Office of the Minister of Health

Chair
Cabinet Business Committee

PROVISION OF ADDITIONAL ELECTIVE SERVICES

Proposal

1 I propose to increase the number of elective procedures currently performed each year in public hospitals by approximately 10,000. This increase will be in the order of 10 percent. This will lower the access threshold thus making elective services (predominantly elective surgery) more available to new patients referred to their public hospital by their General Practitioner (GP).

2 People in need of elective services are often severely limited in their ability to work or live a normal life because of the pain and disability they suffer. This proposal will enable a number of those treated to regain functional independence. This will have a positive impact across a number of portfolios including employment, income support, social development and health.

Executive summary

3 New Zealand provides a world class service to patients presenting acutely to a public hospital – we do not experience "ambulance bypass", as they do in the UK and Australia. Consequently the area of elective services becomes a focus for public attention and it is one of the key yardsticks by which the relative success of the health system is judged.

4 Over the longer term, preventative measures (and the effect of the primary health care strategy) may help reduce the demand for elective services. However, these measures will not impact on conditions that occur as part of the natural ageing process, or arise from a congenital deformity.

5 At present, patients across New Zealand do not have equity of access to elective services. This proposal will assist in addressing this issue. The recent work done by the sector to comply with the principles of the booking system has better identified the groups of patients currently unable to access services in each specialty area.

6 The estimated total cost of the proposal depends largely on the number of additional patients who will receive treatment. Costs are also associated with the ongoing monitoring of the programme.

Background

7 Every country in the western world is faced with ever increasing demands for health services. In some instances these demands overwhelm the ability of hospitals to cope with acutely ill patients who need immediate treatment. While this does not happen in New Zealand, there are nevertheless serious pressures on our ability to deliver to public expectations. This is because:

- New Zealand's population is ageing
- Clinical advancements mean we can intervene more for more people
- There are demands for any new technology or new drug to be made available irrespective of cost.

8 The ever increasing cost of treating serious, life threatening diseases with their associated high resource utilisation, impedes the sector's ability to deliver to those seeking to access services, which are by definition, elective. Nevertheless public expectations in this area continue to grow.

9 Since the New Zealand health sector provides a world class service to acutely ill people, the area of elective services becomes a focus for public attention. Poor access to elective surgery has an adverse impact on people's trust in the public health system.

10 Addressing this problem of poor access has not been easy for a number of reasons:

- Historically DHBs have been able to offset any increase in acute demand with a commensurate decrease in elective volumes
- It has been the policy of successive Governments since the late 90s to match commitments made to patients to the sector's capacity to deliver services. However, until recently providers have not fully addressed the issue. Thus large numbers of patients continued to be placed on "waiting lists" without any realistic expectation of receiving service
- Clinicians have been slow to recognise their duty of care to prioritise patients based on an assessment of clinical need / ability to benefit. This has made it impossible to gain a clear picture of those who would be unable to gain access within the current capacity
- Current purchasing mechanisms between DHB funders and providers can restrict the ability of the latter to develop innovative ways to increase the delivery of services within existing budgets.

11 Options to protect elective volumes have been identified in a sector based working party report on the issue. This policy incorporates the establishment of baseline and target volumes for electives, as detailed in the report.

12 Over recent months District Health Boards (DHBs) have made concerted efforts to bring their management of patients waiting for elective services into line with Government policy. The principles of clarity, timeliness and fairness that underlie this policy are sound and ethically defensible.

13 In many instances these efforts have resulted in DHBs recognising that they could not deliver services to all those they had waiting in the booking system. As a consequence, numbers of patients have been advised that, given current resources, they would not receive publicly funded services. This process has highlighted the fact that current capacity is not able to meet the needs of all patients.

14 A recent New Zealand Medical Council Statement on "safe practice in an environment of resource limitation", together with an opinion of the Health and Disability Commissioner on the prioritisation practices of a Southland urologist, has brought home to the medical profession their clear responsibility to prioritise patients to the best of their clinical ability and then to act in accordance with the priority assigned.

15 Potential disincentives to innovative service delivery have been identified. Each DHB has been charged with addressing the issues relevant to it. This task, together with other activity on productivity and efficiency, such as the collaborative work with the Royal Australasian College of Surgeons and the Royal Australasian College of Anaesthetists on theatre management, will enhance the delivery of elective services.

16 The recent Government initiatives around primary hip and knee replacement, and cataract operations, have been well received by both the health sector and the public. To date, both initiatives have exceeded their target volumes. This proposal builds on that success and is based on similar principles.

17 In the light of all the above, it is now an opportune time to look to a targeted increase in the level of elective services provided to the population of NZ.

Comment

The case for change

18 Among the patients who currently cannot access elective services are some for whom surgery is the only treatment option. Were they to receive treatment their quality of life would be significantly improved through relief of pain, restoration of function and independence, and improved emotional well being.

19 While international intervention rates for specific elective procedures are not readily available (because of differences in the way data is collected and standardised), we do know that in a number of instances we are not able to meet internationally accepted best practice guidelines. For example:

- it is recommended that at the time of mastectomy all patients should have the option of breast reconstruction offered to them. In some places in NZ this option is not offered to any patient, and nowhere is it offered to every patient
- some paediatric patients with congenital conditions have to wait outside recommended timeframes for their surgery.

20 Failing to provide such surgery on a timely basis incurs costs to society that may exceed the cost of the surgery. A study at Christchurch hospital showed that providing timely access to gall bladder operations (cholecystectomies) rather than managing patients conservatively through several acute episodes of cholecystitis, would reduce the cost to the health system by 50%.

21 As DHBs move to match the commitments they give to patients to their capacity to provide services, they need to improve their process for ranking patients in priority of need / ability to benefit. This will enable better identification of that group of patients who would be offered service when additional capacity was made available.

Benefits of the proposal

22 The most obvious benefit is that more people will receive access to elective services. There is a considerable amount of correspondence from the public to Members of Parliament providing anecdotal evidence of the impact of treatable conditions on individuals and their families. Long waits and high thresholds for elective surgery have the potential to detract from achievements in the public health system.

23 The Ministry currently makes available on a public website each DHB's standardised intervention rates for a number of key elective procedures. This shows that access to these procedures is not equitable across the country (refer Appendix 1). This pattern, together with detailed work currently underway with the sector, will inform where additional resources should be targeted to bring about improved equity. To achieve this, in some instances funds will be used to increase volumes of specific procedures, and in others, to achieve an overall increase in the caseweights delivered by a specialty.

24 The current intervention rate for a number of elective procedures is such that many patients with significant disability do not receive an operation because they fall below the treatment threshold.

25 The numbers seeking to access elective surgery, or even specialist assessment exceed current capacity. In most countries, including New Zealand, there will be an inevitable increase in demand as a result of the ageing population. A failure to lift the volume of elective services will compound the existing unsatisfactory situation.

Requirement for services

26 Preventative public health interventions may reduce the impact of diseases that require elective treatment. The Ministry of Health provides practical advice to people on these issues. However, any projections of disease prevalence that indicate a decline over the next 50 years due to healthier lifestyles and advances in medical treatment will be more than offset by the increasing number of older people.

27 A number of elective procedures rank highly on the international Quality Adjusted Life Years (QALYs) scale, a measure of the relative value of various health or social interventions.

28 There is a cost to both patients and the country in failing to provide appropriate treatment. Patients waiting for surgery need to be managed in primary care, often with the aid of pharmaceuticals and allied health support. Managing patients for whom surgery is the only option places a significant burden on general practitioners.

Risk management

29 Risks associated with this proposal are that:

- DHBs cannot increase their capacity to the level required and therefore the desired volumes are not delivered;
- DHBs may attempt to replace the funding of current baseline activity with funding from the new initiative;
- The initiative does not lead to sustained improvements in prioritisation and operational management practices.

30 These risks can be managed in a number of ways:

- Providing DHBs with sufficient lead time to "gear up" to meet the targets required (it should be noted that a number of DHBs are in a position to start immediately);
- Spreading six months' allocation over the first eight months of the initiative;
- Allowing sufficient flexibility around allocations of funding so that the effect of unforeseen events can be mitigated;
- Holding funding centrally and paying DHBs on invoice in arrears with demonstration that the individual patients covered by the invoice fall within the categories for which additional funding is made available;
- The DHBs requiring clinicians in services seeking to access additional funding to prioritise patients and treat broadly in order of the priority assigned;
- The DHBs requiring clinicians to monitor and audit their prioritisation practice;
- Requiring DHBs to maintain sound patient flow management processes (as indicated by ongoing compliance with Elective Services Patient Flow Indicators (ESPIs)).

Implementing the proposal

A collaborative approach

31 Accurate projections of capacity and the successful implementation of this initiative will depend on the engagement and support of DHB clinicians and

management. Planning has been undertaken in close collaboration with the DHBs. A number of basic parameters have been developed and discussed with each DHB. DHBs have been asked to evaluate and report on their ability to increase capacity in both the short and medium term. Intervention rate data will be used to inform decisions as to the targeting of funding on a DHB by DHB basis.

A population based allocation

32 The only fair and equitable formula for allocating funding for this initiative is one based on population. Thus, DHBs that have invested in elective services will not be disadvantaged because of their 'good' behaviour. To take any other approach would destabilise the whole elective services programme. If those DHBs who, historically, have not funded elective services to the current national average intervention rates were to receive a disproportionately large allocation, it would send a signal to all DHBs that the way to attract extra funding is to under-deliver services.

33 Where a DHB is achieving intervention rates above the national average because of historic funding patterns, so long as current elective volumes are maintained, funding from this initiative can be used to replace the transitional funding pool.

Scope of proposal

34 Work is underway with each specialty to identify intervention rates for a group of common, core elective procedures. This will assist DHBs in deciding where the additional funds will be targeted. This will differ from DHB to DHB. In some instances, funds will be used to increase volumes of specific procedures, and in others, to achieve an overall increase in the caseweights delivered by a specialty.

35 Examples of clinical procedures that may be provided in increased numbers through this proposal include breast reconstruction post mastectomy, correction of congenital facial deformities and heart operations.

36 Funding can also be used to increase the volume of elective procedures delivered in a non-hospital setting.

DHB Requirements

37 For a DHB to access additional funding, they will need to (inter alia):

- Maintain compliance with ESPIs, both at an overall DHB level and in the services where additional funding will be utilised
- Demonstrate that sound prioritisation practices are in place and being monitored on a regular basis.

38 This funding should be used to increase capacity in the public sector. Spare neighbouring DHB capacity should be used ahead of the private sector. Any suggestion to use publicly funded, privately provided delivery should be a short-term measure only.

DHB Accountability

39 Requirements for reporting and delivery to agreed volumes will be effected through Crown Funding Agreements with DHBs.

Consultation

40 This proposal has been developed in close collaboration with DHBs. Individual discussions have also been held with a number of DHB Chief Executives.

41 The following departments have been consulted on this proposal: Treasury, the Office of Disability Issues and the Department of the Prime Minister and Cabinet. Comments from those consulted have been incorporated into this memorandum.

Financial implications

42 The proposal is based upon a ten to eleven percent increase in the current (2005/06) number of elective caseweights (this will translate into approximately the same increase in the volume of elective procedures). Based on responses from DHBs, this level of increase is achievable. The cost of the initiative is:

Table 1: Cost of ten to eleven percent increase in elective services

Year $ millions	2006/07 (Nov – June)	2007/08	2008/09 & outyears
Proposed increase in volume of elective services	29.500	59.000	59.000
Monitoring costs	0.350	0.500	0.500
Total costs	**29.850**	**59.500**	**59.500**

43 I propose to fund the increased costs of this initiative from existing Vote Health baselines in 2006/07 and to allocate the outyear funding required from the Health allocation in Budget 2007.

Explanation of Costs

44 The collaborative approach used to assess sector capacity means it is reasonable to accept each DHB's assessment of the volumes they can deliver. DHBs have indicated they can deliver volumes to an annual cost of $59.000 million, leading to a total requirement of $59.500 million including other costs.

45 The majority of the cost of the initiative is in the provision of the additional volume of elective services. This includes:

- First Outpatient Assessments: this allows for the number of assessments required to achieve the additional volume of patients that proceed to surgery;
- Inpatient Episodes: this covers the anaesthetic pre-assessment clinic visit and the period from admission to discharge from the acute setting (including the costs of the operation);
- Follow-up Outpatient Visits: this reflects an estimated volume of follow-up visits for each surgical intervention.

46 Costs of the proposal also include monitoring costs. Experience with the Orthopaedic and Cataract Initiatives have demonstrated the need to maintain close oversight of DHB performance. Therefore, resources will be required within the Ministry of Health to administer the project, and to monitor both the agreed incremental volumes and each DHB's performance against other expectations. In addition, data collection and payment processes have to be established and maintained.

47 No allowance has been made for any capital requirements arising from the need to increase capacity. These will be met from within existing Vote Health baselines.

Treasury Comment

48 Treasury consider that Ministers have options for funding this proposal. We believe the Ministry of Health can fund the out-year costs from existing non-departmental baselines, by using existing risk provisions and by reprioritising low priority programmes as part of the current baseline assessment process managed by Families Young and Old theme Ministers.

49 This paper proposes to fund the out-year costs of increased elective services as a pre-commitment against the Budget 2007 health operating allocation. This would be in addition to the existing pre-commitment of $50 million, against an allocation of $750 million (Cab Min (06) 11/7(25) refers).

50 Pre-commitments reduce flexibility. A high level of pre-commitments limits the ability of the Minister of Health to manage emerging pressures within planned health allocations.

51 Funding within baselines is an option. A $45 million per annum risk reserve was established within Vote Health as part of Budget 2006 to fund emerging between-Budget pressures such as this. In addition the Vote holds a significant provision for funding DHB deficits. The Ministry asserts in their baseline assessment that they have been successful in substantively reducing DHB deficits. This means that it should be possible to reduce this provision and reprioritise the funding. If the reduced DHB deficit provision proves to be inadequate, it can be increased as future Budget allocation funding becomes available.

Ministry Comment

52 This proposal could commence from the 1 July 2007 once the 2007 Budget Package for Vote Health has been finalised. However, it is proposed to utilise some one-off funding held within existing Vote Health baselines in 2006/07 so the benefits of this proposal can be introduced earlier.

53 Cabinet has previously agreed an indicative Health allocation in Budget 2007 (Cab Min (06) 11/7(25) refers) and funding over and above this allocation will not be required to fund this proposal.

54 The current funding within Vote Health contains an ongoing funding stream from 2006/07 of $38 million which is insufficient to fund this proposal. It would be prudent to retain this to fund other pressures that may emerge during 2006/07.

55 Reducing the deficit provision in 2006/07 would not produce the ongoing funding stream required to fund additional elective services from 2007/08.

56 There is a level of uncertainty around the funding that may be required to fund deficits in the outyears and there is less funding in the provision to address this pressure. Given this uncertainty and that some flexibility is required in managing this risk it is not considered prudent to divert funds from the provision to fund additional elective services in the outyears.

Human rights

57 There are no Human Rights Act 1993 implications arising from this paper's proposal beyond those associated with the Government's existing elective services policy settings.

Legislative implications

58 There are no legislative implications arising from the proposal in this paper.

Gender implications

59 As the services where funding will be applied is not yet clear, it is not possible to determine whether more men or women will receive additional services. However, allocations will be based on clinical need and there are therefore no gender implications arising from this initiative.

Disability perspective

60 Depending on the areas funding is applied to, the proposal may reduce levels of impairment and the related experience of disability in particular groups within the community. In any case, ongoing disability caused by inability to access elective services will be reduced.

Regulatory impact and compliance cost statement

61 The proposal does not have any regulatory impacts or compliance costs for business.

Publicity

62 If the proposal is approved, I intend to issue a media release announcing it. Letters will also be sent to DHBs from the Ministry of Health to coincide with the announcement, confirming levels of funding and providing further details.

Recommendations

63 I recommend that the Committee:

1 **note** that patients face high treatment thresholds for a number of elective services and face significant disability and distress because of this

2 **note** that when this initiative is fully implemented, an additional 10–11% publicly funded elective procedures will be performed each year (approximately 10,000 procedures)

3 **note** that on 3 April 2006 Cabinet noted that indicative operating allocations of $750 million per annum have been agreed for Vote Health for Budgets 2007 and 2008

4 **note** that on 3 April 2006 Cabinet agreed that the Minister of Health may advance decisions that pre-commit the indicative allocations to a maximum of $50 million in 2007/08, $65 million in 2008/09, and $77 million per annum in 2009/10 and outyears against Vote Health (Cab Min (06) 11/7 (25) refers)

5 **note** that the Minister of Health has not as yet advanced any decisions that pre-commit the indicative allocations for Budgets 2007 and 2008

6 **note** that the proposed $29.85 million increase for elective services can be funded from within existing Vote Health baselines in 2006/07

7 **agree** that $59.5 million of the Budget 2007 Health operating allocation can be pre-committed in 2007/08 and outyears so the proposed increase in elective services can continue beyond 2006/07

8 **note** that, as part of the process for developing the Budget 2007 package of initiatives for Vote Health, officials from the Ministry of Health and Treasury will work together to review the management of pre-commitments and baselines to maximise the flexibility of the vote to fund emerging pressures within agreed Health allocations.

9 **direct** officials to report back to Cabinet by end May 2007 on progress towards the ten percent increase in electives at DHB level.

Hon Pete Hodgson
MINISTER OF HEALTH