Implementing the New Zealand Health Strategy 2010

The Minister of Health’s report on progress on implementing the New Zealand Health Strategy, and on actions to improve quality
From the Minister of Health

New Zealand's public health service is operating in a period of great change. Rising costs, increasing demand, an ageing population and international workforce shortages mean we need to rethink how we provide sustainable services where and when they are needed.

Our goal is a high-quality, patient-centred health service that ensures everyone has the same opportunities for good health. Economic constraints mean we must make the very best use of limited health resources while delivering the improvements in services that New Zealanders expect.

The last year has been a busy time for the sector, with the implementation of a programme of improvements to unify the health and disability system and drive improvements in frontline care. The cornerstone of the programme has been the creation of the National Health Board within the Ministry of Health and a new focus on the challenges we face.

District Health Boards have delivered more, higher-quality services and reduced their deficits. The Ministry too has continued delivering services within a lower funding path, freeing up $47 million for new workforce, mental health, elective surgery and maternity services initiatives.

Recruiting, retaining and supporting our medical workforce has been the focus of Health Workforce New Zealand. Sixty new medical school places were created this year and a further 20 will be added in 2011. Over 500 medical practitioners, midwives and nurses have taken advantage of the voluntary bonding that will help ensure skilled people are available where they are needed most.

Improving quality and safety will make a significant difference to the care patients receive. This year the Health Quality and Safety Commission was established to drive improvements in quality and safety across both the public and the private health sectors. Priorities for the coming year include reducing medication errors and reducing hospital-acquired infections.

Much has been achieved in a short time although there is still a lot more to be done. I am confident we have the people, the skills and the passion to help New Zealanders live longer healthier and more independent lives.

Hon Tony Ryall
Minister of Health
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1. Introduction

This report details the actions taken throughout 2010 to progress the following priority areas that have been signalled to the sector:

- financial management and sustainability
- clinical workforce and leadership
- ensuring quality.

These priority areas remain consistent with the New Zealand Health Strategy and will continue to be priority areas for the medium term.

This report fulfils the Minister of Health’s responsibilities under section 8 of the New Zealand Public Health and Disability Act 2000 to report annually on the implementation of the New Zealand Health Strategy (see Sections 2 and 3 of this document). It also meets the requirements under section 9 of the New Zealand Public Health and Disability Act 2000 to report annually on progress on implementing the National Strategy for Quality Improvement (see Section 4).
A range of actions to progress the Ministerial priority of financial management and sustainability has been undertaken in 2010. Of particular note is that:

- District Health Board (DHB) deficit management exceeded expectations through improved productivity
- restraint was maintained in employment relations settlements
- greater efficiencies and productivity were achieved in non-departmental expenditure (NDE) managed by the Ministry of Health (the Ministry)
- Ministry of Health departmental expenditure was reduced
- a shared services organisation (Health Benefits Limited) was established, PHARMAC expanded its focus to prioritising and procuring hospital medicines and medical devices over time, and a Health Quality and Safety Commission was established
- legislative reforms to encourage regional collaboration were made.

**DHB productivity**

DHBs continue to plan and deliver to the deficit reduction track set by the Ministry of Health while maintaining per capita service coverage. DHB deficits have reduced by $98 million from an expected $200 million in June 2009 to $102 million at June 2010.

DHBs had a significant focus on improving hospital productivity during 2010, including through the introduction and spread of internationally proven hospital productivity initiatives (such as improved ward, theatre and emergency department utilisation). The ongoing roll-out of hospital productivity initiatives is on track to achieve forecast labour productivity cost savings of $81 million.

At the same time, DHBs have delivered higher-quality services. They have shortened the average length of stay, reduced administrative overheads and shifted resources to frontline services, as evidenced by an increased number of doctors and nurses. Savings are retained by DHBs to improve delivery of services to patients. An emphasis on clinical leadership means the right people with the right knowledge are enabled to make decisions to improve the delivery of health services. This initiative has been achieved while increasing the number of elective surgical discharges, improving access to subsidised medicines and improving performance against a range of health targets (such as increased immunisation and shorter wait times for cancer treatment).

**Affordable employment relations settlements**

DHBs have delivered on the objective to settle all current employment negotiations within the available funding and in alignment with the Government Expectations for Pay and Employment Conditions in the State Sector (the Expectations). The National Terms of Settlement (NToS) jointly proposed by the Ministry, DHBs, and health sector unions affiliated to the Council of Trade Unions (CTU) have now been agreed by all major workforce groups covered by the CTU whose agreements have come up for renewal between September 2009 and December 2010.
The Ministry has monitored other groups not covered by the NToS (eg, senior doctors, junior doctors, medical radiation technologists, medical laboratory workers) to ensure proposals for settlement are within the NToS parameters and are consistent with the Expectations. This monitoring has been accompanied by increased investment in workforce initiatives focused on recruitment, retention and training.

**Greater efficiencies achieved in Ministry-managed non-departmental expenditure**

Ministry-managed non-departmental expenditure (NDE) has continued to deliver services within a lower funding path, with efficiency savings of $56 million achieved against potential expenditure. In addition, $47 million of ongoing Ministry departmental expenditure and NDE funding has been reprioritised in Budget 2010. The savings were achieved through carefully targeting funding increases, managing disability services in the community instead of in residential care, and seeking greater efficiencies in contracted funding. This funding has been used for a modest package of new initiatives aimed at key areas such as workforce, mental health, elective surgery and maternity services.

**Ministry of Health departmental expenditure**

The Ministry has delivered savings in departmental expenditure through a reduction in Full Time Equivalents (FTEs) from 1675 to 1390 by 1 July 2010. The Ministry is committed to reducing FTEs further to 1290 by July 2011 – representing one of the largest reductions in the state sector.

**Ministerial Review Group reforms**

Vote Health has continued to respond to the issues identified by the 2009 Ministerial Review Group report and subsequent reforms. This response has included the establishment of the new National Health Board, a shared services organisation (Health Benefits Limited) and the Health Quality and Safety Commission; an expanded focus for PHARMAC; and legislative reforms to enable greater regional collaboration.

**National Health Board**

The National Health Board has been established to provide greater sector leadership, support and monitoring in order to improve health services in New Zealand. Its activities include monitoring fiscal performance against District Annual Plans, improving planning and accountability, supporting collaborative decision-making through Regional Service Plans and reducing variability across the system thereby improving efficiency.

**Shared services organisation**

The establishment of a shared services organisation (Health Benefits Limited) to realise further savings in back office functions is complete and progress is on track with plan. The aim of the organisation is to reduce the costs of non-clinical support functions and undertake bulk purchasing and procurement on behalf of DHBs.

**Health Quality and Safety Commission**

Preventable adverse events impose a significant burden on the health system through complications, longer stays and readmissions. A recent study placed the annual cost of avoidable errors at between $320 and $590 million. Some mistakes are avoidable through improved system design and processes.
The Health Quality and Safety Commission has been established and the Interim Board is on track to appoint permanent staff from December 2010. The Commission will review adverse events and drive safety improvements and preventative measures across the sector in order to deliver a more efficient health service to New Zealanders. It is estimated that cumulative annual reductions in adverse events of 1–2 percent are achievable.

Expanded focus for PHARMAC
Expenditure on hospital medicines is growing by about 8–10 percent per year. In contrast, expenditure on community pharmaceuticals managed by PHARMAC has grown by about 2 percent per year since 1993, whilst the number of treatments funded and the volume of prescriptions filled are still increasing. The Ministerial Review Group recommended expanding PHARMAC’s role on the grounds that it could result in significant savings. In June this year it was decided that PHARMAC should become responsible for managing the prioritisation, assessment, standardisation and procurement of hospital medicines and eventually medical devices. It is anticipated that this decision will reduce costs, improve evidence-based prescribing and address inequalities in access between DHBs, ensuring the public health service gets the best health outcomes possible for money spent.

Legislative reforms to enable greater regional collaboration
Legislative amendments to the New Zealand Public Health and Disability Act 2000 introduced a new objective and function for DHBs. DHBs are now to collaborate with relevant organisations to plan and co-ordinate at local, regional and national levels for the most effective and efficient delivery of health services. The legislation also established new powers of direction for the Minister of Health and new dispute resolution powers to enable disagreements in the health sector to be resolved.
3. Clinical Workforce and Leadership

The health and disability sector employs approximately 164,200 people. DHBs employ approximately 67,000 health workers, with the remainder working in areas such as the private sector, home-based and residential care and support services, and non-government community services.

National overview

In February 2010 the Health Workforce New Zealand (HWNZ) Board was established under section 11 of the New Zealand Public Health and Disability Act 2000, with a secretariat in the Ministry of Health. HWNZ’s goals are to lead health workforce planning, education, training, development and purchasing. The intention is for HWNZ to facilitate and encourage a fit-for-purpose, sustainable, productive, skilled and responsive health workforce.

The establishment of HWNZ has enabled the consolidation and rationalisation of the health workforce development activities of a range of organisations, committees and advisory groups, including around 50 health workforce development contracts from across the Ministry. This national overview will enable all the activities to be prioritised to improve the value for money and productivity resulting from health workforce development investment and to ensure investment priorities are focused on the areas of greatest need and vulnerability.

Clinical leadership

Clinical leadership is an important factor in lifting the performance of the health system and driving quality improvements. A range of strategies has been implemented to strengthen clinical leadership, including supporting the development of clinical leaders, increasing the involvement of health practitioners in service planning and management decisions, and developing and expanding service-based clinical networks, including regional networks.

Increasing the supply of medical practitioners

An additional 60 new medical students entered training in 2010, taking the total number of medical students to 425 (with a further 20 places being introduced in 2011).

An additional 50 general practice (GP) training places were established, increasing the total number of GP training places available from 104 to 154 per year. GP training has been reviewed and will be changed to meet projected future requirements as well as develop practitioners who can work in both hospital and community settings, and who may have a range of clinical special interests.

Attracting practitioners to areas of need

The voluntary bonding scheme introduced in 2009 continues to be a useful strategy to attract newly registered practitioners to areas of need. In 2010, 64 medical practitioners, 46 midwives and 392 nurses took advantage of the scheme.

The voluntary bonding scheme has been extended to advanced medical trainees through the Advanced Trainee Scheme to retain New Zealand–trained medical practitioners in New Zealand and address shortages in specific specialties. The scheme will provide scholarships for up to 25 medical specialist trainees per year to take up supported overseas
training positions. The trainee will be bonded for two years. By building strong long-
term relationships with medical graduates early in their careers and by ensuring there are
permanent positions for them to come back to, DHBs can ensure more medical graduates
return after training overseas.

Co-ordinating career planning and training

Four new regional training hubs are being established with an initial focus on postgraduate
medical training within DHBs. A roll-out to other workforces and levels of training by the
end of December 2011 is planned. The training hubs will replace the current ad hoc training
arrangements. They will improve the quality and reduce the cost of training by reducing
duplication and improving the equity of placements and consistency of training.
4. Ensuring Quality

In its 2009 report, the Ministerial Review Group identified the need to accelerate national quality and safety improvement initiatives, and recommended the establishment of a national quality entity.

In December 2009 Cabinet agreed to establish a Health Quality and Safety Commission (the Commission) as a stand-alone Crown entity to create a sustained focus on quality and safety improvement independent of the regulatory, funding and performance functions of the Ministry of Health. On 31 May 2010 the Commission’s Interim Board was established to oversee the establishment of the Commission and its initial business plan. The Commission will also assume the mortality review functions of the New Zealand Public Health and Disability Act before 26 April 2011. The Commission will be working with the mortality review committees to ensure a smooth transition of those functions.

As a result of the efforts of previous committees, groups and individuals, the Commission was established on strong foundations. The Commission will continue to build on these foundations to develop a ‘uniquely New Zealand Quality Movement’ and thereby contribute to better health outcomes, reduced health inequities and, in the medium- to long-term, a sustainable health and disability sector.

On 1 December 2010 the Commission became a stand-alone Crown entity. It now continues to establish core operating systems and processes (human resources, information management and technology, finance, communications), recruit staff, refine its Statement of Intent and other key planning documents, and establish mechanisms for working across and with the wider health and disability sector.

The Commission is responsible for assisting providers across the whole health and disability sector (public and private) to improve service safety and quality and therefore outcomes for all who use these services in New Zealand. Improving the quality and safety of care will provide better value for money and more efficient and effective use of taxpayer funding.

The Government has agreed that the Commission will:

- provide advice to the Minister of Health to drive improvement in quality and safety in health and disability services
- lead and co-ordinate improvements in safety and quality in health care
- identify data sets and key indicators to inform and monitor improvements in safety and quality
- report publicly on the state of safety and quality including performance against national indicators
- disseminate knowledge and advocate for safety and quality.

Through its leadership function, the Commission will develop and promote innovative initiatives across the sector to drive quality improvements. The Commission will work with other organisations (eg, Health Workforce New Zealand, Accident Compensation Corporation, the Health and Disability Commissioner, employers, professional colleges and member organisations) to help promulgate a culture that is open, transparent and committed to learning.

Clinical leadership is fundamental to the success of quality improvement initiatives, and the Commission will ensure there is appropriate clinical leadership of its programmes.
As the Commission replaced the Quality Improvement Committee’s functions, it also inherited oversight of the National Quality Improvement Programmes. The following four programmes were contracted under Crown Funding Agreements to lead DHBs to deliver on behalf of all DHBs:

- Safer Medication Management (Hutt Valley DHB)
- Optimising the Patient Journey (Counties Manukau DHB)
- Incident Reporting (Waikato DHB)
- Infection Control and Prevention (Auckland DHB).