Clinical leadership in a changing world

5 April 2017

Dr Andrew Simpson, Chief Medical Officer, Ministry of Health
Who does what?

The Ministry:

• principal advisor and support to the Minister and Government

• direct purchaser of a range of national services (including disability support and public health services)

• provides *clinical and sector leadership* of New Zealand’s health and disability system and has overall responsibility for the management and development of that system

• has a number of monitoring, regulatory and protection functions to ensure that the health system is delivering on the Government’s priorities and that health sector organisations are well governed and soundly managed from a financial perspective

• provides health sector information and payment services
Who does what?

**DHBs:**

- most of the day-to-day business of the system, and nearly three-quarters of the funding, is administered by district health boards (DHBs)

- DHBs plan, manage, provide and purchase health services for the population of their district, implement government health and disability policy, and ensure services are arranged effectively and efficiently for all of New Zealand

- includes funding for primary care, hospital services, public health services, aged care services and services provided by other non-government health providers, including Māori and Pacific providers
Breakdown of the $16,142m Vote Health budget 2016/17

- DHB: 76%
- National health and disability services: 16%
- MoH: 3%
- Capital investment: 5%
Overall, our health system performs well

- The health of our population has continuously improved for the last 25 years.
- New Zealanders are living longer, and are living longer in good health.
- Between 1985 – 1987 and 2007 – 2009, life expectancy increased by 7.3 years for males and 5.3 years for females, and we expect to see further improvements over time.
- Current life expectancy for New Zealand women is 83.2 years and 79.5 years for New Zealand men.
Delivering more services

- A wide range of DHB outputs have increased at a faster rate than population and aging:
  - Primary care consultations are up by 12.57 percent
  - Elective surgical discharges by 11.79 percent
  - ED admissions by 14.39 percent
  - Home support hours for the elderly by 27.47 percent
  - And mental health clients by 20.41 percent

- To deliver these services, the number of doctors has increased by 16.41 percent and nurses by 10.83 percent

- Overall, this means that there are more health service outputs per person than ever before, reflecting the drive to improve access to services.
Examples of what the health and disability system does for our customers

- **48,000** Prescriptions are dispensed in 2015
- **58,000** children receive their B4 School Checks in 2015
- **1.2 million** people have had a cardiovascular disease risk assessment in the last 5 years
- **908,760** women received a cervical cancer screen between 2013 and 2015
- **4,407,263** New Zealanders are enrolled in a PHO in 2016
- **200,323** elective surgeries took place in 2015
- **44.4 million** funded prescription items as at June 2016
- **13.2 million** GP visits take place per year
- **489,458** smokers ordered brief advice in 2015
- **13,890** eight month olds immunised in 2015
- **1.1 million** emergency department visits occur per year

Delivered by:

### Organisations and infrastructure
- 1013 General Practices
- 20 DHBs
- 76 Private Hospitals
- 2661 General Dental Practices
- 32 PHOs
- 991 Pharmacies
- 225 Māori Health Providers
- 46 Accident and Medical Centres
- 664 Certified Rest Home Providers
- 35 Pacific Health Providers
- 39 Public Hospitals

### Workforce
- 15,144 Doctors
- 53,922 Nurses
- 3,100 Midwives
- 63,000 Kalāwhina
- 24,834 Other Allied Health Workforce
Spending on health continues to increase
And compares well - health expenditure per capita
Health expenditure by GDP
There are challenges ahead

- **Growing population**: By 2025, the population is expected to increase from 4.6 million to between 5 and 5.5 million.
- **Increasing diversity**: Over time, the Māori, Asian and Pacific populations will increase as a share of the total New Zealand population.
- **Ageing**: People are living longer; the number of people aged 65 years and older will roughly double to around 1.4 million in 30 years.
- **Regional differences**: Different regions have increasingly different demographics: almost one-third of the total population currently live in Auckland.

This influences the way health services are planned and delivered.
Determinants of health and wellbeing

- Genetic predisposition: 30%
- Clinical Care: 10%
- Behavioural patterns: 40%
- Social circumstances: 15%
- Environmental exposures: 5%

New Zealand Health Strategy

New Zealand Health Strategy
Future direction

All New Zealanders
live well
stay well
get well

New Zealand Government
Released Apr 2016

New Zealand Health Strategy
Roadmap of actions 2016

All New Zealanders
live well
stay well
get well

New Zealand Government
Released Apr 2016
5 key themes of the New Zealand Health Strategy

- People-powered: Mā te iwi hei kawe
- Smart system: He atamai te whakaraupapa
- Closer to home: Ka aro mai ki te kāinga
- Value and high performance: Te whāinga hua me te tika o ngā mahi
- One team: Kotahi te tīma

All New Zealanders live well, stay well, get well.
People powered

- understanding **people’s needs/preferences**
- **accessible technology & information**
- make **choices**
- **partner** to design services
- **communicate** well
Closer to home

- care closer to where people live, learn, work and play, especially for managing Long Term Conditions (LTCs)
- integrate health & wider public services
- promote wellness & preventing LTCs
- invest in health & wellbeing early in life
- focus on children, young people, families and whānau
Value and high performance

- better use of funding, better directed to greatest need
- measure outcomes
- information & insight to drive learning & decision-making
- quality improvement
- clear roles & responsibilities across the system
- investment approach to address complex health & social issues
One team

- **one team** in a high-trust system working together
- with the **person, their family, whānau & communities** at the centre of care & as carers
- use **workforce** in the most effective & flexible way
- develop **leadership, talent and workforce skills** throughout the system
- **Ministry of Health leading the system** effectively
- collaborate with **researchers**
Smart system

• effective *innovations* across the system

• *new & emerging technologies* adopt & standardised

• *data & smart information systems* that improve evidence-based decisions, management reporting & clinical audit

• *reliable, accurate information* that is available at the point of care

• *online health records for all*
The Ministry’s six strategic priorities

- Implement our investment approach
- Improve health outcomes for population groups with a focus on Māori, older people and children
- Improve access to, and the efficiency of, health services for New Zealanders with a focus on disability support services, mental health and addictions, primary care and bowel cancer
- Improve outcomes for New Zealanders with long-term conditions with a focus on obesity and diabetes
- Improve our understanding of system performance
- Deliver Ministry on the Move
Understanding what we are delivering

**National Patient Flow**

- National Patient Flow (NPF) is a new national patient referral collection
- the collection receives and connects related patient referrals, which tell a story about the patient and their secondary care journey
- it is not a clinical registry or clinical outcomes database, but the data will give valuable insight into what happens to patients as they are referred for elective or cancer treatment
Benefits of National Patient Flow

- less anecdote and more fact will allow allocation of resources more effectively
- better understand demand for hospital services at “pathway” level, and how DHBs respond to this demand
- clarify the waiting times between events for patients and pathways, and where these are system driven
- assist with benchmarking, enhance national consistency and equity in access and delivery for different pathways
- manage and reduce risk of “lost” or “stranded” patients
- identify patients on complex pathways, and support better integration of services, within and across DHBs
- illuminate the complexity of the ‘patient journey’ in secondary care, and connect related patient referrals
# National Patient Flow data

Number and percentage of referrals received in June 2016 for publicly funded FSAs by responsible DHB and prioritisation outcome

<table>
<thead>
<tr>
<th>Responsible DHB</th>
<th>Total received</th>
<th>Total accepted</th>
<th>Below threshold</th>
<th>Insufficient information</th>
<th>Not eligible</th>
<th>Service not required</th>
<th>Total declined</th>
<th>Total not decided</th>
<th>To another DHB</th>
<th>To another specialty</th>
<th>Total transferred</th>
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<tr>
<td>Auckland</td>
<td>5,715</td>
<td>4,875</td>
<td>387</td>
<td>67</td>
<td>8</td>
<td>176</td>
<td>638</td>
<td>-</td>
<td>202</td>
<td>-</td>
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<tr>
<td>Bay of Plenty</td>
<td>3,361</td>
<td>2,855</td>
<td>363</td>
<td>45</td>
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<td>408</td>
<td>31</td>
<td>11</td>
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<td>Canterbury</td>
<td>6,276</td>
<td>6,023</td>
<td>72</td>
<td>16</td>
<td>0.3%</td>
<td>90</td>
<td>293</td>
<td>471</td>
<td>9</td>
<td>0.1%</td>
<td>4</td>
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<td>Capital &amp; Coast</td>
<td>5,277</td>
<td>4,802</td>
<td>72</td>
<td>16</td>
<td>0.3%</td>
<td>2</td>
<td>114</td>
<td>149</td>
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<td>Counties Manukau</td>
<td>3,962</td>
<td>3,772</td>
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<td>-</td>
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<td>2,006</td>
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<td>168</td>
<td>313</td>
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<td>Hutt Valley</td>
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<td>52</td>
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<td>Lakes</td>
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<td>1,053</td>
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<td>MidCentral</td>
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<td>0</td>
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<td>0.1%</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Northland</td>
<td>3,506</td>
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<td>South Canterbury</td>
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<td>10</td>
<td>5</td>
<td>1</td>
<td>0.1%</td>
<td>0</td>
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<tr>
<td>Southern</td>
<td>4,921</td>
<td>4,263</td>
<td>421</td>
<td>49</td>
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<td>1</td>
<td>161</td>
<td>632</td>
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<td>0.5%</td>
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<tr>
<td>Taïaramiti</td>
<td>816</td>
<td>778</td>
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<td>103</td>
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<td>17</td>
<td>214</td>
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<tr>
<td>Taranaki</td>
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<td>2,241</td>
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<td>134</td>
<td>463</td>
<td>22</td>
<td>0.8%</td>
<td>15</td>
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<tr>
<td>Waikato</td>
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<td>4,550</td>
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<td>189</td>
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<td>507</td>
<td>795</td>
<td>0</td>
<td>0.0%</td>
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<tr>
<td>Wairarapa</td>
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<td>1,264</td>
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<td>0.0%</td>
<td>-</td>
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<td>Waitemata</td>
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<td>198</td>
<td>283</td>
<td>5.4%</td>
<td>-</td>
<td>115</td>
<td>596</td>
<td>143</td>
<td>2.7%</td>
<td>24</td>
</tr>
<tr>
<td>West Coast</td>
<td>592</td>
<td>465</td>
<td>56</td>
<td>8</td>
<td>1.4%</td>
<td>-</td>
<td>20</td>
<td>84</td>
<td>8</td>
<td>1.4%</td>
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<td>Whanganui</td>
<td>1,237</td>
<td>983</td>
<td>64</td>
<td>52</td>
<td>5.2%</td>
<td>-</td>
<td>172</td>
<td>237</td>
<td>14</td>
<td>1.1%</td>
<td>3</td>
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<td>New Zealand</td>
<td>57,213</td>
<td>50,074</td>
<td>2,326</td>
<td>1,077</td>
<td>1.9%</td>
<td>125</td>
<td>2,300</td>
<td>5,828</td>
<td>305</td>
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Published on MoH website 31 January 2017. Note data is developmental.
Making rational decisions

Example 1) Clinical Prioritisation

prioritisation is a tool for helping doctors decide, from those patients who would benefit from elective surgical procedures, which individual should have priority, given the available capacity of publicly funded services.

clinical prioritisation DOES NOT

• decide if the patient needs, and would benefit from surgery as the best option for treatment

• determine which treatment/procedure (if there is a choice) is the best for the patient

• this is what the clinician does
Why are clinical priority for access decisions made?

• we need to live within our means
• not all healthcare needs can be met
• decisions to give one patient priority over another are inevitable

“Referrals to a service with limited resources should be seen in order of priority and a patient should receive treatment in accordance with his or her assigned priority. Prioritisation systems should be fair, systematic, consistent, evidence-based and transparent.”
Creating clinical prioritisation tools

- the Ministry **does not** create the tools
- the Ministry supports clinical working parties (including clinical networks, colleges and professional associations) to develop and implement clinical prioritisation tools
- prioritisation tools reflect clinical consensus
Making rational choices

Example 2) Choosing Wisely

- a global initiative aiming to promote a culture where low value and inappropriate clinical interventions are avoided, and patients and health professionals have well-informed conversations around their treatment options

- the New Zealand Choosing Wisely campaign was launched in October 2016 by the Council of Medical Colleges in partnership with the Health Quality & Safety Commission and Consumer New Zealand, and with funding from the Ministry
ANZICS’ 5 recommendations

1. for patients with limited life expectancy ensure patients have a ‘goals of care’ discussion at or prior to admission to ICU and for patients in ICU who are at high risk for death or severely impaired functional recovery, ensure that alternative care focused predominantly on comfort and dignity is offered to patients and their families

2. remove all invasive devices, such as intravascular lines and urinary catheters, as soon as possible

3. transfuse red cells for anaemia only if the haemoglobin concentration is less than 70gm/L or if the patient is haemodynamically unstable or has significant cardiovascular or respiratory comorbidity

4. undertake daily attempts to lighten sedation in ventilated patients unless specifically contraindicated and deeply sedate mechanically ventilated patients only if there is a specific indication

5. consider antibiotic de-escalation daily
Ensuring we are doing the right things, well
Our goal

All New Zealanders
live well
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