - 15 Ministry of Health Acute Readmission Report for DHBs to September 2018.