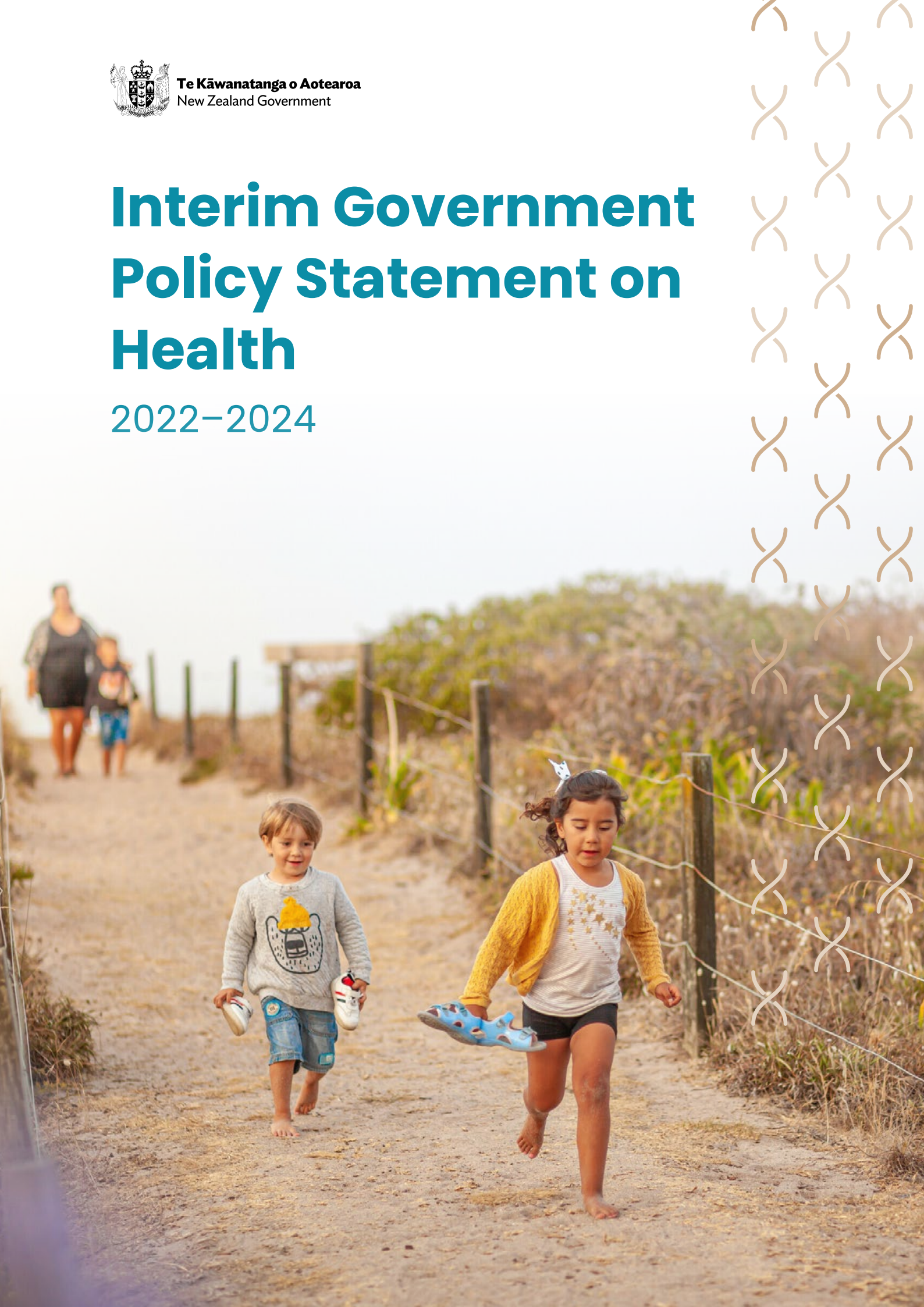




Te Kāwanatanga o Aotearoa
New Zealand Government

Interim Government Policy Statement on Health

2022–2024



Citation: Ministry of Health. 2022. *Interim Government Policy Statement on Health 2022–2024*. Wellington: Ministry of Health.

Published in July 2022 by the Ministry of Health

PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-99-110062-7 (online)

ISBN 978-1-99-110063-4 (print)

HP8132

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Minister of Health's foreword



Our health sector has strong foundations: a skilled and dedicated workforce, engaged and passionate

communities, and an ability to work together to get things done when we need to – as we've shown in responding to COVID-19. For most people, our sector delivers health outcomes that compare well with other countries around the world.

However, these overall figures mask significant gaps between groups in our population. Across different health outcomes, the same groups are consistently under-served and left behind: Māori, Pacific peoples and disabled people. On average, these groups die younger and live more of their lives in poor health than their fellow New Zealanders. Many other communities also experience inequity on the basis of their health condition, culture, ethnicity, gender, sexual orientation, where they live, their income and other factors. This is not acceptable, and we can – and must – do better.

Historically, the health system has not met its obligations to Māori, including tāngata whaikaha Māori, (disabled Māori), under Te Tiriti o Waitangi / the Treaty of Waitangi. Māori are under-represented at all levels across our system, and their voice is too rarely heard in how services are designed and how decisions that affect them are made.

There are many examples of excellence across our health system. However, the system has become fragmented, with too many organisations working in isolation, competing for resources and not acting in the interests of all New Zealanders. Services are not always designed around the needs of people and whānau – meaning that the growth of services in our homes and communities, underpinned by new and improved technologies, has been much slower than anticipated by successive governments. Recent years have seen these challenges exacerbated by underfunding and financial deficits.

The opportunity of reform is to address these longstanding problems and create a health system that is Te Tiriti-consistent, equitable, accessible, cohesive and whānau-centred. By doing so, it will be sustainable, resilient and affordable, ensuring that it is there for future generations and able to cope with future challenges.

Our vision is simple: that all New Zealanders achieve pae ora (healthy futures). Achieving pae ora means that people and whānau will live longer in good health, have improved health and quality of life, are part of healthy, inclusive and resilient communities, and live in environments that sustain their wellbeing. The role of our health system is to put in place the services, initiatives and partnerships to protect, promote and improve health and wellbeing, achieve equity and provide pae ora.

In the coming years as we work towards achieving our vision of pae ora, we expect to see five shifts in how our system works and what it delivers for people.

The health system will uphold Te Tiriti o Waitangi

A health system that honours Te Tiriti will uphold the rights of Māori (including tāngata whaikaha Māori) and give effect to the principles of the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act). This means re-orienting the system to one that is more enabling of Māori leadership, sharing power and resources, tackling racism in all its forms, and developing authentic tāngata whenua and tāngata Tiriti partnerships to realise Māori aspirations, including in the prioritisation, design, development and delivery of health services for Māori.

People and whānau will be supported to stay well and connected to their communities

People and whānau will be enabled to better manage their own health and wellbeing and remain independent for longer, through information, advice, community support and targeted, tailored services. There will be a stronger, sector-wide emphasis on prevention of illness, and promoting health and wellbeing. More health services will be provided at home and in our communities to keep people well and avoid unnecessary trips to hospital, and the health sector will work with other sectors to address the wider determinants of health.

High-quality specialist and emergency care will be equitable and accessible to all when it is needed

When people need services in an emergency or for specialist treatment, these services will be delivered consistently, informed by the best evidence, and adapted to fit the needs of individuals and whānau. Hospital services will be planned and managed to work cohesively across Aotearoa New Zealand so that the needs of the whole population are met equitably, and to ensure high-quality care and continuous improvement of clinical practice.

Digital services and technology will provide more care in people's homes and communities

Building on the progress digital services made during the COVID-19 response, the health sector will harness technology to provide more options for people and whānau to access safe, high-quality and convenient digital health services. Better data systems mean we are better informed and able to respond more effectively.

Our health workforce will be valued and well trained, ensuring we have enough skilled people to meet future needs

The health sector will recognise and value our workforce, driven by shared values and a shared commitment to people. There will be greater long-term, national planning to improve pathways into health, help the health workforce to develop and achieve their ambitions, and ensure the right skills are in the right places.

We will not achieve this overnight: it will require time, investment and all entities and people in our health sector pulling together. This interim Government Policy Statement on Health starts the journey, by setting the Government's priorities and expectations for the first two years of the reformed system.



Hon Andrew Little
Minister of Health

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Introduction

Purpose of the interim Government Policy Statement on Health

The interim Government Policy Statement on Health (iGPS) sets the Government's priorities for the publicly funded health sector in Aotearoa New Zealand in order to protect, promote and improve the health of all New Zealanders, to achieve equity in health outcomes, in particular for Māori, and to build towards pae ora (healthy futures) for all New Zealanders. It is a public statement of what Government expects the health sector to deliver and achieve, what funding and support are available, and how progress will be measured and monitored.

The iGPS is focused on what should be achieved in the next two years – from July 2022 to June 2024. But these shorter-term actions provide the foundations for the longer-term direction, expected outcomes and objectives that will take more, sometimes many more, years to deliver. This document describes both the broader priorities and the more specific actions that are intended.

The iGPS sets priorities for the whole of the publicly funded health sector. The actions required will vary for different health entities but the core direction and outcomes will be consistent to ensure that all health entities work towards common goals that matter for our people and whānau.

The iGPS also sets clear parameters for the interim New Zealand Health Plan, which will demonstrate how the different entities that make up the publicly funded health sector will deliver on the Government's priorities. The iGPS therefore forms an important part of how Ministers, Parliament and the public will hold the health entities to account.

The next two years will be critical to achieving pae ora

The first two years of the reformed health system are crucial. In these early years the new system will be established, tested and refined, new relationships and cultures will be fostered, and new system-wide plans will be developed.

The initial reforms are focused on putting in place new structures as the basis for improving how the health system works for New Zealanders. These structures will be better placed to implement changes to how health services are designed and will work together more effectively and efficiently. Improvements in health outcomes and equity will take time, but it is essential that work starts now to build towards the future.

Lay the foundations for an inclusive, dynamic health sector with Te Tiriti at its core

Achieving pae ora will require all entities in the health sector to work collectively and in partnership with each other, with the communities they serve, with iwi, hapū and Māori, and with the wider organisations that contribute to the health and wellbeing of our whānau.

The next two years provide an unprecedented opportunity to reset our shared expectations for culture, behaviours and relationships at all levels. The new system design must place Te Tiriti o Waitangi at its heart, as set out in the health sector principles in the Pae Ora Act 2022. It will strengthen Māori leadership and decision-making at all levels, increase access to kaupapa Māori and whānau-centred services, improve the responsiveness of general health services for Māori and work towards equity in health and wellbeing.

Each of the priority areas in this iGPS explicitly incorporates the relevant aspects of Te Tiriti o Waitangi, giving effect to Crown's obligations under Te Tiriti as set out in Section 6 of the Pae Ora Act 2022.

The new system must also become more inclusive for other communities who have been under-served in the past, recognising that groups within our diverse population differ in their health needs, goals and aspirations. This system will recognise and provide for the rights and obligations of all groups, including Pacific peoples, disabled people and others who, because of their ethnicity, identity or where they live, have been excluded from decision-making about their care and their local health services.

This requires action at all levels, including in the design and operation of governance and accountability arrangements, and in the process for setting direction and determining national and local priorities. It also requires changes in the way that services are designed, delivered and evaluated, and in how outcomes are monitored. This will call for greater innovation, use of new technologies and scaling of approaches that have been shown to work. It will mean changes in priorities and funding over time.

It also requires a step-change in how health entities address population health and work collectively to create healthy environments. This will include the design and implementation of localities and local provider networks that cover all areas of Aotearoa New Zealand.

The Government expects all health entities to undertake the next steps of this journey together, with a shared commitment to partnership and a recognition of each other's unique roles, skills and knowledge.

Realise the early benefits of transformation

With the right relationships, structures and working arrangements in place, the health sector will work more effectively and begin to deliver real change for people and whānau in the first two years of reform.

Strategy, policy, planning, commissioning, co-commissioning and service delivery arrangements will all need to change to reflect our expectations that consumer, whānau and community voices will be included at all levels. Early actions should enable improved progress towards equity in access, quality of care and outcomes, starting with a focus on groups who have been most poorly served by the system. This must include steps to ensure culturally safe and inclusive services, including those that are grounded in and framed by te ao Māori (the Māori world view), enacted through tikanga Māori (Māori ways of doing the right thing) and encapsulated within mātauranga Māori (Māori knowledge systems).

The early years of reform will create space for entities to test and implement new models of care and ways of working that improve quality, safety and health outcomes. New service models and processes should become increasingly evident and start to deliver benefits.

- Hospital networks that are nationally planned and regionally managed will redesign how services are delivered across different communities, identifying and tackling unjustifiable variation where the disparity of inequity in access, quality of care and health outcomes is greatest.
- New digital care models, and wider digital infrastructure, will support services and organisations to provide more integrated, person- and whānau-centred care, closer to home, and empower people to take control of their own health and wellbeing.



- The locality approach will bring together primary and community health services to focus on shared objectives for the communities they serve, and integrate services around the needs of people.
- The way that health entities work at national, regional and local levels will create opportunities to align their plans and processes – making the most of our people and resources, reducing duplication and waste, identifying best practice and targeting support to maximise the value of taxpayers' money.

The Government expects health entities to deliver the interim New Zealand Health Plan in a way that ensures that early benefits of transformation are realised and spread.

Ensure stability and continuous improvement through transition

Transformation must be achieved with stability. The health system already faces significant challenges and our workforce is under considerable pressure.

People should not fear or feel disruption to the health services they access day to day. Change is necessary but should be delivered in a way that reduces the risk to continuity of care and minimises the impact on the health workforce.

Existing priorities – including the COVID-19 health response – must be maintained during the reforms. Operational performance must not be allowed to worsen. These ongoing responsibilities should pass to the new health entities where relevant and should become part of the new system plans.

The Government expects all health entities to continue supporting staff through the transition to the reformed system, and to ensure stability and continued improvement in their functions.

The Government will support the health system to continue this journey

The two-year transitional Vote Health package in Budget 2022 represents the first step towards a multi-year funding approach for health. The Government's intention is to introduce a three-year funding cycle from Budget 2024.

The two-year transitional Vote Health package agreed in Budget 2022 includes an investment of \$1.8 billion in the first year and an additional \$1.3 billion in the second. This will clear historical deficits and fund cost pressures. There is also new investment to progress the implementation of the system operating model and accelerate transformation in areas that will deliver early and tangible benefits for under-served groups based on the shifts and priorities outlined in this iGPS. New investment includes funding to start establishing comprehensive primary care teams, increased funding for general practices in high-needs areas and to support locality provider networks, as well as funding for specific Māori and Pacific health initiatives. There is also additional funding for investment in major hospital rebuilds and to complete existing projects, as well as investment in establishing a national public health service, boosting population and public health services and continuing the transformation of New Zealand's approach to mental wellbeing.

Information about funding for Health in Budget 2022 can be found here:

www.health.govt.nz/about-ministry/what-we-do/budget-2022-vote-health.

Outline of this document

The iGPS is broken into six priority areas that match the ambitions and objectives described above. There is no intended priority order between the chapters and they are all equally weighted. Each of these chapters sets out what the Government expects the health sector to work towards in the next two years, what specific actions are anticipated and how success will be measured. The chapters are arranged according to the following priorities:

- Priority 1: Achieving equity in health outcomes.
- Priority 2: Embedding Te Tiriti o Waitangi across the health sector.
- Priority 3: Keeping people well in their communities.
- Priority 4: Developing the health workforce of the future.
- Priority 5: Ensuring a financially sustainable health sector.
- Priority 6: Laying the foundations for the ongoing success of the health sector.

References in this document to 'the health sector' should be read as applying to all publicly funded health entities under the Pae Ora Act 2022, as appropriate to their functions.

This document sets out the Government's key expectations and requirements at a high level. It does not repeat every legislative obligation for health entities or cover more detailed service, business and administrative requirements. The iGPS should be read together with the Government's Minimum Service Coverage Expectations for the health sector, requirements relating to Vote Health expenditure, and mandatory data reporting from health entities. Further information on these wider expectations can be accessed at the Ministry of the Health's website at the following link: www.health.govt.nz





Priority 1

Achieving equity in health outcomes

Why this matters

In Aotearoa New Zealand, people differ in their health outcomes in ways that are not only avoidable but unfair and unjust. Many communities experience poorer health outcomes based on inequity related to health conditions, culture, ethnicity, gender and gender identity, sexual orientation, where they live, their income and other factors. It is not enough to deliver good outcomes for some groups, but to leave others behind.

Equity recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes. It seeks to benefit people according to their strengths, needs and circumstances, led by the perspective and experience of communities themselves.

The reasons for inequity can be complex, including:

- the impact of the wider determinants of health
- racism and discrimination in how services are designed, commissioned and delivered, including inaccessibility of services
- how funding has been historically allocated.

Addressing inequity requires a whole-system approach to change priorities and attitudes, including through the actions described in the other chapters of this iGPS.

While the specifics of what needs to change to improve health equity for different groups will differ (eg, for Māori, Pacific peoples, disabled peoples, tāngata whaikaha Māori, LGBTQI+ communities, Asian peoples, refugee and migrant communities, and people with lived experience of mental health and addiction), the starting point is the same: to build relationships and deepen understanding of what matters to people, whānau and their communities, as well as their contexts, histories and aspirations.

Outcomes we are working towards

The overall outcome is to have a health system that delivers high-quality health and wellbeing outcomes for all people and groups no matter where they live, what they have or who they are. This is a core objective of the Government's health reforms and is written into the Pae Ora Act for the new system.

How this priority gives effect to Te Tiriti

Ōritetanga (equity) for Māori in Aotearoa New Zealand is guaranteed by Article 3 of Te Tiriti. Equity is further specified as a principle of Te Tiriti by the Waitangi Tribunal¹ and has been enshrined in the health sector principles in the Pae Ora Act 2022. The objectives and actions under this priority, combined with those in the other priorities, direct the health system to take all necessary actions to achieve equity.

¹ Waitangi Tribunal. 2019. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington: Waitangi Tribunal. pp. 163–164.

Objectives for 2022–2024

Objectives	Description of actions
<p>1.1 Māori will attain equitable health and wellbeing outcomes</p>	<p>Through the objectives specified in Priority 2 and delivering on the aims of He Korowai Oranga and the priorities and actions in Whakamaua, the sector will make measurable progress in achieving ōritetanga for Māori.</p> <p>These actions can also be evidenced throughout the priorities and objectives across this iGPS.</p>
<p>1.2 Pacific families are thriving in Aotearoa New Zealand</p>	<p>Pacific people will be actively involved in the development and implementation of policies and services concerning their health and wellbeing. The health sector will work to enable Pacific peoples to lead flourishing lives. Priorities for these efforts will include:</p> <ul style="list-style-type: none"> • supporting Pacific peoples to make informed choices about their health and wellbeing • changing the way the system operates to deliver more responsive, more accessible and high-quality care • strengthening preventative actions within government and across sectors to create environments that improve health equity for Pacific communities.
<p>1.3 Disabled people, including tāngata whaikaha Māori, have the highest attainable standards of health and wellbeing</p>	<p>The health sector will support the aspirations and needs of disabled people. Disabled people, including tāngata whaikaha Māori, will be actively involved in the development and implementation of policies and services concerning their health and wellbeing.</p> <p>Access to mainstream health services will be barrier-free and inclusive, and health services, communications and products that are specific to disabled people will be of high quality, available and accessible.</p> <p>All health and wellbeing professionals receive the training and support necessary to ensure disabled people are treated with dignity and respect.</p>
<p>1.4 New Zealanders experience equitable cancer outcomes</p>	<p>The health sector will work towards New Zealanders having a system that delivers consistent and modern cancer care. This will be achieved through a focus on reducing the number of New Zealanders who develop cancers while also enabling better and equitable cancer survival through delivering improvements to supportive care and end-of-life care.</p> <p>Agencies should design an integrated approach to clinical leadership for cancer care that supports consistency across organisations and enables the sharing of support and best practice.</p>

Objectives	Description of actions
<p>1.5 Communities who have been under-served by the health system are at the heart of how we strengthen services, access and outcomes</p>	<p>The health sector will centre on the lived experiences of communities who have been historically under-served – including Māori, Pacific peoples, disabled peoples including tāngata whaikaha Māori, LGBTQI+ communities, Asian peoples, refugee and migrant communities, rural communities, and people with lived experience of mental health and addiction – to ensure that as our system is reformed, it seeks to close the gaps in equity of access and outcomes. This means building relationships and a deep understanding of what matters to people, whānau and their communities, as well as their contexts, histories and experiences.</p>
<p>1.6 Ensure a zero-tolerance approach to racism and discrimination in all its forms</p>	<p>The health system will prioritise eliminating racism and discrimination in all its forms and at all levels.</p> <p>The health system will make meaningful progress towards an environment and culture that is free of racism and discrimination, with policies and procedures in place to address any instances of racism or discrimination.</p>

How we will measure progress

Measuring progress against this priority will emphasise insights relating to the experience of preventative approaches and health services for people and their whānau, with a specific focus on people and communities who have historically been under-served.

Variation in health outcomes, service quality and access to services will be important markers of areas for action and improvement. The Government will also consider whether the gains made from a greater focus on prevention and moving care into the community are spread equitably between groups.

To support measurement of progress in this area in the next two years, we intend to draw on a basket of high-level measures that reflect our key priorities and objectives, and in which we expect to see a change in performance over time. The measures for this area include:

1. variation in clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area
2. proportion of people who start first treatment for breast, cervical or bowel cancer after a screen result (presence of cancer), reported by ethnicity and geographic area

3. variation in the rates of access to key identified services by ethnicity, geographic area and other characteristics. Initial areas include surgery, first specialist assessments, gender affirming care, colonoscopies, access to specialist mental health (including for rangatahi), and screening
4. missed appointments for specialist care, reported by ethnicity and geographic area
5. rate of diabetes complications, reported by ethnicity and geographic area.

A number of further measures from other areas of the iGPS will also be relevant to measuring progress in relation to achieving equity. The basket above will be supplemented by those measures, as well as by other relevant sources of information, including patient, consumer and whānau feedback.

More detail on the iGPS measures can be found in Appendix 1.





Priority 2

Embedding Te Tiriti o Waitangi across the health sector

Why this matters

The health sector is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi / The Treaty of Waitangi (Te Tiriti). Regarding the text of Te Tiriti, the Crown, as the kaitiaki and steward of the health system (under Ko te Tuatahi Kāwanatanga / Article 1 of Te Tiriti), has the responsibility to enable Māori to exercise authority over their health and wellbeing (under Ko te Tuarua Tino Rangatiratanga / Article 2) and achieve equitable health outcomes for Māori (under Ko te Tuatoru Ōritetanga / Article 3). The Crown should also consider how to enable Māori to live, thrive and flourish as Māori (Whakapuakitanga Ritenga Māori / Ritenga Māori declaration).

The Government's approach to meeting its obligations under Te Tiriti is outlined in section 6 of the Pae Ora Act 2022. The legislation contains specific provisions intended to give effect to the Crown's obligations. In particular, the health sector principles incorporate key outcomes and behaviours derived from the principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal.

The Pae Ora Act will underpin the sector's commitment to Te Tiriti and guide its actions towards the achievement of pae ora for Māori as outlined in He Korowai Oranga: Māori Health Strategy. He Korowai Oranga will remain the Hauora Māori Strategy from July 2022 with the continued aim of achieving pae ora. Pae ora is a holistic concept and includes three interconnected elements: mauri ora (healthy individuals), whānau ora (healthy families) and wai ora (healthy environments).

The Government's plan for meeting the aims of He Korowai Oranga is contained in Whakamaua: Māori Health Action Plan 2020–2025. The outcomes, objectives and priorities outlined in Whakamaua were developed through extensive engagement with iwi, hapū, whānau and Māori communities and hauora Māori service providers, and encompass the Crown's response to the non-legislative recommendations from the Waitangi Tribunal's Hauora report.

At the same time, the creation of the Māori Health Authority and legislative recognition of iwi-Māori partnership boards bring a positive and transformational dynamic to the health sector. These developments encompass the Crown's response to the legislative recommendations from the Waitangi Tribunal's Hauora report. This enhanced leadership for Māori health will help the health sector to deliver on the Government's strategies and priorities for Māori health and wellbeing.

The Māori Health Authority will work with Health New Zealand and the Ministry of Health to progress and evolve the priorities and actions of Whakamaua over the coming two years. The Māori Health Authority will have an important role in working with the Ministry to develop the next Hauora Māori Strategy and actions in partnership with iwi, hapū, whānau and Māori communities.



Outcomes we are working towards

Health entities will continue to respond to important cultural, social, economic and population health challenges present in Aotearoa New Zealand. The outcomes the health sector is working towards remain the outcomes expressed in Whakamaua, which align closely with what Māori have said and what the evidence indicates is necessary to shift the health system towards achieving Māori aspirations and pae ora. They are:

- iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing
- the health system is fair and sustainable and delivers more equitable outcomes for Māori
- the health system addresses racism and discrimination in all its forms
- mātauranga Māori is included and protected throughout the health system.

In addition, tāngata whaikaha Māori are supported to equitably contribute alongside their iwi, hapū, whānau and communities.

Objectives for 2022–2024

Whakamaua will guide action across the system to improve Māori health over the period of this iGPS. Health entities across the publicly funded health sector will be expected to plan and deliver on actions that further the objectives below. Just over \$20 million has been allocated in Budget 2022 to fund secretariat, analytical and engagement-focused staff to support iwi-Māori partnership boards to fulfil their

important role in the new system. This investment is expected to enable Māori engagement in the design, planning and delivery of health services at a locality level.

As well as involving the objectives listed here, embedding Te Tiriti spans the breadth of this iGPS. Other priorities and objectives in this document will also contribute to embedding Te Tiriti.

Objectives	Description
<p>2.1 Ngā pātuitanga i waenga i te Māori me te Karauna Māori-Crown partnerships</p>	<p>All health entities across the publicly funded health sector will have strong active relationships with Māori in designing, implementing and monitoring health services. The quality of Māori-Crown relationships at all levels of the health sector will be measured over time by both parties to drive improvements and accountability.</p> <p>Iwi and hapū will have the resources and support to develop kaupapa Māori and whānau-centred services that meet the health aspirations of their own communities. The health sector will lift its performance to better respond to Māori health aspirations and ensure that Te Tiriti commitments are met.</p> <p>Iwi-Māori partnership boards will be supported and resourced to effectively represent local Māori perspectives on the needs and aspirations of Māori in relation to Māori health outcomes.</p>
<p>2.2 Ngā kaiārahi Māori Māori leadership</p>	<p>Māori health leadership at all levels of the health sector will increase in capacity and capability. It will be informed by mātauranga Māori as well as insights from health sciences and global indigenous knowledge. It will build an accomplished workforce that is able to collaborate with a wide range of agencies across sectors and equally across Māori communities and iwi. Māori health leadership, including tāngata whaikaha Māori, will be distributed and networked, and have accountability to Māori and to government.</p> <p>Current and aspiring Māori health leaders will be equipped with the confidence and skill set necessary to actively engage and participate in and influence health sector decision-making processes, particularly in Health New Zealand and the Māori Health Authority. Increased Māori leadership will inform health service design, delivery and evaluation and reflect more of the local Māori population's needs, leading to better health outcomes.</p> <p>Māori health leaders will be supported to collaborate in a shared learning environment, building regional Māori health whanaungatanga and local leadership networks, and can progress towards more autonomous arrangements.</p>

Objectives	Description
<p>2.3 Ngā kaimahi o te rāngai hauora Māori</p> <p>Māori health workforce</p>	<p>There will be a clear strategic direction and long-term plan for developing the Māori health workforce. The Māori health workforce will continue to increase in capacity and capability, with progress made towards achieving Māori population parity and matching services to need, including disability representation for tāngata whaikaha Māori. Most health and disability disciplines will experience an uplift in the number of Māori studying, graduating and entering paid employment.</p> <p>The Māori health workforce will reflect Māori values and Māori models of practice – recognising and acknowledging mātauranga Māori as a professional skill. This is further discussed in Priority 4: Developing the health workforce of the future.</p>
<p>2.4 Te whakawhanaketanga o te rāngai hauora</p> <p>Māori health sector development</p>	<p>The Māori health sector and Māori communities will be adequately supported to deliver high-quality health and disability services according to mātauranga Māori; including ways of knowing, doing and being, and world view. The equitable commissioning of the Māori health sector will foster innovation and locally led kaupapa and mātauranga Māori solutions, with mātauranga Māori recognised as a legitimate source of knowledge and evidence in funding and commissioning processes. There will be increased investment in Māori health sector development and initiatives to respond to Māori health needs.</p>
<p>2.5 Te kōtuitui i ngā mahi a ngāmomo rāngai</p> <p>Cross-sector action</p>	<p>Addressing the broader determinants of health and wellbeing is key to achieving pae ora. Investing in, and planning and being accountable for Māori wellbeing are shared responsibilities that span the social and economic sectors.</p> <p>The health sector will foster collaboration and coordination across government agencies to maximise Māori health and wellbeing. In many areas, cross-sector action will be locally driven to support integrated, timely and holistic whānau-centred services. Wai ora (healthy environments) in particular is a focus area for cross-sector action and acknowledges the important role that the built and natural environments have in supporting Māori wellbeing.</p>
<p>2.6 Te whai kounga me tenohohaumarū</p> <p>Quality and safety</p>	<p>Māori whānau, hapū and iwi will receive high-quality services that are culturally and clinically safe, effective, whānau-centred, accessible, timely and efficient. The health sector will set and monitor quality standards and practice requirements reflective of Te Tiriti obligations, Māori perspectives and whānau-centred approaches.</p> <p>Shifting cultural norms and addressing racism and discrimination, including ableism for tāngata whaikaha Māori, in all their forms within the health sector, are critical to ensuring that Māori receive high-quality health services that enable them to live and thrive as Māori.</p> <p>Agencies will take action to be genuinely accountable to Māori for tackling inequities of access and health outcomes, and to lift their capability to achieve change for Māori. This includes building the knowledge of all staff in relation to Te Tiriti o Waitangi and mātauranga Māori, and taking steps to address bias in decision-making.</p>

Objectives	Description
<p>2.7 Ngā kitenga me ngā taunakitanga</p> <p>Insights and evidence</p>	<p>The health sector, in partnership with Māori and other agencies, will routinely invest in kaupapa Māori and mātauranga Māori approaches to gain evidence and insights that support mātauranga Māori and elevate Māori health and wellbeing. Measures of Māori wellbeing will create a greater understanding of system change requirements towards pae ora.</p> <p>Evidence and insights, including whānau voice, will provide a clearer understanding of system performance for Māori. Information will be readily available to inform innovation, service design and models of care. Whānau, hapū, iwi and Māori organisations will have access to, and the capacity and capability to utilise, powerful insights, evidence and data to transform services and wellbeing for individuals, whānau and communities.</p>
<p>2.8 Ngā whakatutukinga me te nohohaepapa</p> <p>Performance and accountability</p>	<p>The health sector will meet its Te Tiriti obligations and progress towards achieving equitable health outcomes for Māori (including tāngata whaikaha Māori). The Māori Health Authority and Health New Zealand will measure performance and outcomes, and openly drive decisions that support embedding a kaupapa Māori and population health approach and the development and sustainability of high-quality health services for Māori.</p>

How we will measure progress

The Government will use a mixed approach to measure the health sector's progress against this priority over the next two years. This will include a range of quantitative outcome measures drawn from those in Whakamaua, a qualitative evaluation jointly commissioned by the Ministry of Health and the Health Research Council, and the monitoring of the delivery of the New Zealand Health Plan.

To measure progress in this area, we intend to draw on a basket of high-level measures that reflect our key priorities and objectives, and in which we expect to see a change in performance over time. The measures for this area include:

1. health entity spending on identified Māori health service providers
2. experience of health services for Māori, as measured by the primary health care patient and adult inpatient experience surveys
3. geographical coverage and utilisation of rongoā Māori services
4. feedback from the iwi-Māori partnership boards on how they are fulfilling their role and whether they are receiving the support they require.

A number of further measures from other areas of the iGPS will also be relevant to measuring progress in relation to embedding Te Tiriti. The basket above will be supplemented by those measures, as well as by other relevant sources of information, including feedback from iwi-Māori partnership boards, hauora Māori organisations, iwi, hapori and whānau Māori.

More detail on the iGPS measures can be found in Appendix 1.





Priority 3

Keeping people well in their communities

Why this matters

The health system has a longstanding aim to prevent ill health, to promote and improve health and wellbeing, and to support people and their whānau in the community. These changes reflect efforts that will make a difference for people, and what is best for a sustainable health system.

However, the health sector has struggled to achieve these goals consistently. The reformed system provides an opportunity to reflect and reset, and to put in place the early actions needed to deliver a step change in the way we plan and deliver health services, programmes and initiatives, with the aim of supporting people to be well for longer.

Achieving these changes requires actions that span all parts of the health sector across the continuum of need, and across a broad range of services, professions and competencies.

- People and whānau will be empowered to control their own health and wellbeing through a greater focus on targeted preventative and health promotion activities for those who need the most support.
- A population health approach will be embedded across the health sector and with wider partners to take a broad view of the actions that prevent ill health, and to plan and deliver more holistic community-based services and initiatives.
- There will be greater access to a wider range of health services provided in communities, reducing the need for people to travel for their care. Primary and community services will be integrated around the needs of people, implementing new service models that break down traditional boundaries and support the whole of a person's health, including kaupapa Māori and mātauranga Māori models, and integrated mental health and addiction support. This includes preventative interventions and other services that help keep people and their whānau well, and community-based treatment services that are whānau-centred and culturally safe and that fit with people's lives. This will be supported by investment into primary care, such as to establish comprehensive primary care teams, and adjustments to improve the funding formula for general practice.
- High-quality hospital, specialist and emergency care will be more readily available when people need it, with a focus on clinical excellence and implementing models that work to help people return and stay at home. New models and technology will increasingly allow services to be provided in homes and communities rather than hospitals.

Outcomes we are working towards

The overall outcome we are working towards is a health system that protects, promotes and improves the health of all New Zealanders, across the continuum of need and throughout their lives. The services offered by the health sector will increasingly be based on what matters to whānau and on supporting whānau to exercise choice and decision-making for their own health and wellbeing.

Health services will be integrated, and multidisciplinary teams will take a holistic approach to working with people in their care. Over time, people will be able to access more services in community-based settings, including services that would traditionally be provided in hospital settings. This will include efforts to increase access to safe, high-quality and convenient digital health services.

At the specialist end of the continuum, health entities will undertake actions to address variation in access and health outcomes from emergency and specialist services over the next two years. This includes rolling out additional community-based specialist mental and addiction health services funded in Budget 2022, including community crisis services, maternal and infant specialist services, and child and adolescent services. Hospital networks will be established to support services working cohesively together to support national planning and sharing of best practice.

How this priority gives effect to Te Tiriti

Providing a platform where health services are delivered by Māori for Māori in their communities and are culturally safe and responsive is integral to improving Māori health and honouring the Crown's obligations under Te Tiriti. There is a need to ensure Māori providers are fairly treated and adequately resourced to provide timely outreach to whānau and culturally safe, holistic and integrated services – working with whānau and across sectors in ways that address the broader determinants and whole-of-life health and wellbeing challenges that Māori face.

An investment in accelerating the spread of kaupapa Māori and whānau-centred services (see Priority 2, objective 2.4) is an investment in wellness, wellbeing and preventing longer-term health inequities. The Māori Provider Development Scheme, which will be managed by the Māori Health Authority, has been increased by \$30 million in Budget 2022 to support Māori provider development, help to hire and retain staff and help providers to develop and validate new service delivery models that work for Māori. Integrated holistic approaches place the needs of Māori and their whānau at the centre of high-quality health and disability services.



Objectives for 2022–2024

Objectives	Description of actions
<p>3.1 Improve equitable access to public, primary and community health services designed around the needs of people and their whānau</p>	<p>The health system will roll out community-based services that shift services out of hospitals, with a focus on improving access to support for Māori, Pacific peoples, disabled people and other groups with the poorest health outcomes. To achieve this, agencies will need to adopt Te Tiriti-based commissioning practices and invest in kaupapa Māori, hauora Māori, Pacific and whānau-centred services to ensure meaningful options, cultural appropriateness and choice of services.</p> <p>This shift includes:</p> <ul style="list-style-type: none"> • completing the roll-out of the Government’s Budget 2019 and subsequent mental wellbeing initiatives, including the programme to expand access to and choice of new primary and community mental health and addiction services so that access is available for 325,000 people per year by the end of June 2024 • improving access to culturally safe care for children under the age of six years, their parents and whānau, with a focus on developing te ao Māori and Pacific options • testing and implementing new models of care, including new workforce models, that provide integrated support for people with the highest needs and others who have been under-served and support connections between service areas (for example, between aged residential care and primary care).
<p>3.2 Build the foundation and begin to roll out a coordinated care in the locality approach</p>	<p>Health New Zealand and the Māori Health Authority will implement locality prototypes to test, refine and evaluate the locality approach set out in the Pae Ora Act 2022. Health New Zealand and the Māori Health Authority will take the lessons from these prototypes and expand localities to cover 100% of the population by July 2024.</p> <p>The agencies will determine the boundaries for future localities to cover the whole of New Zealand, ensuring that there is alignment between the localities and the iwi-Māori partnership boards to provide a Māori voice into locality development and engaging with local authorities and communities themselves.</p>
<p>3.3 Embed a population and public health approach</p>	<p>Population and public health approaches will be central to keeping people well in their communities. Health entities will ensure that planning and design for public health services and preventative activities consider the wider determinants of health and wellbeing, prioritise achieving equity in health outcomes and use a wide evidence base, including mātauranga Māori and Pacific wellbeing approaches.</p> <p>These approaches will be based on partnerships with iwi and hapū including iwi-Māori partnership boards, with wider agencies, with Pacific health and community leaders, the wider sectors and other groups, environmental and digital sectors, and other groups working with whānau and communities. This will deliver tailored population and public health programmes and whānau-based and mātauranga Māori informed service models that enable choice and support whānau ora, mauri ora and wai ora.</p>

Objectives	Description of actions
<p>3.4 Expand access to digital models of care</p>	<p>Health New Zealand and the Māori Health Authority will deliver a roadmap for expanding access to digital models of support to keep people well in their communities, including a strong digital inclusions component and an investment strategy for data and digital development. Digital models of care will focus on improving access to high-quality health services from anywhere, empowering consumers to take control of their own health and connecting providers.</p> <p>Specifically, agencies will work to improve access to digital consumer engagement channels and the digital enablement of Māori and Pacific providers, including through the locality prototypes.</p>
<p>3.5 Ensuring equitable access to high-quality emergency and specialist services</p>	<p>The health system will take steps to ensure equitable access to high-quality emergency and specialist services when they are needed, with a focus on implementing models of care that support people to retain and regain their health and independence and reduce hospitalisation.</p> <p>The Planned Care Taskforce, established by Health New Zealand and the Māori Health Authority, will develop a national plan by September 2022 to support hospitals to identify short-term measures to reduce waiting times and prioritise tackling inequities between groups in the next two years.</p>

How we will measure progress

Progress against this priority will be measured by monitoring a number of existing measures, together with wider information and intelligence. There is a wide range of relevant existing measures and metrics relating to population and public health, and primary and secondary care, reflecting the breadth of the objectives of this priority area. Where relevant, these will be used as contextual information to support monitoring of progress.

To support measurement of progress in this area in the next two years, we intend to draw on a basket of high-level measures that reflect our key priorities and objectives, and in which we expect to see a change in performance over time. The measures for this area include:

1. proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area
2. proportion of people waiting for planned specialist care who receive it within four months, reported by ethnicity and geographic area
3. uptake of immunisations for key age groups, reported by ethnicity and geographic area

4. rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups
5. complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by the end of June 2024
6. enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area
7. standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area.

Over time, new metrics will be developed to monitor public health and primary and community services, including investment, access and outcomes at national level. A number of further measures from other areas of the iGPS will also be relevant to measuring progress in relation to keeping people well in their communities. The basket above will be supplemented by those measures, as well as by other relevant sources of information, including patient, consumer and whānau feedback.

More detail on the iGPS measures can be found in Appendix 1.





Priority 4

Developing the health workforce of the future

Why this matters

The health workforce is the most important enabler for achieving genuine change that improves health outcomes for New Zealanders, including achieving equity and addressing racism and discrimination in all its forms. The health workforce is diverse and includes regulated and unregulated workers, vital non-clinical support staff, service managers and commissioners, amongst others.

Across Aotearoa New Zealand we have a talented, skilled and dedicated workforce. However, our health workforce is under significant pressure and proactive interventions are required to grow and develop a future workforce that is resilient, sustainable and representative of the entire population, and ensure that our existing workers are valued, developed and supported.

While some of the risks facing the workforce today can be mitigated through immediate actions such as recruitment and retention initiatives, a longer-term plan is required to meaningfully address long-term issues of workforce supply and demand. This includes planning and management to build the workforce of the future, with the skills and competencies to respond to people's diverse needs and support system change. The health workforce will be supported to develop their careers and make the most of their potential, supported by new ways of working and training and a more flexible approach to qualifications.

The workforce as a whole will also promote diversity across all levels of leadership that reflects our communities. This will support cultural safety of services for Māori, other ethnicities and other communities including Pacific peoples, disabled peoples including tāngata whaikaha Māori, LGBTQI+ communities, Asian peoples, refugee and migrant communities, rural communities and people with lived experience of mental health and addiction.

Outcomes we are working towards

The Government’s priority is to cultivate a health workforce that upholds Te Tiriti, responds to the needs of people and whānau, and protects, promotes and improves the health of all New Zealanders. The health workforce needs to be representative of the communities it serves, be fairer, and take action to achieve equity in health outcomes. We want to create an environment where health is a career of choice. This will be achieved by taking a whole-of-system, whole-of-workforce approach, underpinned by data, and by working with key stakeholder bodies.

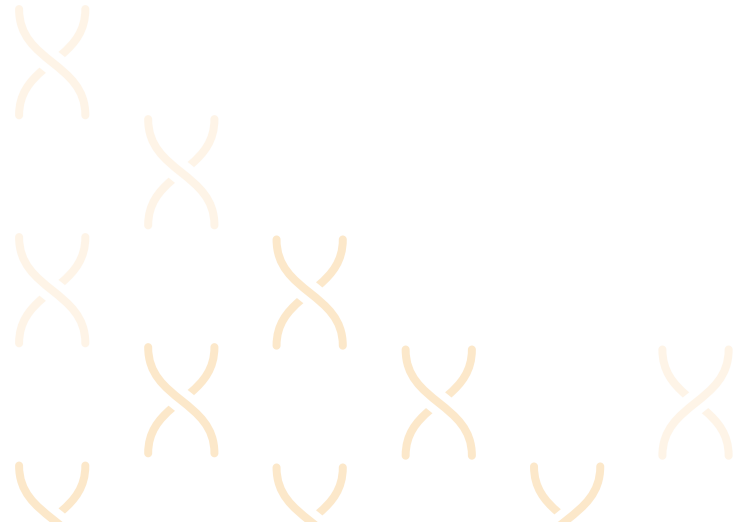
To support health as a career of choice, there will be a focus on developing positive, high-performance workplace cultures and environments so that work is rewarding and satisfying, and longstanding impediments are resolved. This will be achieved by fostering a positive culture of workforce engagement, with strong leadership and stewardship for the entire workforce. Health entities will embed the New Zealand Health Charter to guide the values, principles and behaviours for the health sector and the health workforce.

As well as the objectives listed here, other priorities and actions in this document contribute to the development of the health workforce and there is intentional overlap throughout this iGPS.

How this priority gives effect to Te Tiriti

Across many forums, Māori have recognised the importance of growing the Māori health workforce while also ensuring that the workforce is culturally safe. This priority will support and reinforce the work in Priority 2, particularly objective 2.3 (Ngā kaimahi o te rāngai hauora Māori / Māori health workforce).

The health workforce is a key enabler for improved health outcomes and equity for Māori. A diverse health workforce matched to needs of hāpori and whānau Māori can make a significant contribution to addressing racism in the health system by providing culturally safe and responsive care.



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Objectives for 2022–2024

Objectives	Description of actions
<p>4.1 Establish a system-wide plan for the development of the health workforce</p>	<p>Health New Zealand and the Māori Health Authority will establish a system-wide plan for the development of the health workforce in partnership with providers, iwi and community groups, unions, representative bodies, professional colleges, education providers, and regulators, amongst others. This plan will cover both regulated and unregulated health workers.</p> <p>This plan will include a comprehensive view of workforce supply and demand data and forecasting, and be differentiated by key demographic groups. The plan will ensure it is planning and preparing for a future Health workforce that is better reflective of the population of Aotearoa New Zealand. It will also include a focus on creating a pathway to achieve safe staffing over time.</p>
<p>4.2 Tackle skills and capacity gaps to reduce pressures on the current workforce</p>	<p>Building on objective 5.1 (where possible), Health New Zealand and the Māori Health Authority will design and deliver interventions, including interventions informed by and based on mātauranga Māori, to address immediate workforce recruitment and retention needs. This includes actions to address the risks and opportunities created by COVID-19, alongside an ongoing focus on priority groups in the health workforce.</p> <p>The plan will ensure it is planning and preparing for a future Health workforce that is better reflective of the population of Aotearoa New Zealand.</p> <p>The existing workforce will be empowered to work to the full range of their scopes of practice. Innovative ways of training and working for both regulated and unregulated workers will be explored.</p>
<p>4.3 Embed Te Tiriti o Waitangi across all areas of workforce development</p>	<p>The health workforce plays an important role in achieving the outcomes the health sector is working towards, as outlined in Priority 2. For health agencies, this means actions across all areas of workforce development from strategy development and regulation to pipeline interventions to address issues of supply and demand.</p> <p>Agencies will demonstrate how they are:</p> <ul style="list-style-type: none"> • partnering to increase strategic workforce planning and development • increasing efforts to grow the capacity and capability of the Māori health workforce, including ongoing Māori leadership development • enabling iwi to shape pathways for rangatahi Māori growing into health careers in their rohe • acknowledging the value of mana Māori and mātauranga Māori in how people are trained, recruited, retained and developed • supporting the cultural safety of all workforces to meaningfully respond to the needs of Māori.

Objectives	Description of actions
<p>4.4 Promote health as a career of choice</p>	<p>Employers across the health sector will promote health as a career of choice across a diverse range of roles, from clinical and non-clinical to strategy and policy, planning, commissioning, service management, research, education and evaluation, amongst others.</p> <p>Employers and educators will promote innovation in education and training approaches, including kaupapa Māori and mātauranga Māori approaches. This will include a greater emphasis on apprenticeship and earn-as-you-learn models and improved opportunities for retraining and upskilling.</p>
<p>4.5 Value and retain the workforce</p>	<p>As outlined in Priority 6, objective 6.2, the health sector, including health entities, will foster and embed a positive culture of workforce engagement, with strong leadership and stewardship for the entire workforce. The New Zealand Health Charter will be embedded to guide the values, principles and behaviours for the health workforce.</p> <p>Employers across the health sector will develop recruitment and retention practices that support career progression, including into leadership. This will actively prioritise groups under-represented in the workforce and in leadership positions, to build a workforce that reflects our diverse communities.</p> <p>Workforces will be supported to be responsive to whānau and community needs, and deliver new models, including kaupapa Māori and mātauranga Māori models. Agencies will work with relevant stakeholders towards more flexible pathways for training and education, including to explore opportunities for innovative approaches to clinical credentialing and qualification, and to encourage workforce retention within the publicly funded health sector.</p>

How we will measure progress

Progress against this priority should focus on whether we are building and retaining a highly engaged, diverse and skilled workforce. This will include monitoring critical steps and processes to be taken forward such as the development of a national workforce plan.

To support measurement of progress in this area in the next two years, we intend to draw on a basket of high-level measures that reflect our key priorities and objectives, and in which we expect to see a change in performance over time. The measures for this area include:

1. staff engagement survey on culture and shift towards a 'one team' ethos
2. proportion of Māori and other under-represented groups in the regulated and unregulated health workforce, compared with the proportion of the total population

3. number and proportion of graduates of health training programmes from demographic groups under-represented in the health workforce, compared with the proportion of the total population
4. proportion of Māori and Pacific peoples in leadership and governance roles across the Ministry of Health and health entities.

A number of further measures from other areas of the iGPS will also be relevant to measuring progress in relation to developing the workforce. The basket above will be supplemented by those indicators, as well as by other relevant sources of information, including staff feedback.

More detail on the iGPS measures can be found in Appendix 1.





Priority 5

Ensuring a financially sustainable health sector

Why this matters

A financially sustainable system is one that manages and allocates resources in a way that achieves the best possible levels of population health and equity within available resources and funding, now and in the future. Available resources include not only new funding, but also resources that can be released by improving efficiency or by shifting existing resources to higher-value uses, driving the key system shifts.

The health sector faces fundamental sustainability challenges, including the immediate pressures of the COVID-19 pandemic, alongside the ongoing challenges of population ageing, a growing (and unequally distributed) burden of disease due to chronic and complex conditions, and rising expectations fuelled, in part, by technological change. It will not be affordable to continue doing the same things in the same way.² A key part of meeting these challenges will be working in collaboration across the social, economic, commercial, environmental and digital sectors to address the determinants of health and wellbeing.

Internationally, institutional arrangements that provide the basis for 'choosing wisely' within available resources play a key role in health system sustainability, by supporting prioritisation of quality and value for money. These arrangements include clinical guidelines, evidence dissemination, benchmarking and, where appropriate, incentives (financial or non-financial) to encourage best practice. Strengthening the focus on prevention and health protection will be a key part of how value is defined, and a top priority.

The reforms have been designed to support financial sustainability, by reducing unnecessary duplication and making it easier to plan and implement arrangements supporting improved efficiency, effectiveness and value for money, and by embedding a population health approach to prevent and reduce need for health services. New national funding settings will give the new entities greater flexibility, including the ability to make optimal decisions over longer time periods.

To be sustainable for future generations, and to maximise the value of taxpayers' money today, the health system also needs to work towards environmental sustainability and reduce its environmental impact. Delivering a pathway to a climate-resilient system is a key opportunity of the reforms and supports the Government's Carbon Neutral Programme. Creating healthy environments (taiao) also supports population health and wellbeing.

² The Treasury, He Tirohanga Mokoopuna 2021 The Treasury's combined Statement on the Long-term Fiscal Position and Long-term Insights Briefing, <https://www.treasury.govt.nz/publications/strategies-and-plans/long-term-fiscal-position>.



Outcomes we are working towards

A financially sustainable system will allocate available resources in a way that maximises the health and wellbeing of people and whānau. To achieve this, funding should be prioritised to:

- meet the Crown's Te Tiriti obligations
- support people and whānau to stay well in their communities, including through strengthened preventative approaches
- target resources to achieve equity across groups
- build resilience to adapt to and recover from challenges and shocks, such as the response to and recovery from COVID-19.

A health system that is financially sustainable should prioritise investment to achieve the greatest value, making sure not only that we invest in the right places but also that funding is invested well and achieves the results we want as efficiently as possible. An important element of this will be how effectively the sector assesses its performance, identifies unwarranted variation, benchmarks good and poor practice and targets support for improvement.

Investing now to realise future benefits is a critical part of achieving value for money and can contribute to financial sustainability. Investment includes funding fixed assets and data and digital infrastructure, as well as investing in prevention, early intervention and population health approaches.

How this priority gives effect to Te Tiriti

The processes for allocating funding and making decisions must uphold the principles of Te Tiriti, consider the need for investment now to realise future value and create resilience, and reflect the importance of the broad determinants of health. This includes ensuring partnership in decision-making for investment at all levels: between Health New Zealand and the Māori Health Authority; with iwi-Māori partnership boards and communities; and with social sector and other agencies. Addressing inequity will entail being innovative and deliberate in how we prioritise investment in a way that responds to known inequity and empowers Māori providers.

Objectives for 2022–2024

Objectives	Description
<p>5.1 Ensure that the system will 'live within its means'</p>	<p>The Government expects that the new health entities will work together and manage expenditure so that additional funding is not needed over the period of the initial multi-year allocation.</p> <p>To support this, during the two-year transition period entities are expected to implement strong, integrated planning processes, including a medium-term plan for managing cost pressures and building resilience. A central part of this will be integrating service and infrastructure planning (including data and digital infrastructure). These plans will be expected to reflect:</p> <ul style="list-style-type: none"> • developing understanding of the cost structure across all parts of the system • developing understanding of the short- and medium-term risks • steps to build system resilience.
<p>5.2 Identify and harness efficiency and productivity gains</p>	<p>The health sector will ensure that services and initiatives deliver the best possible quality and output for the investments made. Health entities will reduce duplication and wastage and support ways of working that focus on the key shifts in order to improve efficiency, effectiveness and equity. Early benefits associated with changes to the way the health system operates will be realised, including through benchmarking and reductions in performance variation.</p> <p>The reformed system will rapidly develop the capability and capacity to fund high-priority, high-value initiatives from within total budgets, both from efficiency savings and by reinvesting resources from low-value activities.</p> <p>Over time, the system will develop measures and processes to inform prioritisation and metrics, including ways of addressing sustainability from a mātauranga Māori perspective.</p>
<p>5.3 Implement new funding and financing arrangements to support equity, value for money and quality</p>	<p>Entities will review and implement mechanisms for allocating funding that incentivise and support equitable allocation of resources and drive the implementation of the reforms.</p> <p>Alongside the arrangements for Crown entity funding, commissioning and contracting arrangements with external providers will be stood up that similarly support the Government's reform objectives, address the determinants of health and wellbeing outcomes and reflect the commitments to Te Tiriti made throughout this document.</p> <p>Funding mechanisms will in particular support population health approaches and integration, including integration across different local services, across the continuum of care and between the health system, the social sector and other sectors.</p>

Objectives	Description
<p>5.4 Continue to grow investment in mental health and addiction, public health and primary and community care</p>	<p>While the system will be expected to 'live within its means', this cannot be at the expense of priority investment areas. Health entities will continue to grow investment in mental health and addiction services, public health, and primary and community services under the new system arrangements. This will include mechanisms to track relevant spending across appropriations.</p> <p>The mental health and addiction ring-fence mechanism will remain in place to ensure that existing expectations are met or exceeded. Health entities will work together to progress longer-term work to enhance the funding mechanisms used to protect mental health and addiction funding in the future.</p>
<p>5.5 Continue the development of robust capital settings and management</p>	<p>Health entities will build systems and processes that support consolidation of infrastructure investment capability and capacity, with a focus on:</p> <ul style="list-style-type: none"> • integrated planning and prioritisation across physical assets, data and digital infrastructure and services, including maintenance of existing assets • management of existing assets as well as continuing capital projects already under way and the identified pipeline • reporting and accountability in line with governance arrangements to be agreed by Cabinet. • designing and implementing systems and practices that set aside depreciation funding for future asset renewal. <p>Over the transition period, Health New Zealand will build capability and capacity and develop an Investment Strategy and National Asset Management Strategy, alongside the development of the New Zealand Health Plan.</p>
<p>5.6 Reduce the health system's environmental impact</p>	<p>The health system should meet the requirements of the Carbon Neutral Government Programme, to achieve a 25 percent reduction in relevant emissions by 2025. This should include setting specific targets for emissions from all levels of the system and prioritising early actions to reduce emissions and waste.</p>



How we will measure progress

Measuring progress against this priority will utilise regular financial reporting by health entities. This will include reporting on assets to liabilities, expenditure compared with plan, compounded leave liability, and so on. The entities' systems and process for ensuring financial sustainability, prioritising high-value services and equity, capital asset planning, management and decision rights, and efficiency tools will also be assessed.

To support measurement of progress in this area in the next two years, we intend to draw on a basket of high-level measures that reflect our key priorities and objectives, and in which we expect to see a change in performance over time. The measures for this area include:

1. Whether actual expenditure is consistent with budgeted and there is overall balance in both budgeted and actual revenue to expenditure ratios
2. A measure of quality-adjusted, system-level productivity (under development)
3. The proportion of total expenditure directed to mental health and addiction, to public health, and to primary and community care services and initiatives
4. The development of an Investment Strategy and a National Asset Management Strategy by December 2023.

A number of further measures from other areas of the iGPS will also be relevant to measuring progress in relation to financial sustainability. The basket above will be supplemented by those indicators, as well as by other relevant sources of information.

More detail on the iGPS measures can be found in Appendix 1.







Priority 6

Laying the foundations for the ongoing success of the health sector

Why this matters

The first two years of the reformed health sector will be critical to establishing and refining new structures, roles and relationships.

Health entities across the publicly funded health sector have an unprecedented opportunity to examine their roles, structures and processes, to test new models and ways of working – including digitally enabled ways of working – and to improve how they exercise their functions both individually and together. The reform of the health system provides an opportunity to harness and spread good practice, to enhance the productivity of the whole sector, and to challenge and change the aspects that have not worked for our workers and communities.

By the end of the first two years, the Government expects the health sector to be close to a ‘steady state’, in which entities have refined and settled their operating models and are ready to deliver the first three-year New Zealand Health Plan from July 2024. To be ready, there will need to be a sustained focus on assuring and improving how health entities work, and rapid progress in implementing new models and approaches.

At the heart of the new health sector should be the voice of our people and communities. The way that the sector is led and managed, how decisions are made, and how services are designed and delivered should be driven by the needs and aspirations of those who use health services, and their whānau. The reformed system will be more responsive to the people it serves at all levels and build in processes to ensure that all groups have a voice in issues that affect them.

Outcomes we are working towards

The expectations in this priority area will support the Government’s intended outcomes for the health sector and provide the basis for achieving our five system shifts over the coming years. The way that the health system is organised, how entities discharge their functions, and the critical underpinning workforce and infrastructure will together create the environment to achieve pae ora.

The reformed system places a strengthened focus on public health and keeping people well in their communities. Budget 2022 includes investment to enable the continued roll-out of localities, to cover 100 percent of the New Zealand population by July 2024. Funding will also support the establishment of the Public Health Agency and the National Public Health Service.



How this priority gives effect to Te Tiriti

The reformed health system will provide for new structures, frameworks and relationships that will set the basis for giving effect to Te Tiriti. These elements, underpinned by the Pae Ora Act 2022, determine how health entities will discharge their functions and how they will work together to give effect to Te Tiriti. This will include both how the system is designed to embed Māori leadership and decision-making opportunities at all levels (see Priority 2, objective 2.2) and how the system is operated to involve and engage Māori on a day-to-day basis (see Priority 2, objective 2.1).

The roles of the Māori Health Authority and iwi-Māori partnership boards in the reformed sector will be especially important to supporting mana whakahaere, mana motuhake, mana tāngata and mana Māori; but the responsibility for upholding Te Tiriti extends to all entities as set out in the Pae Ora Act.

Objectives for 2022–2024

Objectives	Description of actions
<p>6.1 Implement the reformed system model</p>	<p>All employers in the publicly funded health sector will ensure that their employees understand the reforms, their purpose and opportunity, and are able to see their role within the future. All workers moving to a new entity will be transferred effectively and well supported.</p> <p>New or reformed entities will establish systems and processes for managing their responsibilities, assets and liabilities and ensure that there is minimal disruption to frontline activities. They will establish digital infrastructure to enable effective collaboration.</p> <p>Health New Zealand and the Māori Health Authority will establish processes for planning, commissioning, co-commissioning and service delivery and embed a cycle of continuous improvement over these functions. These processes will be clear as to how they give effect to Te Tiriti, including how they support iwi-Māori partnership boards to fulfil their role.</p> <p>Clinical leadership, science, research, intelligence, analytics and innovation, including mātauranga Māori, will be harnessed and embedded across the new health system, with plans established to grow capability.</p> <p>The implementation of the reformed system should build on existing good practice and ensure ongoing delivery of the COVID-19 response.</p>
<p>6.2 Establish a one-system culture and ethos</p>	<p>The health sector will foster and embed a positive culture within and between entities including workforce engagement, with strong leadership and stewardship for the entire workforce. This will include promoting organisational values that support wellbeing, healthy workplace culture and performance excellence.</p> <p>The health sector and workers within it will demonstrate the values, principles and behaviours as stated in the New Zealand Health Charter, at an organisational level and individually.</p> <p>Health entities will establish strong relationships, processes and ways of working to ensure a focus on improving health outcomes and achieving equity. This will include creating positive and productive relationships at all levels (governance, management, clinical, etc), with Te Tiriti partners and between entities, health providers, the Ministry of Health, wider government, sectors and agencies, and community partners.</p>

Objectives	Description of actions
<p>6.3 Build the system around the voices of people and whānau</p>	<p>The way the health sector is led and managed should be centred on the voices of the people who the system serves. Health entities must become more responsive to consumers and whānau in the design, prioritisation and monitoring of services and initiatives.</p> <p>The health system will establish the expertise, mechanisms and information flows to ensure the views, knowledge and experience of Māori, Pacific peoples, disabled people, people with lived experience of mental health and addiction, whānau and populations with specific needs drive decision-making at all levels.</p> <p>This capability will include clear and accessible mechanisms for feedback, improving and streamlining complaints and dispute resolution procedures, and delivering the code of consumer and whānau engagement.</p>
<p>6.4 Improve the use of health information for people and communities</p>	<p>The health sector will continue the development of Hira, the national health information platform, to support accessible and actionable data and information for whānau, and to enable innovation across the health sector.</p> <p>People and their whānau will lead their own health journeys with improved access to their health information and support to navigate the system. This will include co-designing approaches that honour Māori data sovereignty.</p> <p>Health entities will ensure that health data and insights, including patient-reported information, are used to inform decisions and action, to monitor progress and inform quality improvement. The ability for all entities in the health sector – Crown and non-governmental organisations – to gather, evaluate and act on insights is essential for continuous performance improvement.</p>
<p>6.5 Strengthen governance and leadership for quality, safety and equity</p>	<p>Health entities will establish a whole-system approach to quality and clinical governance, to continuously improve the quality and safety of health services.</p> <p>The approach should include embedding benchmarks of quality care, improvement methodologies, and actions to address underperformance and learn from best practice, wherever these occur in the system. It should also ensure clear protocols for routine information-sharing and escalation, including reporting to Ministers.</p> <p>Networks and partnerships will be essential to shared leadership of quality. Entities should develop approaches to assessing and improving quality that include the voices of patients, consumers and whānau, alongside clinicians, managers and commissioners of services.</p>

How we will measure progress

The Government will measure the health system's progress through regular reporting by health entities, staff and public feedback, and reviews by monitoring agencies including the Ministry of Health, the Māori Health Authority, Te Puni Kōkiri and the Office of the Auditor-General. This will include monitoring of reform milestones, and deliverables set by new health entities in their establishment plans.

The Government expects the Ministry of Health and health entities to work towards providing the public with access to a regular flow of information about system and entity performance at national, regional, local and service levels, including monitoring data collected by the Ministry of Health.

To support measurement of progress in this area, we intend to draw on a basket of high-level measures that reflect our key priorities and objectives, and in which we expect to see a change in performance over time. The measures for this area include:

1. (Measure to be developed) of whether health entities are clear about their own and other entities' roles and responsibilities, and are delivering to these
2. experience of primary health care and adult inpatient health services measured across demographic groups using patient experience surveys
3. proportion of entities or services that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4
4. proportion of medical appointments completed through digital channels (initially outpatients and expanding to include general practitioner appointments when data is available).

More detail on the iGPS measures can be found in Appendix 1.





Technical appendices

Appendix 1: iGPS measures

The Government will monitor progress against the objectives of the iGPS using a range of sources of information. This will be intended to ensure that the health system as a whole remains on track to achieve the priorities and outcomes specified and will support regular reporting to Parliament and the public.

Monitoring of the iGPS will draw on a range of quantitative and qualitative information, including feedback from staff, patients, consumers and whānau, and wider system intelligence from experts. This will be supported by a core set of 28 measures, which have been selected to reflect the key priorities and objectives in the iGPS and set parameters for the interim New Zealand Health Plan.

Each of these measures represents an area in which performance improvement is expected in line with the iGPS objectives. Progress against these measures will be monitored quarterly by Ministers, with further actions taken as necessary to respond to any issues that are identified.

The measures are presented in relation to the priority area of the iGPS to which they principally relate. Each priority area has a basket of measures that is intended to provide for a broad basis for monitoring. However, many of the measures have relevance to more than one of the priority areas (for example, many are relevant to embedding Te Tiriti o Waitangi, even though they are included in the basket for another priority area). Most of the measures will be able to be broken down to show differences between different population groups and will therefore also support monitoring of equity. Our aim is that all relevant measures will, in time, be able to be disaggregated for a wider range of appropriate groups, including disability and rurality. The approach to monitoring and reporting at a national level will consider all relevant measures.

Table 1: iGPS measures by priority area summarises the core set of 28 measures.

Table 1: iGPS measures by priority area

iGPS Priority	iGPS measures
<p>1 Achieving equity in health outcomes</p>	<p>1.1 Variation in clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area</p>
	<p>1.2 Proportion of people who start first treatment for breast, cervical or bowel cancer after a screen result (presence of cancer), reported by ethnicity and geographic area</p>
	<p>1.3 Variation in the rates of access to key identified services by ethnicity, geographic area and other characteristics. Initial areas include surgery, first specialist assessments, gender affirming care, colonoscopies, access to specialist mental health (including for rangatahi), and screening</p>
	<p>1.4 Missed appointments for specialist care, reported by ethnicity and geographic area</p>
	<p>1.5 Rate of diabetes complications, reported by ethnicity and geographic area</p>
<p>2 Embedding Te Tiriti o Waitangi across the health sector</p>	<p>2.1 Health entity spending on identified Māori health service providers</p>
	<p>2.2 Experience of health services for Māori as measured by the primary health patient care and adult inpatient experience surveys</p>
	<p>2.3 Geographical coverage and utilisation of rongoā Māori services</p>
	<p>2.4 Feedback from the iwi-Māori partnership boards on how they are fulfilling their role and whether they are receiving the support they require</p>
<p>3 Keeping people well in their communities</p>	<p>3.1 Proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area</p>
	<p>3.2 Proportion of people waiting for planned specialist care who receive it within four months, reported by ethnicity and geographic area</p>
	<p>3.3 Uptake of immunisations for key age groups, reported by ethnicity and geographic area</p>
	<p>3.4 Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by ethnicity and key age groups</p>
	<p>3.5 Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by the end of June 2024</p>
	<p>3.6 Enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area</p>
	<p>3.7 Standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area</p>

iGPS Priority	iGPS measures
<p>4 Developing the health workforce of the future</p>	<p>4.1 Engagement survey on culture and shift towards a 'one team' ethos (measure will be in development as part of work to build data collection)</p>
	<p>4.2 Proportion of Māori and other under-represented groups in the regulated and unregulated health workforce, compared with the proportion of the total population</p>
	<p>4.3 Number and proportion of graduates of health training programmes from demographic groups under-represented in the health workforce, compared with the proportion of the total population</p>
	<p>4.4 Proportion of Māori and Pacific peoples in leadership and governance roles across the Ministry of Health and health entities</p>
<p>5 Ensuring a financially sustainable health sector</p>	<p>5.1 Actual expenditure is consistent with budgeted and there is overall balance in both budgeted and actual revenue to expenditure ratios</p>
	<p>5.2 Develop agreed measures of quality-adjusted, system-level productivity</p>
	<p>5.3 At a system level, monitor the proportion of total expenditure directed to mental health and addiction, public health, and primary and community care services and initiatives</p>
	<p>5.4 Develop an Investment Strategy and National Asset Management Strategy by December 2023</p>
<p>6 Laying the foundations for the ongoing success of the health sector</p>	<p>6.1 (Measure to be developed) Health entities are clear about their own and other entities' roles and responsibilities, and are delivering to these</p>
	<p>6.2 Experience of primary health care and adult inpatient health services measured across demographic groups using patient experience surveys</p>
	<p>6.3 Proportion of entities or services that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4</p>
	<p>6.4 Proportion of medical appointments completed through digital channels (initially outpatients and expanding to include general practitioner appointments when data is available)</p>

Appendix 2: Health sector accountability and monitoring framework

Health sector accountability framework

Both the Ministry of Health and the Māori Health Authority have statutory monitoring roles in the reformed health system and work in partnership to develop and embed the health sector accountability framework.

The Ministry of Health has a strengthened role as chief steward and will evaluate the delivery and performance of services provided or funded by the Māori Health Authority. The Māori Health Authority has statutory functions to: monitor the delivery of hauora Māori services by Health New Zealand and provide public reports on the results of that monitoring; and monitor, in cooperation with the Ministry of Health and Te Puni Kōkiri, the performance of the publicly funded health sector in relation to hauora Māori.

Improving accountability arrangements to lift health sector performance and better manage risk is a key goal of the health reforms. To support changes over time, Ministers have agreed a high-level design for an accountability framework for the future health system.

As outlined in the diagram at the end of this appendix, the health sector accountability framework has four key elements:

- a. **direction-setting**: how priorities, expectations and requirements are set, including through the iGPS
- b. **planning**: how health entities translate expectations and requirements into substantive plans for delivering health services and their other functions. This will include the New Zealand Health Plan, other service plans, and entities' own business plans
- c. **monitoring and reporting**: how we assure progress towards system goals, identify risks and monitor progress on agreed plans, including the role of entities themselves and their boards, and the role of system monitors and Ministers
- d. **intervention**: what happens if monitoring highlights risks, issues or opportunities for improvement at any level of the health sector.

The Ministry of Health, health entities and other agencies have different roles across the elements of the framework. Together this framework ensures that there is a comprehensive picture of how the health sector is performing over time, is clear on respective roles and ensures health entities are held appropriately to account for their responsibilities.

The focus of monitoring and reporting is on three areas outlined further below: outcomes, priority actions and operational performance.

Outcomes

The ultimate focus of how the health sector performs for New Zealanders should be on the outcomes achieved. These outcomes should be the end results that matter most to people – like improved quality and length of life, improved population health and strengthened communities. They will also include system outcomes that are key elements of the Government's reforms, such as reducing variation and inequity, shifting care into communities and optimising the use of resources.

These types of outcomes help set a clear direction for all parts of the health sector, recognising that entities will make different contributions towards them. While many of these outcomes will move only slowly over time, it's important that we monitor them to ensure we're moving in the right direction.

The Ministry of Health will publish a health sector outcomes framework to outline the shared expectations of Ministers, New Zealanders and health agencies for the performance of the health system overall. This outcomes framework will both help focus monitoring from July 2022 on the areas that matter most and indicate where we expect to see improvements over time – including through planned investments. The outcomes framework will be reviewed and updated as part of the development of the next New Zealand Health Strategy.

Priority actions

In addition to monitoring outcomes, there is a range of priorities where we would expect to see actions completed and milestones achieved over time, because these will all contribute to our desired outcomes. These will include actions indicated by the iGPS, health strategies, the interim New Zealand Health Plan, Budget 2022 investments and other priority initiatives (such as the Access and Choice programme). They will also incorporate the necessary activities to implement and refine the new structures, functions and ways of working as part of the Government's health reforms.

The Ministry of Health, the Māori Health Authority and other system monitors will monitor progress against these priorities and milestones to ensure the system is making sufficient progress. The monitoring of priority actions will assist in identifying areas where further support or investment might be needed, or where there are emerging barriers to achieving planned activities. This will often provide us with faster feedback than outcomes, and can assure sustained progress.

Operational performance

Alongside outcomes and priorities, the monitoring of overall operational performance of health entities will ensure that the mechanics of the health system continue to operate well. Monitoring operational performance brings together indicators from across the health sector, including from the New Zealand Health Plan, Statements of Intent, Vote Health and Service Performance Expectations, Health System Indicators and other measures (such as those used by the Health Quality & Safety Commission).

Indicators will be reported in targeted ways to provide an overall view of performance at monthly, quarterly, annual or biannual periods; and at national, regional and district levels as appropriate. Much of the day-to-day reporting on these measures will be led by Health New Zealand, with the Ministry of Health and the Māori Health Authority retaining a role in interpreting these to provide insights on overall system performance.

How we will monitor and report

All health entities will be expected to report on progress against their objectives and the Government's expected outcomes and priorities on a regular basis. Monthly and quarterly reports will support routine monitoring of entities' performance at an appropriate level of detail, supported by statutory annual reports. All of these reports will include the outcomes, priorities and operational performance areas of focus noted above.

Health entities will develop their own reporting for their boards and internal governance arrangements; and these will be shared with the Ministry of Health in its role as the lead monitor for the health sector. Specific expectations for reporting cover entity-level and sector-level reporting.

Entity-level reporting will:

- a. focus on service-level and organisational activity on a monthly basis, including using quarterly and annual checkpoints to check the value added by activity delivered through public funding
- b. include reporting against the interim New Zealand Health Plan and the entity's Statement of Intent and Statement of Performance Expectations to outline progress against the Government's agreed goals and health reforms – both through formal reporting avenues and more regular, informal reporting to Ministers.

Sector-level reporting will:

- a. focus on delivery of outcomes and priorities across the whole-sector, including monitoring of progress on the iGPS and health strategies. Quarterly reporting by the Ministry of Health will draw on entity reports and provide additional insights, including deep dives into identified areas of risk or opportunity
- b. support the Minister to provide quarterly reports to Cabinet on progress with the reforms, and identify any issues for discussion or action that can then be taken forward through the regular engagement with the entities. The reports at this level will also inform statutory annual progress reports.

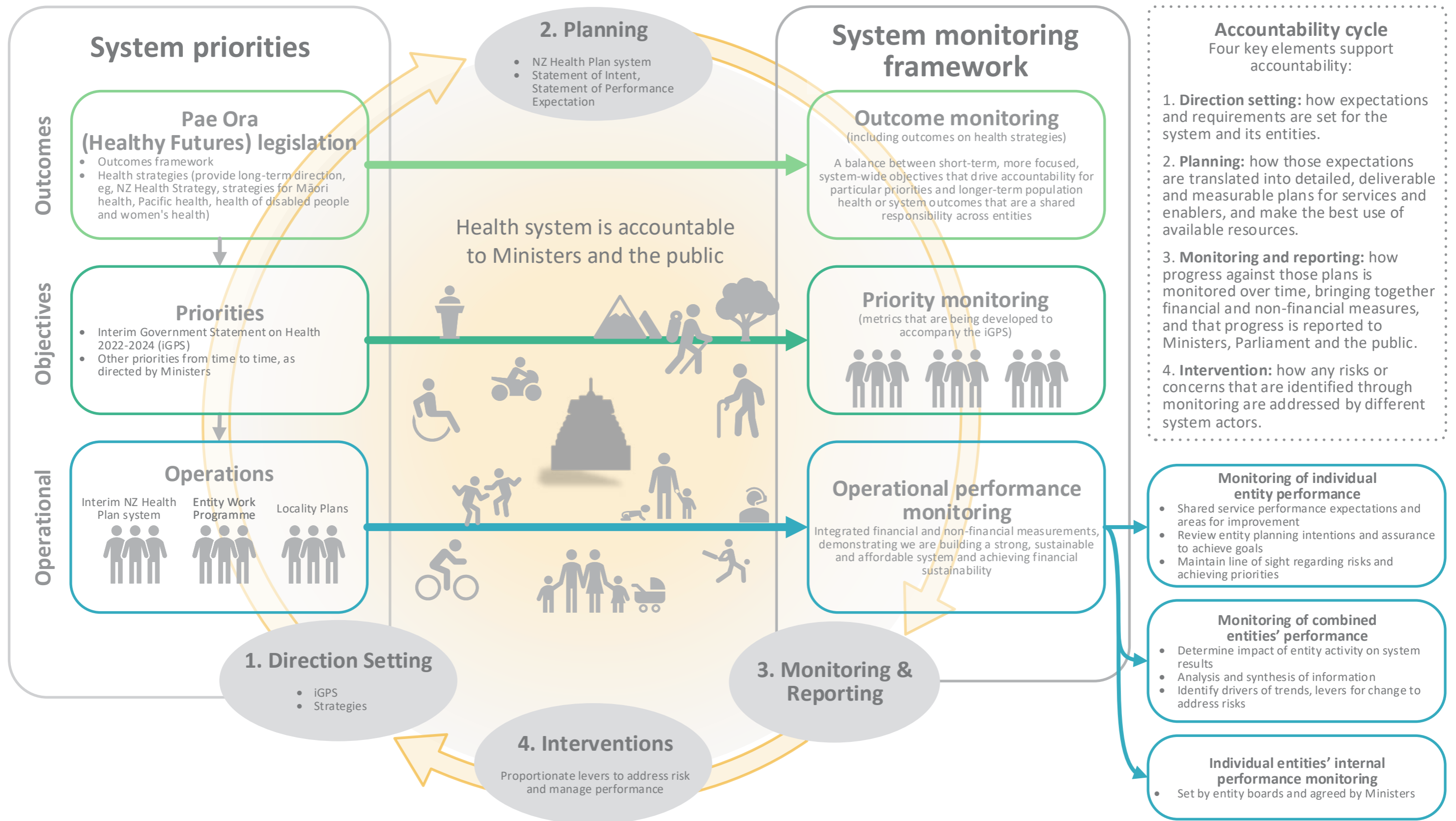
Regular reports will be made publicly available to share progress against health sector goals, for both individual entities and the system as a whole, and will be audited by the Auditor-General where relevant.

Over time, this reporting will also include the routine publication of national data for the public and other stakeholders, so that there is transparency of key information. It will also be supplemented by the publication of annual reports for each locality on progress against their locality plans (in line with the requirements of the Pae Ora Act 2022).

In the short term, reporting will rely on the data available today and on measures that are currently used to evaluate entity and system performance (eg, Health System Indicators). These will be progressively expanded through to 2023/24 to provide a more comprehensive picture of entity and system performance over time, once new data can be identified and collected, and new measures are adopted. Progress will be measured against agreed baselines and expected goals, so that real and expected progress can always be compared.

Wherever possible, indicators will be disaggregated for reporting by demographic characteristics including age, ethnicity, gender and geographic location as appropriate, and as data sources allow.

The health system reforms include establishing an approach to **system-wide planning and accountability** that is **coherent, reflects system priorities and outcomes, and links long-term strategic direction with service and capacity planning**. This approach will be **multi-year** and will directly connect **budgets with organisational actions**. The **high-level design** that comprises a number of different functions **working in alignment**.



Appendix 3: Summary data definitions for the measures in the iGPS

Priority 1: Achieving equity in health outcomes

1.1 Variation in clinical prioritisation for cancer treatment and elective surgery, reported by ethnicity and geographic area

Initially this measure will reflect ESPI 8. The definition below reflects the existing measure definition.

Expectation for July 2022 – June 2024	100% of patients were prioritised using approved nationally recognised processes or tools
Data source	National Collections – NBRIS
If quantitative, measurement definitions	Numerator: Number of patients prioritised in the month who were prioritised using an approved national or nationally recognised tool Denominator: Total number of patients prioritised during the month
Frequency that data is available	Monthly
Level of disaggregation of data available	Ethnicity, specialty, geographic area
Data period	About six to eight weeks in arrears
Related or prior performance measure code	ESPI 8 (also part of previous DHB non-financial monitoring framework and performance measures – SS07)

1.2 Proportion of people who start first treatment for breast, cervical or bowel cancer services after a screen result (presence of cancer), reported by ethnicity and geographic area

[TBC] Breast screening	
Initially this measure will reflect Element 3.2.8 'Where the diagnosis is cancer, ≥90% of women have their initial treatment performed within 31 calendar days of the final decision to treat' ³	
Expectation for July 2022 – June 2024	Where the diagnosis is cancer, ≥90% of women have their initial treatment performed within 31 calendar days of the final decision to treat (treatment is defined as an MDT decision ⁴)
Data source	Concerto Breast Screening (cBS), Breast Screening Data Mart and Annual Monitoring Report
If quantitative, measurement definitions	Numerator: Number of women have their initial treatment performed within 31 calendar days of the final decision to treat (treatment is defined as an MDT decision) Denominator: Total number of women who have had a final decision to treat
Frequency that data is available	Annual Monitoring Report – Annual (financial year)
Level of disaggregation of data available	By Lead Provider (Breast Screen Waitematā Northland, Counties Manukau, Auckland Central, Midland, Coast2Coast, Central, South and Otago Southland), ethnicity, five year age group
Data period	24 months to reporting end
Related or prior performance measure code	Element 3.2.8

3 Refer to https://www.nsu.govt.nz/system/files/page/breastscreen_aotearoa_national_policy_and_quality_standards.pdf

4 National Breast Cancer Tumour Standards Working Group (2013).

[TBC] Cervical screening

Initially this measure will reflect Indicator 7.4 – 'Timeliness and appropriateness of treatment in the National Cervical Screening Programme's annual monitoring report <https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/independent-monitoring-reports>

Expectation for July 2022 – June 2024	Ninety-five percent 95% or more of women who: have evidence of clinical suspicion of invasive carcinoma, or a laboratory report indicating 'features suspicious for invasion', or 'changes consistent with squamous cell carcinoma', or similar, must receive a date for a colposcopy appointment or a gynaecological assessment that is within 10 working days of receipt of the referral Indicator 7.4 90% or more of women with HSIL are treated within 8 weeks of histological confirmation of CIN 2/3.
Data source	Operational cervical screening database Annual Monitoring Report by the Cancer Council New South Wales
If quantitative, measurement definitions	TBC
Frequency that data is available	Annual
Level of disaggregation of data available	Ethnicity, geographic area, five year age group
Data period	36 months to reporting end
Related or prior performance measure code	Annual monitoring report. Indicator 7.4 – Timeliness and appropriateness of treatment (page 123)

[TBC] Bowel screening

Initially this measure will reflect Indicator 401 'Timeliness of MDM team meeting following referral to treatment' of the National Bowel Screening Programme <https://minhealthnz.shinyapps.io/nsu-bsp-index/>

Expectation for July 2022 – June 2024	95% of NBSP participants diagnosed with cancer are referred for pre-operative presentation at MDM within 20 working days of diagnosis
Data source	Rshiny app based on data reported to Bowel Screening Register https://minhealthnz.shinyapps.io/nsu-bsp-index/
If quantitative, measurement definitions	Numerator: Number of NBSP participants diagnosed with cancer who are referred for pre-operative presentation at multidisciplinary meeting within 20 working days of diagnosis Denominator: Number of patients referred for treatment
Frequency that data is available	Monthly and Annual based on Annual Report
Level of disaggregation of data available	Ethnicity, sex, five year age group, geographic area
Data period	24 months to reporting period
Related or prior performance measure code	Timeliness of MDM Team Meeting Following Referral to Treatment (401)

- 1.3** Variation in the rates of access to key identified services by ethnicity, geographic area and other characteristics. Initial areas include surgery, first specialist assessments, gender affirming care, colonoscopies, access to specialist mental health (including for rangatahi), and screening.

[To be developed] Surgery

Initially, this will reflect the Standardised Intervention Rates for inpatient Planned Care Interventions which are to be developed.

Expectation for July 2022 – June 2024	Establish a baseline for inpatient Planned Care Interventions delivery rate in year one The baseline will inform an expectation for year two
Data source	National Collections Stats NZ
If quantitative, measurement definitions	TBC
Data period	12 months rolling, eight weeks from the end of each quarter
Frequency that data is available	Quarterly
Level of disaggregation of data available	Geographic area
Related or prior performance measure code	n/a

First specialist assessment

Initially, this will reflect the Standardised Intervention Rates for first specialist assessment delivery.

Expectation for July 2022 – June 2024	Establish a baseline for First Specialist Assessment delivery in year one. The baseline will inform an expectation for year two
Data source	National Collections Stats NZ
If quantitative, measurement definitions	TBC
Data period	12 months rolling, eight weeks from the end of each quarter
Frequency that data is available	Quarterly
Level of disaggregation of data available	By medical and surgical, geographic area
Related or prior performance measure code	Part of previous DHB non-financial monitoring framework and performance measures – SI4 (2018/19)

[To be developed] Gender affirming care

Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Data period	
Frequency that data is available	
Level of disaggregation of data available	
Related or prior performance measure code	

[To be developed] Colonoscopies

Initially, this will reflect the Standardised Intervention Rates for delivery of colonoscopies which are to be developed.

Expectation for July 2022 – June 2024	Establish a baseline for colonoscopy delivery in year one The baseline will inform an expectation for year two
Data source	National Collections Stats NZ
If quantitative, measurement definitions	TBC
Data period	12 months rolling, eight weeks from the end of each quarter
Frequency that data is available	Quarterly
Level of disaggregation of data available	Geographic area
Related or prior performance measure code	n/a

Access to specialist mental health

Initially this measure will reflect Whakamaua measure 3.2. Measures of mental health access for other population groups may be added over time. These measures do not overtake the expectation for existing, similar measurements to continue outside of the iGPS framework.

Expectation for July 2022 – June 2024	An increase in the percentage of people seen within the target timeframe from the 12 months to 30 June 2022 for rangatahi (baseline)
Data source	Programme for the Integration of Mental Health Data (PRIMHD)
If quantitative, measurement definitions	This measure looks at wait times from the day a client is referred (to a specialist mental health service), to the day when the client is first seen by the service The target timeframe is three weeks from referral
Data period	Quarterly (one quarter in arrears)
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, age, gender, geographic area
Related or prior performance measure code	Current Whakamaua measure 3.2 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf

[To be developed] Screening

Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Data period	
Frequency that data is available	
Level of disaggregation of data available	
Related or prior performance measure code	

1.4 Missed appointments for specialist care, reported by ethnicity and geographic area

Expectation for July 2022 – June 2024	A decrease from the 12 months to 30 June 2022 (baseline) and the equity gap between Māori and Pacific people and non-Māori, non-Pacific peoples also reduces
Data source	National Collections – NN PAC
If quantitative, measurement definitions	Numerator: Number of missed appointments for FSAs Denominator: Total number of FSAs (attended and missed)
Data period	Quarterly, about six weeks in arrears
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, age, gender, geographic area
Related or prior performance measure code	Current Whakamaua measure 2.2 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf Part of previous DHB non-financial monitoring framework and performance measures – SS07

1.5 Rate of diabetes complications, reported by ethnicity and geographic area

Expectation for July 2022 – June 2024	A decrease from the 12 months to 30 June 2021 (baseline)
Data source	National Collections – NMDS Virtual Diabetes Register (Ministry of Health) https://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/about-diabetes/virtual-diabetes-register-vdr#downloads
If quantitative, measurement definitions	Numerator: Number of hospitalisations for diabetes complications Denominator: Virtual Diabetes Register (VDR)
Data period	Annually (calendar year), to coincide with the publication of the Virtual Diabetes Register
Frequency that data is available	Virtual Diabetes Register is run at the end of March each year
Level of disaggregation of data available	Ethnicity, geographic area, adults only (aged 25 years and above to account for the inaccuracies in determining diabetes for younger people)
Related or prior performance measure code	Current Whakamaua measure 3.3 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf

Priority 2: Embedding Te Tiriti o Waitangi across the health sector

2.1 Health entity spending on identified Māori health service providers

Initially this measure will reflect Whakamaua measure 1.1 'Funding received by kaupapa Māori health service providers'. The definition below reflects the existing measure.

Expectation for July 2022 – June 2024	Increase in trend in actual expenditure (compared with the average of last five financial years)
Data source	Compiled from sector financial information
If quantitative, measurement definitions	For identified Māori health providers (Māori owned/governed organisations), the amount of service funding received from health funding entities from Vote Health, as a percentage of Vote Health
Data period	For a 12-month financial year, compared with previous financial years
Frequency that data is available	Available annually after the close of the financial year
Level of disaggregation of data available	Data disaggregated by funder (for example HNZ and MHA) and some key service lines
Related or prior performance measure code	Current Whakamaua measure 1.1 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf Latest published report (2020/21 report is being compiled now): https://www.health.govt.nz/publication/funding-maori-health-providers-2015-16-2019-20

2.2 Experience of health services for Māori as measured by the primary health care and adult inpatient patient experience surveys

Initially, this will reflect two of the current Health System Indicators 'People report they can get primary care when they need it' and 'People report being involved in the decisions about their care and treatment'. The definition below reflects the existing measure.

Expectation for July 2022 – June 2024	Improvement in results from June 2021 (baseline used in Health System Indicators)
Data source	Health Quality & Safety Commission survey results
If quantitative, measurement definitions	Based on two current Health System Indicators: Numerator: Number of respondents who answered no Denominator: Number of respondents who answered the question (as per Health System Indicators technical document)
Data period	Quarterly
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, age, gender, geographic area
Related or prior performance measure code	Current Whakamaua measure 2.1 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf An aspect of the survey is a current Health System Indicator

2.3 Geographical coverage and utilisation of rongoā Māori services

The definition below reflects the existing measure.

Expectation for July 2022 – June 2024	An increase in rongoā consultations provided in terms of both total volumes and spread across the country Baseline: Whakamaua Dashboard https://minhealthnz.shinyapps.io/whakamaua-monitoring-year-one/ One: Māori Services/1.2 Rongoā Māori Coverage . Baseline will be available for 2019/20–20/21
Data source	Compiled from rongoā provider reporting received by Māori Health Authority
If quantitative, measurement definitions	Rongoā consultation volumes delivered
Data period	12-monthly for each financial year
Frequency that data is available	Annual (financial year)
Level of disaggregation of data available	Age, location of rongoā provider, type of rongoā service provided Funding of rongoā provider (total amount) should be published as a sub-measure of this (data will be sourced from measure 1.1)
Related or prior performance measure code	Current Whakamaua measure 1.2. https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf

2.4 Feedback from the Iwi-Māori Partnership Boards (IMPBs) on how they are fulfilling their role and whether they are receiving the support they require

Expectation for July 2022 – June 2024	Establish a baseline in year one, and agree change or improvement expectation in year two from baseline.
Data source	Survey to be conducted by the Ministry of Health
If quantitative, measurement definitions	Qualitative analysis of the survey results
Data period	Six-monthly survey as per IMPB settings
Frequency that data is available	Six-monthly survey as per IMPB settings
Level of disaggregation of data available	Geographic by IMPB
Related or prior performance measure code	NA – replacing Whakamaua measure 4.1

Priority 3: Keeping people well in their communities

3.1 Proportion of people reporting unmet need for primary health care, reported by ethnicity and geographic area

Expectation for July 2022 – June 2024	A decrease from the 12 months to 30 June 2019 (baseline) Note: As part of the New Zealand Health Survey programme, this measure is due to be replaced in 2023 and the iGPS measure definition will be revised
Data source	New Zealand Health Survey
If quantitative, measurement definitions	Proportion of people indicating unmet need for primary care in the survey
Data period	Annually (financial year), collected as part of the NZ Health Survey
Frequency that data is available	As per release of the New Zealand Health Survey https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey
Level of disaggregation of data available	Ethnicity, gender, age, geographic area
Related or prior performance measure code	Current Whakamaua measure 1.3 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf

3.2 Proportion of people waiting for planned specialist care who receive it within four months, reported by ethnicity and geographic area

Initially, this will reflect two existing measures – Elective Services Patient Flow Indicator (ESPI) 2 and 5. The definitions below reflects the existing measure definitions.

ESPI 2	
Expectation for July 2022 – June 2024	No patients waiting for an FSA wait longer than four months
Data source	National Collections – NationalBooking Reporting System (NBRS)
If quantitative, measurement definitions	Numerator: Number of patients waiting more than four calendar months for FSA Denominator: Total number of patients waiting at month end for FSA
Frequency that data is available	Monthly
Level of disaggregation of data available	Geographic area, specialty
Data period	Monthly, about 6–8 weeks in arrears
Related or prior performance measure code	ESPI 2 (also part of previous DHB non-financial monitoring framework and performance measures – SS07)

ESPI 5	
Expectation for July 2022 – June 2024	No patients are given a commitment to treatment and are not treated in within four months
Data source	National Collections – NBRS
If quantitative, measurement definitions	Numerator: Number of patients with an Assured status waiting more than 120 days Denominator: Total number of patients waiting with an Assured status
Frequency that data is available	Monthly
Level of disaggregation of data available	Ethnicity, geographic area, age
Data period	Monthly and about 6–8 weeks in arrears
Related or prior performance measure code	ESPI 5 (also part of previous DHB non-financial monitoring framework and performance measures – SS07)

3.3 Uptake of immunisations for key age groups, reported by ethnicity and geographic area

Eight-month-olds	
Expectation for July 2022 – June 2024	95% of eligible children fully immunised at eight months of age for Māori, Pacific and Total populations
Data source	National Collections – National Immunisation Register (NIR) and National Immunisation System
If quantitative, measurement definitions	Numerator: Number of eligible children enrolled on the NIR who have turned eight months of age during the quarter and who are recorded as fully immunised on the end of the day that they turn the milestone age (see further detail below) Denominator: Number of eligible children enrolled on the NIR who have turned eight months of age during the quarter. Those who decline vaccines or who have opted off their information being recorded on the NIR are included in the denominator. (see further detail below)
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, geographic area, deprivation level
Data period	Quarterly
Related or prior performance measure code	Part of previous DHB non-financial monitoring framework and performance measures – CW05
Two-year-olds	
Expectation for July 2022 – June 2024	95% of eligible children fully immunised at two years of age for Māori, Pacific and Total populations
Data source	National Collections – NIR and National Immunisation System
If quantitative, measurement definitions	Numerator: Number of eligible children enrolled on the NIR who have turned two years of age during the quarter and who are recorded as fully immunised on the end of the day that they turn the milestone age Denominator: Number of eligible children enrolled on the NIR who have turned two years of age during the quarter. Those who decline vaccines or who have opted off their information being recorded on the NIR are included in the denominator
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, geographic area, deprivation level
Data period	Quarterly
Related or prior performance measure code	Current Health System Indicator Part of previous DHB non-financial monitoring framework and performance measures – CW08

Five-year-olds	
Expectation for July 2022 – June 2024	95% of eligible children fully immunised at five years of age for Māori, Pacific and Total populations
Data source	National Collections – NIR and National Immunisation System
If quantitative, measurement definitions	Numerator: Number of eligible children enrolled on the NIR who have turned five years of age during the quarter and who are recorded as fully immunised on the end of the day that they turn the milestone age Denominator: Number of eligible children enrolled on the NIR who have turned five years of age during the quarter. Those who decline vaccines or who have opted off their information being recorded on the NIR are included in the denominator
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, geographic area, deprivation level
Data period	Quarterly
Related or prior performance measure code	Part of previous DHB non-financial monitoring framework and performance measures – CW05
Human Papillomavirus (HPV) vaccination	
Expectation for July 2022 – June 2024	75% of eligible boys and girls fully immunised with HPV vaccine for Māori, Pacific and Total populations
Data source	National Collections – NIR and National Immunisation System
If quantitative, measurement definitions	Numerator: Number of girls and boys born in the relevant birth cohort who have completed their HPV immunisation course as per Schedule and recorded on the NIR. The report includes all HPV vaccines given at any time up until 30 June of the reporting year Denominator: For those born from 2006 onwards, the denominator is the eligible population enrolled on the NIR. For those born in 2005 or earlier, the denominator is the estimated from the census population projection denominator for the relevant birth cohort
Frequency that data is available	Annual (data available around July)
Level of disaggregation of data available	Ethnicity
Data period	12 months to 30 June
Related or prior performance measure code	Part of previous DHB non-financial monitoring framework and performance measures – CW05

Influenza for 65+ years	
Expectation for July 2022 – June 2024	75% of eligible population aged 65 years and over immunised against influenza (annual immunisation) for Māori, Pacific and Total populations
Data source	National Collections – NIR Stats NZ
If quantitative, measurement definitions	Numerator: Number of eligible people aged 65 years and over enrolled on the NIR who have completed at least one influenza vaccination for the given vaccination year Denominator: Statistics New Zealand population projections derived from the estimated resident population, by prioritised ethnicity, sex and geographic area, for those aged 65 years and over
Frequency that data is available	Annual (data available around October)
Level of disaggregation of data available	Ethnicity, geographic area
Data period	1 March – 30 September to capture the time from when the seasonal influenza vaccine for that year becomes available until the anticipated end of the influenza season
Related or prior performance measure code	Part of previous DHB non-financial monitoring framework and performance measures – CW05

[Table to be completed] COVID-19 vaccination	
Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Frequency that data is available	
Level of disaggregation of data available	
Data period	
Related or prior performance measure code	

3.4 Rate of hospital admissions for an illness that might have been prevented or better managed in the community, reported by key age groups

Initially, this will reflect two existing measures that are part of the Health System Indicators framework – ASH rates for 0-4 year olds and for 45-64 year olds. Other key age groupings will be investigated for development (eg to reflect older people). The definitions below reflects the existing measure definitions.

0- to 4-year-olds	
Expectation for July 2022 – June 2024	The rate of hospital admissions for children under five years of age for an illness that might have been prevented or better managed in the community reduces (baseline of results 12 months to December 2019 used in Health System Indicators) and/or the equity gap between Māori and Pacific people and non-Māori, non-Pacific peoples also reduces
Data source	National Collections – National Minimum Dataset (NMDS) Stats NZ population projection (based on Health System Indicators technical document)
If quantitative, measurement definitions	Numerator: Number of inpatient ambulatory sensitive hospitalisation (ASH) events for 0- to 4-year-olds from the NMDS. NMDS is used to identify ASH events by applying a list of conditions that has been developed by a clinical panel Denominator: Domiciled population for 0- to 4-year-olds based on Stats NZ projections (based on Health Sector Indicator technical document)
Data period	12-month and one quarter in arrears
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, geographic area, by ASH condition
Related or prior performance measure code	Current Whakamaua measure 3.1 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf Current Health System Indicator

45- to 64-year-olds	
Expectation for July 2022 – June 2024	The rate of hospital admissions for people aged 45–64 years for an illness that might have been prevented or better managed in the community reduces (baseline of results 12 months to December 2019 used in Health System Indicators) and/or the equity gap between Māori and Pacific people and non-Māori, non-Pacific peoples also reduces
Data source	National Collections – NMDS Estimated New Zealand resident population with Stats NZ projections (based on Health System Indicators technical document)
If quantitative, measurement definitions	Numerator: Number of hospital inpatient ASH events for 45- to 64-year-olds from the NMDS. The NMDS is used to identify ASH events by applying a list of conditions developed by a clinical panel Denominator: Domicile population for 45- to 64-year-olds based on Stats NZ population projections and age-standardised based on Stats NZ estimates (based on Health System Indicators technical document)
Data period	12-month rolling and one quarter in arrears
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, geographic area, by ASH condition
Related or prior performance measure code	Current Health System Indicator. Part of previous DHB non-financial monitoring framework and measures – SS05

3.5 Complete roll-out of the Access and Choice programme for primary mental health and addiction support services so that access is available for 325,000 people per year by the end of June 2024

These measures do not overtake the expectation for existing, similar measurements to continue outside of the iGPS framework.

Integrated Primary Mental Health and Addiction Services	
Expectation for July 2022 – June 2024	Establish baseline estimated annual access level and adjustment factor in first quarter of 2022/23 Expectation of an estimated 248,000 annual access level based on fourth quarter access in 2023/24
Data source	NHI-based IPMHA reporting
If quantitative, measurement definitions	Estimated annual access (number of people seen in the year if quarterly access continues at current rate): total number of individuals seen this quarter multiplied by four and by an adjustment factor ⁵ to eliminate people seen across multiple quarters in the year
Frequency that data is available	Quarterly (five to six weeks after the quarter ends)
Level of disaggregation of data available	Access and Choice priority populations: number and proportion of people seen during the quarter who are Māori, Pacific and youth (aged 12 to 24 years) and number of people seen this quarter by geographical area
Data period	Quarterly
Related or prior performance measure code	Health System Indicator in development: Improving mental wellbeing – Access to primary mental health and addiction services over past twelve months

Kaupapa Māori, Pacific and Youth Primary Mental Health and Addiction Services	
Expectation for July 2022 – June 2024	Establish baseline estimated annual access level in the first quarter of 2022/23 Expectation of an estimated 77,000 annual access level based on fourth quarter access in 2023/24
Data source	Summary level reporting by Kaupapa Māori, Pacific and Youth services in the Access and Choice primary mental health and addiction programme
If quantitative, measurement definitions	Estimated annual access (number of people seen in the year if quarterly access continues at current rate): total number of new people seen ⁶ in the quarter multiplied by four
Frequency that data is available	Quarterly ((five to six after the quarter ends)
Level of disaggregation of data available	Access and Choice priority populations: number and proportion of new people seen this quarter who are Māori, Pacific and youth (aged 12 to 24 years) and number of new people seen this quarter by geographical area
Data period	Quarterly
Related or prior performance measure code	Health System Indicator in development: Improving mental wellbeing – Access to primary mental health and addiction services over the past twelve months

⁵ Adjustment factor for IPMHA services will be sourced from analysis of reported NHI-based data for the full 2021/22 year: number of individuals seen during the year divided by sum of the people seen each quarter.

⁶ 'New people seen' for Kaupapa Māori, Pacific and Youth services counts the number of people who have been seen during a month and who have not been seen in the eleven preceding months.

3.6 Enrolment with a primary maternity care provider in the first trimester of pregnancy, reported by ethnicity and geographic area

Initially this measure will reflect Indicator 1 'Registration with an LMC [lead maternity carer] in the first trimester of pregnancy' in the New Zealand Maternity Clinical Indicators. The definition below reflects the existing measure definitions.

Expectation for July 2022 – June 2024	Establish a baseline in year one, and agree change or improvement expectation in year two from baseline
Data source	National Maternity Collection https://minhealthnz.shinyapps.io/maternity-clinical-indicator-trends/
If quantitative, measurement definitions	Numerator: Total number of pregnant people who register with an LMC in the first trimester of their pregnancy Denominator: Total number of pregnant people who register with an LMC https://www.health.govt.nz/system/files/documents/publications/nz-maternity-clinical-indicators-background-document-apr22.pdf
Frequency that data is available	Annual, 12 months after the end of the calendar year
Level of disaggregation of data available	Ethnicity, geographic area
Data period	Calendar year
Related or prior performance measure code	https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/new-zealand-maternity-clinical-indicators-series

3.7 Standardised rate of acute readmissions within 28 days of discharge, reported by ethnicity and geographic area

Initially this measure will reflect the measure included in the acute re-admission report published on the Nationwide Service Framework Library (NSFL) website <https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/reducing-acute>. These measures do not overtake the expectation for existing, similar measurements to continue outside of the iGPS framework, such as measurement of mental health acute readmissions.

Expectation for July 2022 – June 2024	Establish a baseline in year one, and this baseline will inform the expectation for year two Note: Acute readmission 0-7 days will be a sub-component.
Data source	National Collections – NMDS Stats NZ
If quantitative, measurement definitions	Refer to technical definition document at https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/reducing-acute
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, geographic area, age
Data period	12 months rolling, one quarter in arrears
Related or prior performance measure code	Part of previous DHB non-financial monitoring framework and performance measures – SS07

Priority 4: Developing the health workforce of the future

4.1 Staff engagement survey on culture and shift towards a 'one team' ethos (measure will be in development as work to build data collection)

Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Frequency that data is available	
Data period	
Level of disaggregation of data available	
Related or prior performance measure code	

4.2 Proportion of Māori and other under-represented groups in the regulated and unregulated health workforce, compared with the proportion of the total population

Regulated workforce	
Expectation for July 2022 – June 2024	An increase from the 12 months to 30 June 2022 (baseline)
Data source	Registration data from professional councils
If quantitative, measurement definitions	Numerator: Total number of Māori across regulated professions or total number of other under-represented groups across regulated professions Denominator: Total number in each regulated profession
Data period	Annual – starting date of 12-month period variable between professional councils
Frequency that data is available	Annual – starting date of 12-month period variable between professional councils
Level of disaggregation of data available	Ethnicity
Related or prior performance measure code	Current Whakamaua measure 2.3 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf

Unregulated workforce	
Initially this will focus on unregulated HNZ employed workforce.	
Expectation for July 2022 – June 2024	An increase from the 12 months to 30 June 2022 (baseline)
Data source	Initially Health New Zealand (HNZ) employment data
If quantitative, measurement definitions	Total number of Māori across unregulated professions employed by HNZ and total number of Pacific people across unregulated professions employed by HNZ as a percentage of the total numbers in each profession employed by HNZ
Data period	Annually (financial year)
Frequency that data is available	Annually (financial year)
Level of disaggregation of data available	Ethnicity
Related or prior performance measure code	n/a

4.3 Number and proportion of graduates of health training programmes from demographic groups under-represented in the health workforce, compared with the proportion of the total population

Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Frequency that data is available	
Data period	
Level of disaggregation of data available	
Related or prior performance measure code	

4.4 Proportion of Māori and Pacific people in leadership and governance roles across the Ministry of Health and health entities

Expectation for July 2022 – June 2024	Establish a baseline and initial increases in numbers
Data source	Reported by Crown entity and statutory entity organisations in the health sector
If quantitative, measurement definitions	Numerator: Number of Māori and Pacific peoples in leadership and governance roles reported by health sector entities Denominator: Total number of people in leadership and governance roles by health sector entities Note: Leadership and governance roles include boards, senior leadership teams and executive teams
Data period	Annual (financial year)
Frequency that data is available	Annual (financial year)
Level of disaggregation of data available	Ethnicity, organisation
Related or prior performance measure code	Current Whakamaua measure 4.3 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf

Priority 5: Ensuring a financially sustainable health sector

5.1 Actual expenditure is consistent with budgeted and there is overall balance in both budgeted and actual revenue to expenditure ratios

Expectation for July 2022 – June 2024	<ul style="list-style-type: none"> Actual expenditure is well managed through the year to ensure the full-year forecast expenditure expectations do not exceed the approved budget or funding received When budgeting, expenditure is expected to be realistically proportioned to the funding signals Expenditure will also be managed against the multi-year financial plan and cost pressures to ensure financial sustainability goals are achieved
Data source	<ul style="list-style-type: none"> Financial Flatfiles submitted by Health New Zealand, Māori Health Authority, PHARMAC and other Crown entities for both Actuals and Annual Plan Supplementary data Budget Assumptions for cost reductions and efficiency goals, both in-year and multi-year submitted by Health New Zealand and Māori Health Authority
If quantitative, measurement definitions	<ul style="list-style-type: none"> Numerator: Actual expenditure against key line items and Total Denominator: Budget equivalent for the comparative time period to date Numerator: Actual expenditure against key line items and Total Denominator: Actual revenue received or expected to receive, relevant to the period to date Numerator: Expenditure expectations within Annual Plans Denominator: Revenue recognised within Annual Plans Numerator: Spend against key changes, goals and cost reducing initiatives Denominator: Budget equivalent for the comparative time period to date
Frequency that data is available	Monthly – Actuals, Annually – Annual Plan and Budget Assumptions
Level of disaggregation of data available	Common Chart of Accounts (FRED) by provider (hospital and specialist, primary and community care, and corporate and governance)
Data period	Month and year-to-date
Related or prior performance measure code	Current Health System Indicator

5.2 (Measure to be developed) Develop agreed measures of quality-adjusted, system-level productivity

Measures of productivity will be determined and may include matters such as: hospital theatre utilisation, length of stay, FTEs per case-weighted hospital discharge, use of (clinical and non-clinical) workforces.

Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Frequency that data is available	
Level of disaggregation of data available	
Data period	
Related or prior performance measure code	

5.3 (Measure to be developed) At a system level, monitor the proportion of total expenditure directed to mental health and addiction, public health, and primary and community services and initiatives

Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Frequency that data is available	
Level of disaggregation of data available	
Data period	
Related or prior performance measure code	

5.4 Develop an Investment Strategy and National Asset Management Strategy by December 2023

Expectation for July 2022 – June 2024	Develop an Investment Strategy and National Asset Management Strategy by December 2023
Data source	TBC
If quantitative, measurement definitions	n/a
Frequency that data is available	n/a
Level of disaggregation of data available	TBC
Data period	By December 2023
Related or prior performance measure code	n/a

Priority 6: Laying the foundations for the ongoing success of the health sector

6.1 (Measure to be developed) Health entities are clear about their own and other entities' roles and responsibilities, and are delivering to these

Refer to paragraphs 12 and 13 in briefing.

Expectation for July 2022 – June 2024	
Data source	
If quantitative, measurement definitions	
Frequency that data is available	
Level of disaggregation of data available	
Data period	
Related or prior performance measure code	

6.2 Experience of primary health care and adult inpatient health services measured across demographic groups using patient experience surveys

Initially, this will reflect two of the current Health System Indicators 'People report they can get primary care when they need it' and 'People report being involved in the decisions about their care and treatment'. The definition below reflects the existing measure.

Expectation for July 2022 – June 2024	Improvement on results from June 2021 (baseline used in Health System Indicators)
Data source	HQSC survey results
If quantitative, measurement definitions	Based on two current Health System Indicators: Numerator: Number of respondents who answered no. Denominator: Number of respondents who answered the question. (as per HSI technical document)
Data period	Quarterly
Frequency that data is available	Quarterly
Level of disaggregation of data available	Ethnicity, age, gender, geographic area
Related or prior performance measure code	Current Whakamaua measure 2.1 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-2.pdf An aspect of the survey is a current Health System Indicator

6.3 Proportion of entities that have been assessed against the Consumer Engagement Quality and Safety Marker; and of those, the proportion that have been assessed at Level 3 or 4

Expectation for July 2022 – June 2024	Increasing participation of health entities and their local or regional offices, as agreed, that have been assessed against the Consumer Engagement Quality and Safety Marker from 30 June 2022 Establish baseline for places that have been assessed at Level 3 or 4 on the Consumer Engagement Quality and Safety Markers, and agree change or improvement expectation in year two from baseline
Data source	Health Quality & Safety Commission based on entities' self-assessment ratings, submitted examples from entity or service, selected questions from adult inpatient and primary health care patient experience surveys
If quantitative, measurement definitions	Numerator: Number of health entities or offices that have been assessed against the Consumer Engagement Quality and Safety marker Denominator: Total number of health entities or offices Note: Excludes Health Quality & Safety Commission
Frequency that data is available	July and December
Level of disaggregation of data available	By health entity, by service
Data period	October - March, April - September
Related or prior performance measure code	NA

6.4 Proportion of medical appointments completed through digital channels (initially outpatients and expanding to include general practitioner appointments when data is available)

Expectation for July 2022 – June 2024	This measure will initially focus on outpatient services – first specialist assessment (FSA) and follow ups Establish a baseline for the FSAs and follow ups in year one The baseline will inform an expectation for year two
Data source	National Collections – National Non-Admitted Patient Collection (NNPAC) for outpatient data
If quantitative, measurement definitions	Outpatient appointments Numerator: Number of patients receiving an FSA or follow-up where the mode of delivery does not involve the patient being physically present with the clinical staff. Denominator: Total number of FSA and follow-ups
Frequency that data is available	Monthly
Level of disaggregation of data available	Ethnicity, age, gender, geographic
Data period	About six-eight weeks post outpatient appointment
Related or prior performance measure code	n/a



