

Health Policy

Part I: Funding and Framework

In this policy:

- Continuing the current health spending growth track.
- Less bureaucracy, more frontline care for patients.
- Giving doctors and nurses more say.
- District health boards working together.
- Care closer to home.
- Smarter use of the private sector.

NOTE

This is the first in a series of health policy announcements by National. It sets out our funding intentions and the framework we will introduce to improve performance in the public health system. The strategic approach is based on National's Health Discussion Paper: [Better, Sooner, More Convenient](#).

Further health policy announcements will follow.

Endnotes are appended in the Backgrounder that follows this policy paper.

INTRODUCTION

New Zealand is spending more on health but getting less for it.

Despite spending an extra \$6 billion a year on health compared to when Labour came to office, New Zealanders have to be sicker to get surgery¹. It's harder to see a hospital specialist. Emergency departments are gridlocked. Radiotherapy times are frequently excessive. Increasingly, workforce shortages mean people have to wait longer and longer to see their local GP.

Over the past nine years, Labour's obsession with control and structure has ballooned health administration. The unchecked spread of bureaucracy throughout the health system uses money that should be spent on disease prevention and patient care. Under Labour, district health boards have employed nearly two extra managers and administrators for every extra doctor. The Ministry of Health has doubled in size. There is now one bureaucrat for every public hospital bed.

This can't go on. The massive increase in bureaucracy is diverting resources that should be used for patient care. Even worse, it's draining the motivation and commitment out of our health workforce. Health professionals perform better when they are valued and trusted. The current health system is running on their goodwill, and that is rapidly running out.

At the same time, serious staff shortages in many parts of the health system are affecting patient care. Despite more than 50 official reports, Labour still denies there is a workforce crisis.

National wants the public health system to deliver better, sooner, more convenient healthcare for all New Zealanders. We want shorter waiting times, less bureaucracy, and a trusted and motivated health workforce.

New Zealand's health service can be improved to meet these challenges without the distraction of restructuring. We have the right people on the frontline of healthcare. We need to empower them to do the job even better.

I. CONTINUING THE CURRENT HEALTH SPENDING GROWTH TRACK

Our health is affected by everything about us, and everything around us. The support of family and friends, a good job and income, a healthy home, and an active lifestyle all have a positive impact on our health.

By addressing these underlying determinants of health and wellbeing, good government can help prevent ill health and improve our future health.

The link between higher living standards and better health is clear. By increasing prosperity and opportunity, a National-led Government will improve the health of New Zealanders.

Labour has squandered the opportunity of good economic times, failing to make a lasting, positive impact on the wider determinants of health. As a result, many New Zealanders are suffering needlessly.

A comparison of health spending per capita between New Zealand and other OECD countries shows wealthier countries spend more on health than poorer countries².

Countries we like to compare ourselves with – such as Australia – spend more on health, in part because they have higher incomes. Australia provides much better access to healthcare in general than does New Zealand.

It is clear that better economic performance will enable us to spend more on healthcare.

At the same time, New Zealand must strive to get more health service from existing spending by reducing waste and bureaucracy, and lifting productivity³.

National is confident that our economic programme will deliver higher incomes, close the wage gap with Australia, and grow our wealth. That will not only help people directly, but it will allow social spending to grow where needed. It will also allow us to continue growing government investment in health.

National will continue the growth in health spending set out by the Government. This includes the indicative spending allocations in the 2008 Pre-Election Fiscal Update.

National will spend that extra funding more wisely than Labour, as well as get more effective care from existing spending. We will deliver better, sooner, more convenient care and treatment for New Zealanders from the public's investment in health.

NOTE:

This policy was originally released on 11/09/08. It has been updated to include the information provided in the 2008 Pre-Election Fiscal Update.

2. LESS BUREAUCRACY, MORE FRONTLINE CARE FOR PATIENTS

The public health system is stifled by growing bureaucracy and what the Association of Salaried Medical Specialists calls “managerialism”⁵. Despite Helen Clark’s promises to cut a massive swathe through the health bureaucracy⁶, the reverse has actually occurred. Bureaucracy has infected our health system.

A major re-organisation of the Ministry of Health has failed to slow the unchecked growth in its staffing⁷.

Under questioning about this ballooning bureaucracy in Parliament, even the Minister of Health has admitted that bureaucracy is out of control⁸.

As an excuse for inaction, the Labour Government has launched an armada of committees, strategies, plans, visions, and reports. The Minister of Health is unable to say how many committees, consultative groups, councils, or taskforces his ministry officials are involved with⁹.

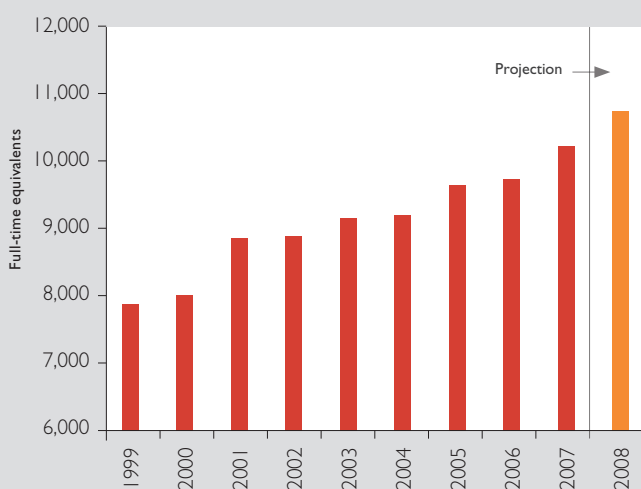
Similar unchecked growth in administrative overhead is happening in the country’s 21 district health boards¹⁰. The number of DHB managers and administrators has grown by 2200 since 2001 (see Figure 1) – almost twice the number of extra doctors employed during that same period.

If those administrators could actually deliver care for patients, we would be in better shape. Rather, too much bureaucracy makes it harder for our health professionals to do their job – by creating hurdles and draining funds.

Incentives for DHB general management to control bureaucratic overhead are clearly ineffective. Left unchecked, more and more resources will end up being diverted from essential frontline services. We should be treating patients, not paperwork.

National will reduce the bureaucracy in health. Savings will be moved to boost frontline care for patients.

Figure 1: Growth in DHB Managers and Administrators¹⁰



3. GIVING DOCTORS AND NURSES MORE SAY

Around the world, clinical leadership is recognised as a fundamental driver for improved care. But under Labour, health professionals have an increasingly-limited say on how health services are provided.

Labour's failure to engage the people who have the expertise – the doctors and nurses who keep the public health system going – is eroding the health service's ability to provide patients with the care they need. Doctors, nurses, and other health professionals need to be able to make the most of their skills and commitment. National will reduce red tape and empower them to do this.

Recent research by McKinsey and Company, based on 126 hospitals¹¹ across the UK, has found a clear link between strong clinical leadership and hospital performance. The researchers found that best-practice operational approaches in hospitals reduced infection rates, improved productivity, readmission rates, patient satisfaction, and value for money.

The key to this success was the level of involvement of clinicians in running their hospital services. Stronger and more direct involvement by doctors, nurses, and other clinicians means more service and better quality.

National will ensure that doctors, nurses and other health professionals have more say in how health services are developed and improved. We will do this by requiring DHBs to involve health professionals in decision-making¹².

This is not to say that we want doctors and nurses to stop doing what they were educated to do and become managers. But we do want to use the wealth of frontline experience they have

accumulated to improve quality of care and rebuild confidence in the public health system.

Better clinical engagement will improve quality and job satisfaction. This will help the public health service retain skilled clinicians and attract new staff.

4. DHBs WORKING TOGETHER

Recent ministerial investigations into several provincial district health boards have demonstrated the increasing fragility of health services at many of the country's smaller general hospitals. The Health and Disability Commissioner has also raised concerns about the ability of these hospitals to survive in the face of mounting workforce and clinical issues, along with ageing and - in some cases – shrinking populations¹³.

Other district health boards face similar challenges:

- Difficulty in recruiting and retaining staff.
- Maintaining sufficient caseloads in particular specialties.
- Higher patient expectations.
- Costly new technology.

Upper North Island DHBs also face the pressure of strong population growth.

As well as these challenges, district health boards face considerable financial pressures. In the past financial year, 17 DHB hospital services reported losses totalling \$161 million¹⁴. Labour has been forced to increase funding to cover overall DHB deficits from \$59m in 2007/8 to \$110m in 2008/9¹⁵.

To overcome these challenges, DHBs need to work more closely together. Sharing clinical services across boundaries can sustain patient access without centralising services, and provide safer workloads¹⁶.

Similarly, a patient's seamless transition from hospital to home can be supported through better links with primary and home care.

Non-clinical services can also benefit from greater co-operation. Such benefits can include:

- Better regional planning.
- Shared capital and technology investment.
- Less administrative duplication and waste.

National's plan to improve healthcare needs the support and total focus of those working in the public health service, and they do not need the distraction of structural upheaval. There will, however, be stronger incentives for DHBs to perform. This includes holding chairs, boards and CEOs more accountable for their performance.

In the past 20 years, the public health system has undergone three significant health reforms: 1989 (Clark), 1992 (Upton), and 2001 (Clark again). According to a Labour Government-funded research project, DHBs are now no more efficient at delivering healthcare than under the previous system¹⁷.

Restructuring doesn't necessarily change the way people work. Structural change diverts the attention of doctors and nurses away from improving patient care. National believes our health service can be improved without the distraction of restructuring.

National will:

- Require the 21 district health boards to work more collaboratively to improve access to services and reduce administrative duplication and waste.
- Not carry out another round of restructuring of the public health system.

5. CARE CLOSER TO HOME

Patients want a wider range of care closer to home with much less waiting. They are frustrated by delays in accessing diagnostic tests, outpatient services, and even their GP. Traffic congestion in many cities also adds to patient delays.

Despite years of Labour rhetoric and a significant financial investment, the Primary Health Care Strategy has failed to deliver a wider range of services in primary care¹⁸.

Labour's Health Workforce Taskforce recently criticised the same lack of progress citing a lack of coherent national leadership¹⁹.

Research suggests that the lack of critical mass in a general practice – that is, its often small scale – has been the main barrier to moving services from hospitals to primary care²⁰.

Issues like capital, operating costs, and personnel prove daunting for any small business looking to change its configuration.

Yet, general practice in New Zealand has evolved over the past 15 years to be strongly networked, with high levels of clinical competence.

More of the diagnostic and outpatients services currently carried out in hospitals could be publicly provided in primary-care settings. This would help patients get direct referral to specialist diagnostics like CT scans, and access specialist assessments in primary-care settings. It would also help patients to get more minor surgery by specially trained GPs.

Patients could also benefit from a wider range of co-located health professionals – such as physiotherapists, podiatrists, and dieticians - where appropriate. This would improve preventive care and improve patients' transition from hospital to

home, producing better health outcomes and more convenient care.

National will devolve more hospital-based services into primary care settings, providing faster access to more care closer to home. We will do this through delegated funding to PHOs and other health providers.

6. SMARTER USE OF THE PRIVATE SECTOR

New Zealanders should have timely, high-quality access to elective surgery when they need it. Research by Victoria University shows surgical output needs to grow by around 51% from 2001 to 2026 just to deliver the current inadequate rates of elective surgery, and grow by 77% to address real elective surgery need²¹.

This cannot be achieved without growing capacity in the public system and using the resources of the private components of the health system.

Labour has told DHBs to use available private hospital facilities only as a last resort, after all public capacity has been expended²². Labour believes that the use of spare private hospital facilities should be only “an interim measure to reduce backlogs of patients”²³.

This ideology encourages last-minute “spot purchasing” activity by DHBs, which is expensive. If the private sector had longer-term contracts with DHBs it would be able to plan for the demand and respond with better prices. Private providers would **supplement** public hospital provided electives, seeing more patients at less cost.

National will focus on getting patients seen and treated, and not obsess about where this gets done. Longer-term arrangements will also be used with other non-government health providers, where appropriate.

National supports the smart use of the private sector to increase the number of people getting timely access to vitally-needed surgery, and reduce hospital waiting lists.

Health Policy Part I: Funding and Framework

Backgrounder

INTRODUCTION

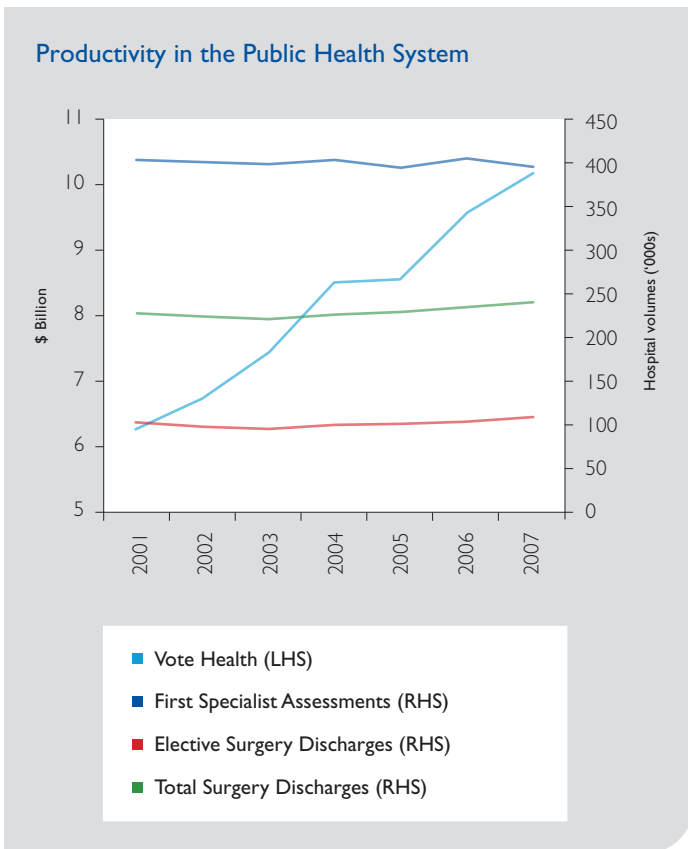
I. Productivity Declining in the Public Health System

Despite a substantial increase in health funding (Vote Health), the number of first specialist assessments, elective surgery discharges, and total surgical discharges has shown no significant improvement.

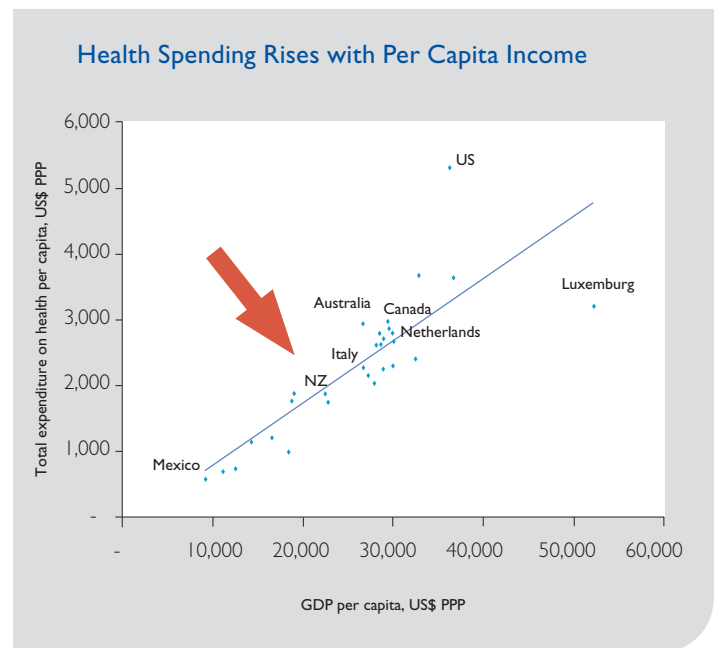
CONTINUING THE CURRENT HEALTH SPENDING GROWTH TRACK

2. Health Spending Rises with Per Capita Income

A comparison of health spending per capita between New Zealand and other OECD countries shows wealthier countries spend more on health than poorer countries.



Source: Ministry of Health and Treasury



Source: OECD

3. Lifting Productivity in the Public Health System

For a discussion on falling productivity in the health system and how we can improve it, see Chapter 4 "Improving Quality and Performance" in National's Health Discussion Paper: [Better, Sooner, More Convenient](#).

4. Continuing the Growth in Health Spending

Under National, health spending will continue to grow. National will commit to the operating spending set out in the 2008 Budget and the indicative spending allocations laid out in the 2008 Pre-Election Fiscal Update.

Forecast spending track 2008/9 Budget Documents

\$ millions, GST exclusive	2008/09	2009/10	2010/11	2011/12
Operating	11,973	11,889	11,834	11,801
+ Forecast new spending allocation (2008 Pre-Election Fiscal Update)		750	1,500	2,250*
Total Operating	11,973	12,639	13,334	14,051

* Assuming the new spending allocation in Budget 2011 will be around that of 2010.

Source: Budget 2008 and 2008 Pre-Election Fiscal Update

LESS BUREAUCRACY, MORE FRONTLINE CARE FOR PATIENTS

5. “Managerialism” in the Public Health System

“The culture of managerialism is pervasive in DHBs despite some positive patches to the contrary.”

- Ian Powell, “ Speech: Avoiding The Matthew Effect: Empowering Health Professionals In District Health Boards: Avoiding The ‘After This Nothing Happened’ Syndrome” (ASMS, 28 July 2007).

6. Helen Clark’s Failure to Cut Health Bureaucracy

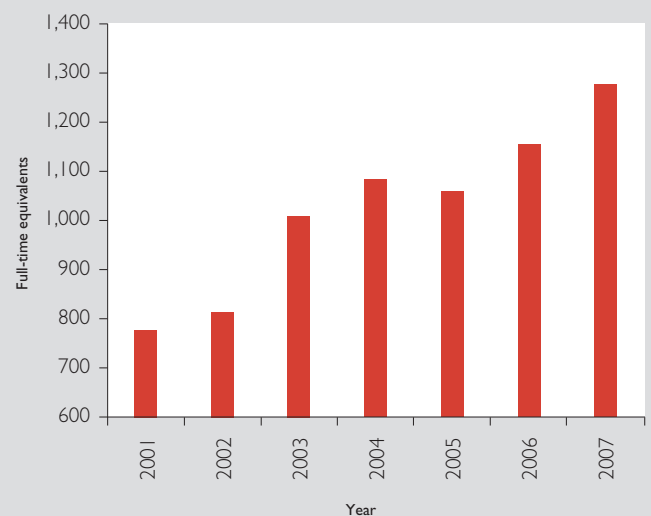
“Unnecessary bureaucratic and administrative overheads in the restructured health system need to be eliminated.”

- Hon Helen Clark, “Speech to Auckland Regional Chamber of Commerce and Industry” (New Zealand Labour Party, 1996).

7. Ballooning Staff at the Ministry of Health

A major reorganisation of the Ministry of Health has failed to slow the unchecked growth in Ministry staffing.

Ministry of Health Employees



Source: Ministry of Health

8. Health Minister Admits Bureaucracy is Out of Control

“I have signalled to the director-general that future output gains should be driven by reprioritisation rather than through significant further fulltime-equivalent staff growth.”

- Hon David Cunliffe, Hansard, 5 August 2008.

9. Health Minister Unable to Say Number of Committees

"I am advised that researching the committees, consultative groups, councils, taskforces or other similar groups the Ministry of Health or its staff is represented on, as requested by the member, would be complicated and time consuming."

- Reply to written question 6468 (2008).

10. Unchecked Growth in Administrators at DHBs

The number of DHB managers and administrators has grown by 2,200 since 2001, and the salary costs have increased by nearly 50%.

- Written questions 4584 (2006), 1003 (2008), 7208 (2007), 6115 (2007), and 1017 (2008).

GIVING DOCTORS AND NURSES MORE SAY

11. Strong Clinical Leadership Improves Hospital Performance

Pedro Castro et al, "A healthier health care system for the United Kingdom", *The McKinsey Quarterly* (McKinsey & Company, February 2008).

12. Involving Health Professionals in Decision-Making

National will ensure that doctors, nurses, and other health professionals have more say in how health services are developed and improved, through Ministerial requirements in DHB Statements of Intent, District Annual Plans and other accountability mechanisms.

DHBS WORKING TOGETHER

13. DHBs Facing Population Pressures

The Ministry of Health projects that over the next 10 years a third of DHB populations will grow, a third will remain stable, while the other third will shrink.

- Ministry of Health presentation.

14. Most DHBs are in the Red

In the past financial year, 17 DHB hospital services reported losses totalling \$161 million.

- Ministry of Health, "DHB unaudited net results for 2007/2008 (Ministry of Health, 2008), available from: [http://www.moh.govt.nz/moh.nsf/pagesmh/6707/\\$File/dhb-report-june08.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/6707/$File/dhb-report-june08.pdf)

15. Labour's Blowout in Deficit Funding

Labour has been forced to increase funding to cover DHB deficits from \$59m in 2007/8 to \$110m in 2008/9.

Health Committee, 2008/09 Estimates for Vote Health (NZ House of Representatives, 2008), pages 16-17.

16. Sharing Clinical Services

Greater Metropolitan Transition Taskforce, *Embracing Change: Report of the Greater Metropolitan Transition Taskforce* (Greater Metropolitan Transition Taskforce, 2004), 3-5.

17. DHB Reforms Have Not Achieved Efficiency Gains

"Analysis of trends in routinely available indicators of performance shows that the post-

2001 public health system is no more efficient, and may be less efficient, than its predecessor.”

- Nicholas Mays and Jacqueline Cumming, *Report No. 10: Performance Of New Zealand's Publicly Financed Health Care System* (Victoria University of Wellington, 2007).

CARE CLOSER TO HOME

18. Labour's Failed Primary Health Strategy

“The strategy envisages that a wider range of services would be provided in the primary care setting (including maternity, well-child, and improved follow-up from hospital services). Co-ordination needs to occur not just within general practice, but across linked service areas (for example, primary health care and hospital; maternity services and primary health care). Generally, co-ordination between the primary care and “hospital” environment is still weak. ... Most PHOs have yet to take full advantage of opportunities to expand the primary health care team and changes at practice level are often limited.”

- Hon Pete Hodgson, “Primary Health Care Strategy Monitoring Its Achievements” (Office of Minister of Health 2006).

19. Labour's Health Workforce Taskforce Criticises Government Leadership

“Lack of clear national leadership in the implementation of the Strategy is not surprising given the number of ‘players’ with diverse interests, often operating in relative isolation from one another. ... While collaboration and team work are specified as a means to achieving the Strategy, nationally there has been a lack of coherent leadership in translating this approach into practice.”

- Workforce Taskforce, *Working Together for Better*

Primary Health Care: Overcoming barriers to workforce change and innovation (Ministry of Health, 2008), page 10.

20. Small Practices Lack Critical Mass

Professor Paul Corrigan, *Size matters: making GP services fit for purpose* (The New Health Network, 2005), page 22.

SMARTER USE OF THE PRIVATE SECTOR

21. Big Boost in Surgical Output Needed

Antony Raymont, John Simpson
“Projections of surgical need in New Zealand”, NZMJ (August 2008).

22. Private Hospitals as a Last Resort

“Available public capacity (including capacity in other centres where this is practicable) should be absorbed before arrangements with private providers are made.”

- Ministry of Health, *Reduce waiting times for public hospital elective surgery* (Ministry of Health, 2000), page 15.

23. Private Hospitals as an Interim Measure

“This provides for publicly-funded surgery and specialist assessments to be provided in private facilities to manage peak demands and as an interim measure to reduce backlogs of patients. The strategy requires available public capacity to be used first, and public disclosure of the contracts with private providers.”

- Annette King, *District Health Boards and the non-government health sector* (Office of the Minister of Health, 2000) page 4.