

Shaping our Future Health System

Overview

1. **Our health journey**
2. **Stresses and strains on the system**
3. **Future challenges**
4. **Information systems directions**
5. **Discussion**

New Zealand's health system's recent journey

Some historical challenges:

- High entry costs to primary care; outlier internationally
- Few people enrolled in chronic disease management programmes
- Electives on demand (not based on clinical criteria); excessive waiting times
- Lacking comprehensive focus on population health goals and reducing inequalities
- Hospital-centric system
- Structural reform fatigue

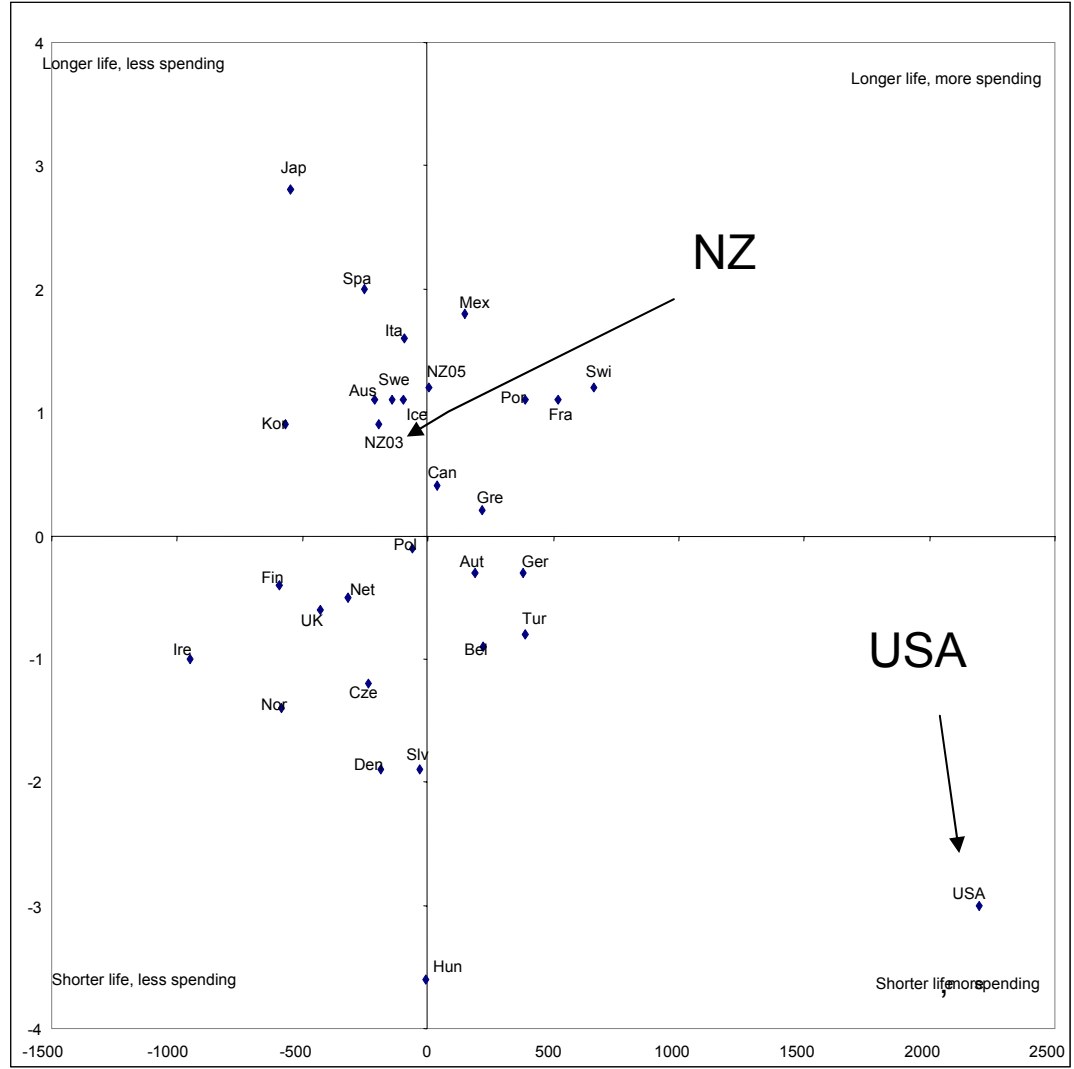
Key strategies to address these:

- NZ Health Strategy – focus on reform, population health and reducing inequalities
- NZ Disability Strategy
- He Korowai Oranga - Māori Health Strategy
- DHB development – community responsiveness
- Primary Health Care Strategy
- Mental Health Development (Blueprint) eg. Like Minds, Like Mind
- Electives – prioritise cases on clinical criteria, reduce waiting times, increase volumes
- Meningococcal B Immunisation Campaign
- And others

Examples of recent key initiatives:

- Targets
- Healthy Eating, Health Action
- Cancer Control Strategy
- Improving allocative efficiency e.g. managing chronic disease in the community
- Service area reviews

Current investment is showing real dividends...



- **NZers are living longer lives than would be predicted from our GDP when compared with other OECD countries**
- **Life expectancy in New Zealand is similar to those of Sweden, Australia, Italy and Iceland – all of whom have higher GDP per capita and invest more in their health system**

...significant indicators of health status are improving...

- Life expectancy has risen by 3.5 years for males and 2.2 years for females over the last 9 years
- Continued decline in deaths from cardiovascular disease – 39% from 1990 to 2004, 10% from 2000 to 2004; approximately 50% due to health system interventions (Tobias, 2007)
- People rating their health status as excellent or very good (age standardised by gender) increased in 2006/07 from previous surveys

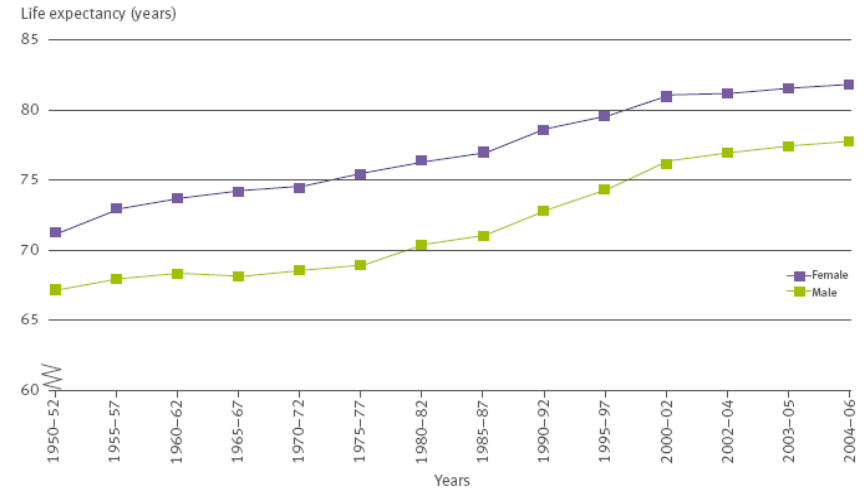
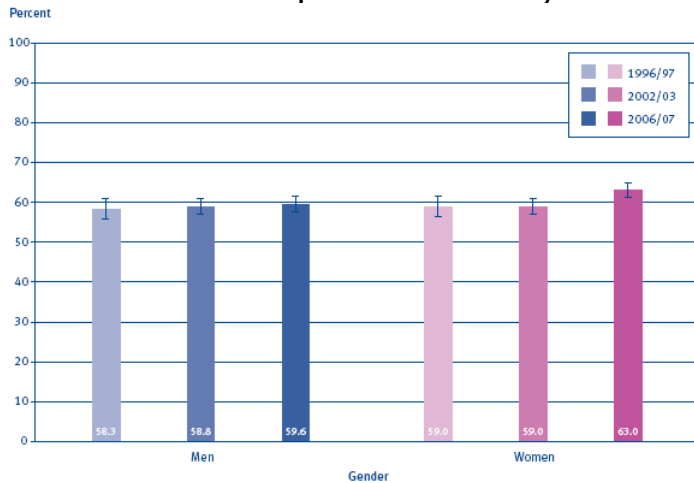
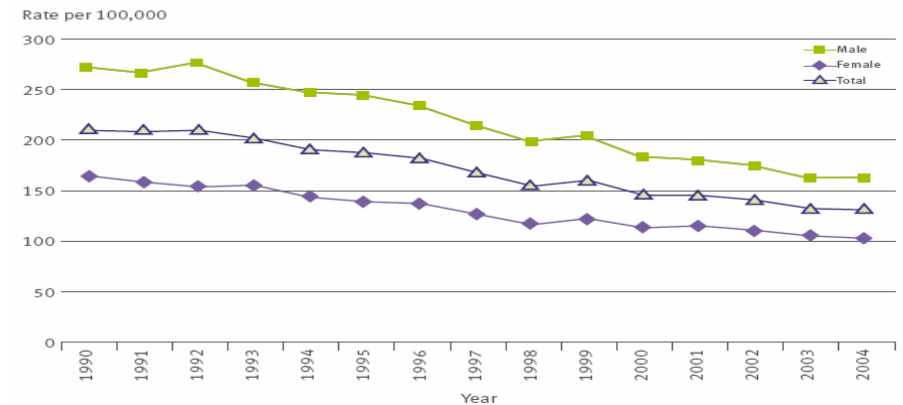


Figure 2.26 Cardiovascular disease mortality, all ages, age-standardised rate per 100,000, by sex, 1990–2004



Source: NZ health surveys, 1996/97, 2002/03 & NZHS 2006/07

...and there is some evidence that health inequalities are reducing

- Infant mortality dropping for both Māori and total population: Maori rate declined from 11.5 per 1000 live births in 1996 to 6.6 per 1000 in 2005 (43%), while total rate declined 28% during the same period
- Between 1996-99 and 2001-04, absolute inequality in all cause mortality (actual standardised rate difference) decreased, more so for Maori than for Pacific ethnic groups. This appears to have stemmed a widening in inequality evident from the early 1990s
- On both life expectancy and infant mortality, the NZ performance is better than England's, where the gap between more deprived and total has not narrowed during roughly the same time period

Trends in inequality, 1981 – 2004 (NZCMS)



These graphs show:

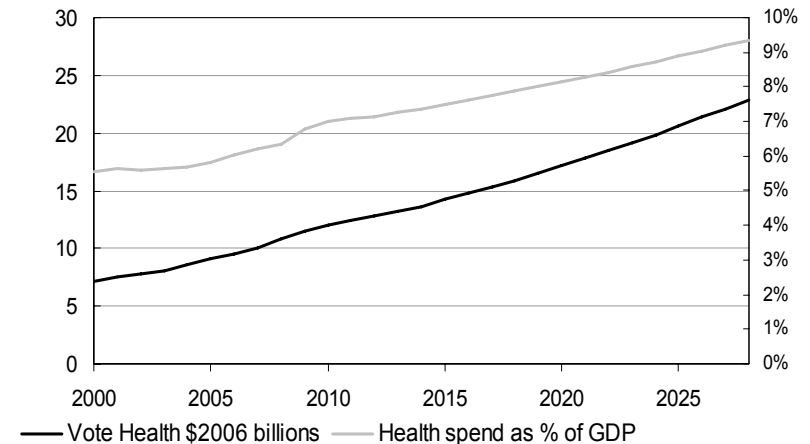
- absolute inequality in mortality between Maori and European ethnic groups has declined since 1996-99
- ethnic inequality has also declined on a relative scale
- Income inequality is not increasing as rapidly as in earlier periods

But there are other challenges as well, in the form of funding levels...

- The future health system cannot expect to consume an ever increasing share of GDP
- Projections suggest we need to continue to improve health outcomes with proportionately smaller increases
- Requires a real and sustained effort to improve value for money, of which productivity is a subset
- Yet, public expectations of the health system continue to grow and the international market for health workforce will continue to drive expenditure growth.

Vote Health \$2006 millions and as percent of GDP: Base Case Projection

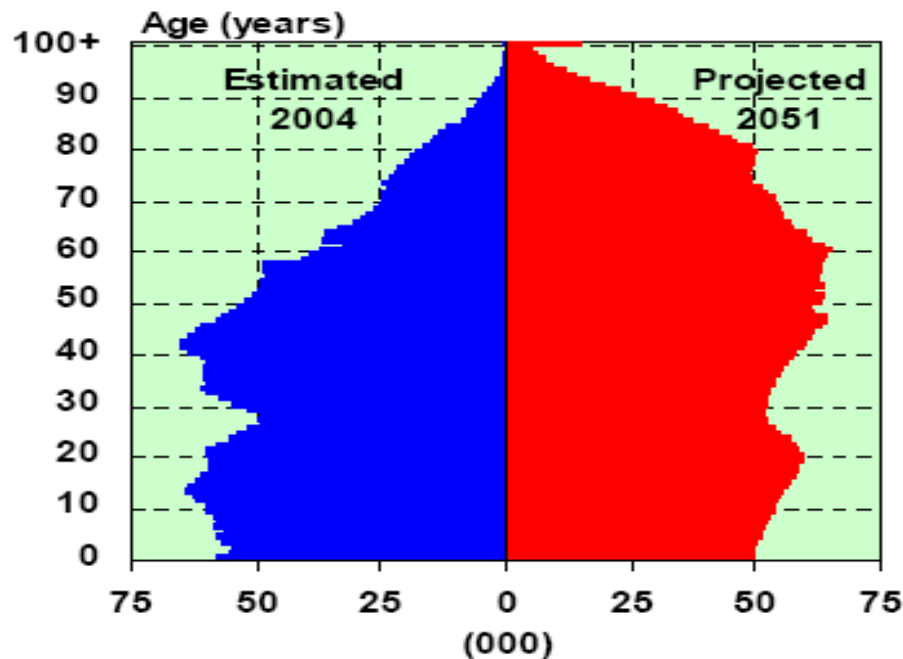
	2006	2028	average annual growth 2006-2028
Vote Health \$2006	9,547	22,925	4.1%
Percent of GDP	6.0%	9.4%	0.2%



(Ref: Ministry of Health/Treasury, June 2008)

... demographic changes in the form of ageing...

NZ's population is ageing



- By 2031 the number of people aged 65+ will more than double
- Considerable variation in age structure between regions
- Older people typically need more health services
- Health workforce shortages

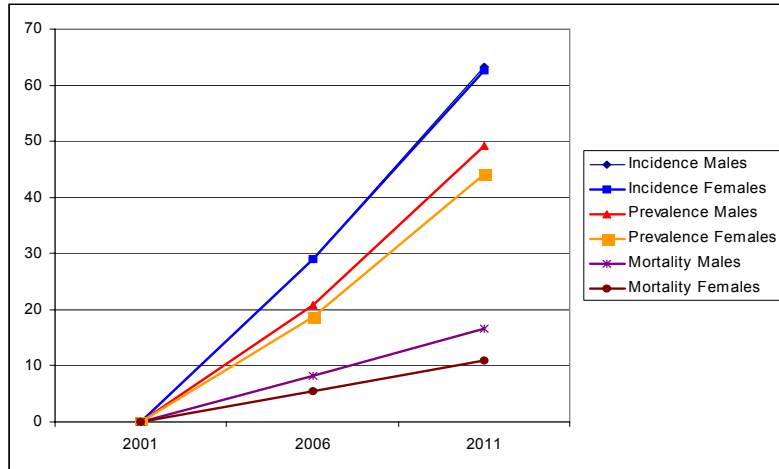
- The OECD predicts that ageing alone will increase total health expenditure by 2% of GDP on average from 2000-2050

- Trends indicate people are living long but healthier lives

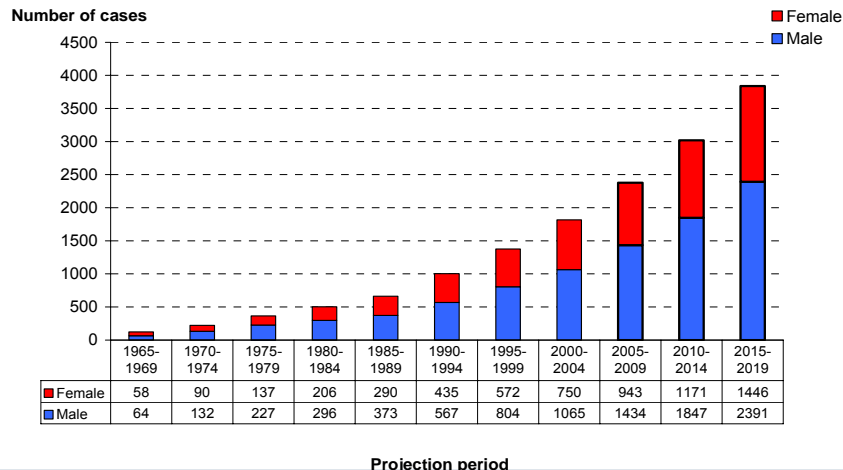
Will our ageing population live longer and healthier lives or longer lives with one or more chronic diseases?

We face the challenge of the rising burden of long-term conditions...

Projected increases in type 2 diabetes, 2001-2011 (%)



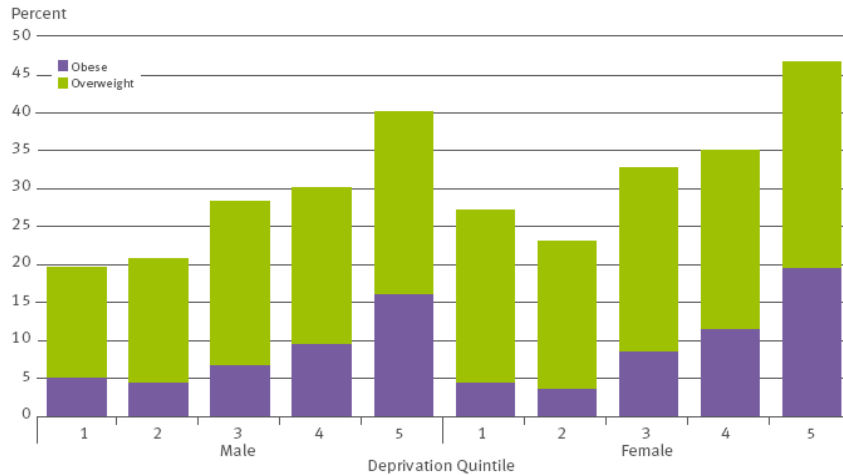
Observed and projected number of new registrations for Chronic Kidney Disease



- 40-50% increase in diabetes prevalence
- Number of new cases of chronic kidney disease expected to more than double in next ten years; expensive, high-end care related to diabetes
- Cancer registrations are forecast to increase
- Rising burden of stroke-related disability
- By 2031 prevalence of Alzheimer's will double

...linked to current lifestyle trends

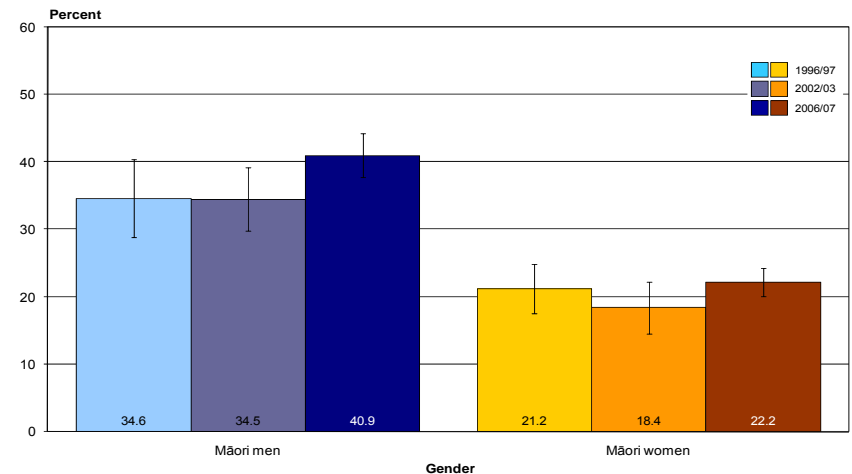
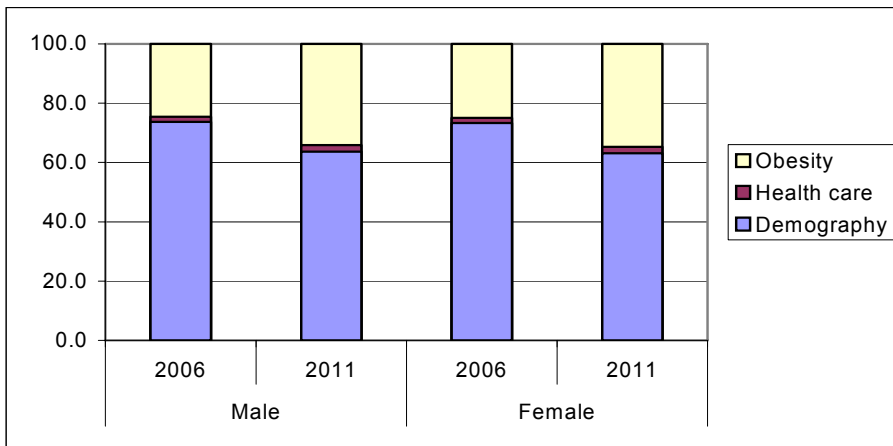
Figure 2.37 Prevalence of overweight and obese children, by deprivation quintile and sex, 2002/03



- 30% of New Zealand children are overweight or obese; however, socially deprived are much more likely to be overweight or obese
- direct link between obesity and diabetes incidence
- patterns of hazardous alcohol use have not improved and are worsening for some groups

Hazardous drinking among Maori men, 1996/97, 2002/03, 2006/07 (NZ Health Survey)

Diabetes prevalence drivers



Whatever the future brings, cost effectiveness is key to getting the best from future health technologies

- **We need to have an effective cost/benefit filter to ensure we support only those technologies that have a strong positive return**
- **We need to continue development towards a nationwide eHealth environment that identifies population health needs, enables self care, and improves coordination of care**
- **We need to pursue the opportunities that telemedicine offers – NZ has been slow to pick this up**

Let's consider prioritisation.....

Where are the dollars being spent in the system currently?

Are they being spent in the right places and sufficiently in the right places?



...by thinking about smoking

Smoking is responsible for (approx):

- Quarter of cancers
- Third of cardiovascular disease
- Eighty percent of chronic obstructive pulmonary disease

Annual cost of smoking related illness to the health system is approx \$350m

Total cost of smoking is estimated at \$1.7b and over 81,000 QALY lost each year

In Counties Manukau - \$41m and nearly 10,000 lost QALY every year

Significant contributor to inequalities

Table 2.12: Current smoking for adults, by ethnic group (unadjusted)

Ethnic group	Prevalence (95% CI)	Number of adults
European/ Other	18.6 (17.5–19.7)	475100
Māori	42.2 (40.0–44.4)	150000
Pacific	26.9 (23.6–30.2)	44300
Asian	11.2 (8.9–13.4)	31200

Source: 2006/07 New Zealand Health Survey

Note: Total response standard output for ethnic groups has been used.

Smoking preventative strategies are working...

In 2007 there were 110,000 fewer smokers than in 2002 – a huge public health gain

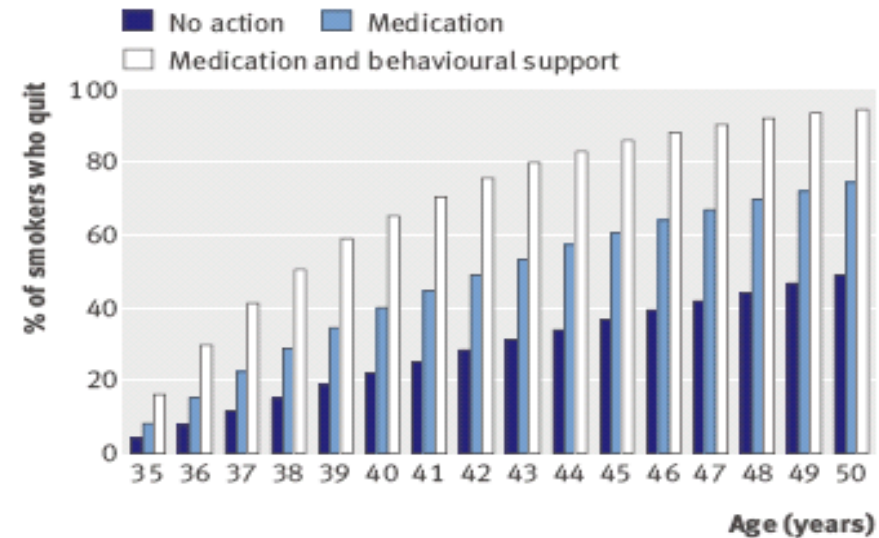


Fig 2 | Effects on smoking prevalence of strategies to help smokers if all smokers made one attempt per year to stop, starting at age 35

... but we still have around 620,000 smokers

Virtually all the smoking related deaths before 2050 will occur in current smokers – we need to reduce that burden

Where are the biggest opportunities?

- Personal health care sector

Are we making the most of this sector?

- No - failing to routinely and actively treat smoking as a vital sign

Where are the dollars being spent currently

- \$33m on tobacco control services (half our annual expenditure on statins)
- Increased baseline by \$18.6 m per annum - much of that on increasing the reach and range of cessation services

vs

- \$350m – health system costs for smoking related illness
- \$1.7b – estimated total cost of smoking

Accelerating health system improvements...

Continued emphasis on realising the potential of ongoing improvements in preventive and primary care

A greater focus on collaboration at local, regional and national levels

Taking forward the quality agenda to ensure services are as safe and effective as possible

Providing a clear and consistent focus on key long term enablers including workforce, and IT

...improve quality in the system through a culture of shared learning...

Stronger national leadership

National quality improvement programmes:

- Safe medication management
- Infection, prevention and control
- Optimising the patient's journey
- National mortality review systems; and
- Management of healthcare incidents

Continued reporting of serious and sentinel events

Strengthen safety and quality assurance processes in the Aged Residential Care sector

Allocated funding and resource to support the sharing of innovation throughout the system

...and further develop information systems

Ministry of Health to drive health information strategy

Continue to invest in the development of national systems

- Stabilise systems, standardise information architecture, and integrate to improve connectivity

Ensure the information environment can support the future direction of primary health care:

- Develop support for self management/self care
- Better enable provider to provider transfer through information standards
- Improve value of investments in decision support systems
- National procurement mechanism to provide better and lower cost access to technology
- Continue to engage stakeholders in the development and design of these initiatives

How do we get the right balance between these needs and our privacy?

Issues to consider:

- Scope and extent (NHI, HPI, all national data collections)
- Audience (consumer advocates and representative groups, the public/community at large, other stakeholders – clinicians)
- Form and nature (what works well, what doesn't, specific channels preferable over others)
- Extent (presumably a one off activity won't do it)
- Engagement (some sections of the community expect information sharing to occur routinely now, others most certainly do not, how do we balance these view points)
- Leadership (who should be seen to be leading any such communication / education?)

Give us your views!

