Detailed Examination of Vote Health: Budget 2010 and Baseline Review

30 November 2009

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Executive Summary

Introduction

1. The Ministry of Health has carried out an examination of the priorities, pressures and existing and historical expenditure in Vote Health as part of the Budget 2010 process, as agreed by Cabinet on 2 November 2009. This report is being submitted by 30 November 2009 to allow Cabinet decisions on the final Budget 2010 operating allowance for Vote Health to be made and to enable a District Health Board (DHB) funding signal to be communicated to the sector in December for planning purposes.

2. There are a number of options for how pressures facing the health system can be managed within available funding in Budget 2010/11 and beyond based on tight cost control, efficiency and productivity savings and potentially a range of policy decisions to improve the ability of the sector to live within its means. The Ministry's review builds on the extensive work already undertaken including: In-depth spending reviews, Line-by-Line reviews of services purchased by the Ministry, the Living within Our Means report, Cabinet decisions on the Ministerial Review Group recommendations, Performance Improvement Actions presented to Expenditure Control Committee on 25 August 2009, Hospital Productivity work, as well as engagement with DHBs about actions that they can take collectively and individually to manage within a lower funding path in 2010/11 and beyond.

3. The work is based on the following parameters:

    a. cuts to frontline services will be the absolute last resort for managing pressures facing the Vote and all options for productivity gains must be exhausted before this is considered

    b. the deficit track for DHBs will be maintained as per the projections set out in DHB 2009/10 District Annual Plans (DAPs) and will not exceed the present forecast track of $89 million in 2010/11.

Reviews of previous expenditure and alignment with Government Priorities

4. Several previous reviews of Vote Health expenditure have identified opportunities for savings and considered where funding for lower value spend, or spend not aligned with Government priorities, can be reprioritised eg In-depth and Line-by-Line Reviews. The report also addresses the following points as per the Terms of Reference for this Baseline Review:

    a. detail how all increases to the Vote since 2005 have been applied and what value has been obtained from that expenditure

    b. demonstrate all areas of expenditure within the Vote have been reviewed and expenditure not aligned with the Government's priorities has been identified

    c. review the number of policy advisors and the cost of policy advice provided by the department and indicate whether some reduction in the cost can be made

    d. demonstrate that any fiscal savings expected as a result of the department implementing its performance improvement actions have been taken into account.

Managing Pressures facing Health in 2010

Pressures

5. Pressures facing Health in 2010 can be categorised at a high level as in Table 1 below.

Table 1: High level pressures facing Vote Health in 2010/11

Item	Indicative amount
DHB price and volume pressures	$403m (full FFT/Demo before productivity gains)
Price and volume pressures in services purchased by MoH	Up to $62m
Government commitments	Approximately $50m
Risk reserve	$0m
Indicative total pressures	**$515 million**[1]

6. DHB Future Funding Track (FFT) and Demographic (Demo) funding represents the top-down assessment of potential pressures for the sector. This reflects current arrangements where DHBs are expected to manage cost pressures within the scope of the funding adjustors. The Ministry's advice is that the pressures facing front line services that are currently purchased centrally by the Ministry are as real as those facing DHB purchased services and a 0% increase, on top of a reduced level of FFT/Demo in 2009/10, would have significant impacts on services, eg Disability Support Services, electives and screening programmes.

7. It should be also noted that $830 million in Ministry appropriations is passed on directly to DHBs for services such as electives and the Clinical Training Agency. A 0% increase to these areas would have flow on impacts to DHBs' funding. Approximately $30 million of the identified $62 million of pressures would be passed on directly to DHBs. Furthermore, $2.5 billion worth of Ministry expenditure is scheduled for devolution in 2010. Running down these services could create more pressures for DHBs when they take them on, in an already challenging environment.

Scenarios developed for allocating the additional $300 million

8. The indicative allocation for Vote Health in 2010 is $300 million. This needs to be allocated across DHB pressures, pressures in Ministry managed health and disability services and Government commitments. High-level allocation scenarios are set out in Table 2 below. These are somewhat stylised for the purposes of illustrating likely impacts – for example, Government commitments are set at approximately $50 million though the potential impact could change depending on final decisions.

[1] This does not include a $27 million projected improvement in DHB DAPs forecasts for 2010/11 which the Government would not expect to fund from the operating allocation but needs to be considered as part of the overall DHB financial position.

Table 2: Allocation Scenarios

Scenario One	Funding Impact $M			Scenario Two	Funding Impact $M			Scenario Three	Funding Impact $M		
	DHBs	**MoH**	**Govt comms**		**DHBs**	**MoH**	**Govt comms**		**DHBs**	**MoH**	**Govt comms**
Government commitments are the first call against the operating allowance.	250 (Demo 183/price pressures 67)	0	50	DHB Demo and price pressures are the only call against the operating allowance.	300 (Demo 183/price pressures 117)	0	0	First call: DHB Demo and national health and disability services funded by the Ministry – residual funding to offset known DHB price pressures.	At least 238 (Demo 183/price pressures at least 55)	Up to 62	0

Flow on impacts of these scenarios to DHB and other sector pressures

9. The Ministry has developed a financial forecasting model that is able to take the high-level scenarios above and calculate their likely impact in terms of an 'all-of-sector' shortfall (comprised of DHB forecast deficit tracks and the other shortfalls that may arise given a particular scenario). For example, assuming that DHBs will be able to deliver *[deleted – negotiate without prejudice]* worth of productivity gains in 2010/11, there would be a net shortfall across the system of *[deleted – negotiate without prejudice]* which will need to be met from a combination of reprioritisation, changes to policy settings and additional productivity gains. This would be on top of the productivity gains already assumed in the DHB sector.

10. The savings required across the system to maintain the present deficit forecast track will change depending on the scenario chosen for allocating the additional $300 million. Assuming a productivity gain of *[deleted – negotiate without prejudice]* by DHBs, in Scenario One the shortfall for DHBs would be around *[deleted – negotiate without prejudice]* and in Scenario Three around *[deleted – negotiate without prejudice]*. This represents the potential deficit risk above the current projected deficit level of *[deleted – negotiate without prejudice]*. However, there are significant trade offs to be considered in deciding which scenario to choose, particularly the impacts on front line services funded by the Ministry (including flow on impacts to DHBs) and the ability to fund Government priorities.

Options for managing the shortfall

11. The menu of options for managing the shortfall identified above include the following:

    a. manage down pressures, especially maintaining restraint on Industrial Relations (IR) settlements and scaling back Government commitments

    b. maintain a strong deficit management policy. *[information deleted in order to maintain the effective conduct of public affairs through the free and frank expression of opinions]*

    c. achieve significant ongoing productivity gains across the sector. The key issue facing Health in this Budget is the ability of the sector to make significant productivity gains in 2010/11 that are sufficient to manage to the current deficit track whilst avoiding service cuts

    d. make changes to high level policy settings eg changes to eligibility settings, tighter targeting of some services or providing greater flexibility to DHBs to manage pressures

e. other options for reprioritisation from lower value expenditure, changes to policy settings and further productivity gains in both DHBs and Ministry managed services.

Beyond 2010/11

12. The Ministry has considered measures to manage within a reduced funding path from 2011/12 onwards. This longer term focus and need for ongoing improvement suggests a shift of emphasis from short term "line by line" type approaches to more fundamental change to reorient and reconfigure the health system, more effective prioritisation of health resources and effective monitoring and accountability tools to maximise opportunities for value for money.

DHB Funding Package

13. A DHB Funding Package needs to be released as soon as possible to enable DHBs to finalise plans for 2010/11. Decisions are required about how the indicative allocation is to be distributed across the pressures in Vote Health outlined above, noting that there are risks and trade offs in each option in terms of deficit risk, impacts on front line services and ability to meet new Government commitments.

Section 1: Budget 2010 - Management of Vote Health

1.1 Introduction

14. The pressures facing Vote Health in 2010 are summarised in Table 3 below.

Table 3: High level pressures facing Vote Health

Item	Indicative amount
DHB price and volume pressures	$403m (Full FFT/Demo without productivity gains)
Price and volume pressures in national health and disability services purchased through Ministry NDE	Up to $62m
Government commitments	Approximately $50m
Risk reserve	$0m
Indicative total pressures	**Up to $515 million**[2]

15. It is useful to contrast these pressures against the top-down assessment of FFT/Demo across the entire Vote, particularly the funding that would have been allocated to manage health and disability services funded through Ministry-Non Departmental Expenditure (NDE).

Table 4: Full FFT/Demo for Vote Health (indicative 2010/11)

	FFT 2.27% ($M)	Demo 1.885% ($M)	Total ($M)
DHBs	220	183	403
Ministry-NDE	58	48	106
Total	278	231	509

16. The pressures are based on the following assessments:

    a. DHB price and volume pressures: $403 million equates to full FFT/Demo before any productivity gains by DHBs are considered. This reflects current arrangements where DHBs are expected to manage cost pressures from within the scope of the FFT/Demo funding adjustors. These estimates are used to drive the financial forecast model the Ministry has developed to help it consider the full impact of the 2010 Budget package across the sector

    b. health and disability services purchased through Ministry-NDE: this is a preliminary assessment of the price and volume pressures faced across the health and disability services funded by the Ministry. This is a bottom-up estimate rather than the more usual top down FFT/Demographic calculation. $30 million of this figure represents price and volume pressures on services delivered by DHBs but funded from Ministry-NDE appropriations. These service pressures on are on top of the $403 million noted above

    c. Government commitments: this figure is based on scaling the original $96 million of pressures outlined in earlier advice from the Ministry of Health to the Minister of Health [HR20091922 refers]. Officials have developed some options for a Government commitments package that could be funded from an envelope of around $50 million.

1.2 DHB Pressures

17. As noted earlier we are using full FFT/Demo to reflect the fact that DHBs are expected to manage their cost pressures from within the scope of the funding adjustors. The figure of $403 million excludes any pressures they will need to manage for health and disability services funded through the Ministry. It should also be noted that there is no formal expectation of productivity gains built into this number.

[2] This does not include a $27 million projected improvement in DHB DAPs forecasts for 2010/11 which the Government would not expect to fund from the operating allocation but needs to be considered as part of the overall DHB financial position.

18. The most significant risk facing the sector is Industrial Relations (IR) settlements which may not be able to be accommodated from the funding likely to be available to DHBs. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice].*

1.3 Pressures on national health and disability services funded through Ministry-managed NDE

19. In 2009/10, on behalf of the Government, the Ministry manages just over $2.5 billion of NDE across a range of health and disability services. $830 million (32%) of Ministry-managed NDE is used to purchase services from DHBs. A further $1.075 billion (41%) is used to purchase front-line services from other providers. The remaining $688 million (27%) is used to purchase services that support frontline service delivery, including health information and research contracts, provider and clinician support and development activities.

20. The Cabinet Terms of Reference for the detailed examination of Vote Health indicated that DHB-managed services and deficits are the key priorities in Budget 2010. This suggests national health and disability services purchased by the Ministry will receive significantly less than forecast FFT/Demo and potentially zero growth. Full FFT/Demo on Ministry-managed NDE would provide for an increase of $106 million to manage price and volume pressures in Budget 2010.

21. A preliminary estimate of the highest priority price and volume pressures in frontline services totals $62.4 million, which would enable services to continue to be delivered at current per capita levels. Further work will be done as part of finalising the Budget 2010 package and this figure may change.

22. $30 million of these cost pressures relate directly to the $830 million of services provided by DHBs but funded by the Ministry. Not funding these pressures would require DHBs to make additional efficiencies or risk an impact on service provision or deficits. More detail about the pressures in these services and the impacts of providing no additional funding to health and disability services funded by the Ministry can be found in Annex 1.

1.4 Government Priorities

23. Table 5 sets out Government priorities and commitments for Budget 2010. Scaling options have been provided that range from $40.22 to $55 million, with detail provided in Annex 2. For the purposes of the high-level fiscal scenarios we have approximated the cost of Government commitments to $50 million.

Table 5[3]: Government Priorities and Commitments for 2010

	Initiative ($millions)	2010/11	2011/12	2012/13	2013/14	Highest Out-year
Full Priorities Package	Boost Med School Places by 140	0.60	2.80	7.10	13.40	55.50
	Boost Medicines funding	20.00	20.00	20.00	20.00	20.00
	Well Child (full)	15.36	15.36	15.36	15.36	15.36
	Voluntary Bonding	0.00	5.13	1.37	1.09	0.00
	Whānau Ora	TBC	TBC	TBC	TBC	TBC
	Electives additional 4000 discharges (estimate only)	23.00	23.00	23.00	23.00	23.00
	Ministerial Review Group Initiatives	TBC	TBC	TBC	TBC	TBC
	Mental Health (P Action Plan and new unspecified initiatives)	20.00	20.00	20.00	20.00	20.00
	Bowel Cancer	1.20	3.80	3.80	3.80	0.00
	Full Priorities Package Total	**80.16**	**90.09**	**90.63**	**96.65**	**133.86**

1.5 Fiscal position of Vote Health relative to total Commitments and Pressures

24. At this time the indicative operating allowance for Vote Health is $300 million. Decisions need to be taken around how this funding is allocated with the key issues being:

    a. whether any funding is allocated to pressures facing the health and disability services funded through Ministry-NDE

    b. the extent to which Government commitments are scaled or funded through alternative sources, for example reprioritisation across the Ministry and DHB baselines.

25. Three high-level scenarios have been developed for the operating allocation to illustrate these tradeoffs. The scenarios are summarised in Table 6.

Table 6: Scenarios for allocating additional funding to Vote Health in 2010/11

Scenario One	Funding Impact $M			Scenario Two	Funding Impact $M			Scenario Three	Funding Impact $M		
	DHBs	MoH	Govt comms		DHBs	MoH	Govt comms		DHBs	MoH	Govt comms
Government commitments are the first call against the operating allowance.	250 (Demo 183/price pressures 67)	0	50	DHB Demo and price pressures are the only call against the operating allowance.	300 (Demo 183/price pressures 117)	0	0	First call: DHB Demo and national health and disability services funded by the Ministry – residual funding to offset known DHB price pressures.	At least 238 (Demo 183/price pressures at least 55)	Up to 62	0

26. There are risks and tradeoffs associated with all three options above. Key risks are:

    a. not providing any funding for health and disability services funded by the Ministry will place real pressures on key frontline services such as Disability Support Services and also pass on further funding pressures to DHBs

[3] Shaded initiatives indicate those initiatives that are the Government's highest priority, as signalled to officials during recent discussions.

b. the trade-offs to be made around the costs of Government commitments versus other cost pressures in the system. For example, more funding for Government commitments increases the risks of DHB deficits which can only be managed against additional productivity gains from DHBs or not allocating funding to other health and disability services that are managed by the Ministry.

27. Taking this analysis further, the Ministry has also used a financial forecast model to quantify at a high-level the fiscal impact of each of the scenarios in terms of their flow-on to the overall shortfall the sector faces for Budget 2010. This is for illustrative purposes only as the sensitivity of the scenarios to key variables (for example, the ability of DHBs to deliver productivity gains for 2010/11) is significant. This analysis is summarised in Table 7.

Table 7: Estimate impact of scenario options

Sources of Funds to Deliver Government Priorities, Meet Cost Pressures & DAP Forecast $ millions	**Scenario 1**	**Scenario 2**	**Scenario 3**
Indicative Vote Health Allocation			
Government Priorities	50	0	0
DHBs			
- Demographics	183	183	183
- Price Pressures	67	117	55
- Total DHBs	250	300	238
Ministry-managed NDE	0	0	62
Total Indicative Vote Health Allocation	300	300	300
plus			
[deleted - negotiate without prejudice]	*[deleted]*	*[deleted]*	*[deleted]*
plus			
Savings required from Service Priortisation and/or Policy Changes (balancing item)			
- to fund Government Priorities	0	50	50
- to achieve current DAP forecast in 2010/11 [1]	**40**	**-10**	**52**
- to achieve balanced NDE budget	62	62	0
Total Savings Required from Service Prioritisation and/or Policy Changes	102	102	102
equals			
Total Sources of Funds to Deliver Government Priorities, Meet Cost Pressures & DAP Forecast	542	542	542

28. It is important to note that the scenarios above include an estimated figure of *[deleted – negotiate without prejudice]* of DHB productivity gains for Budget 2010. DHB productivity is the key variable in the modelling work and drives many of the key outputs such as the overall sector funding shortfall.

29. An increasing focus on productivity/performance improvement gains across DHBs will be needed to support delivery of maximum value for money. It is expected that the improved service and capacity planning and shared-support services capability currently being established across the sector will support this need. Continuing current DHB efforts on tightening cost control, seeking technical productivity gains, progressing service prioritisation; as well as ensuring appropriate policy settings, providing active performance improvement assistance and focused monitoring from the centre will also be necessary.

30. Other points to note in considering Table 7 are:

a. the *[deleted – negotiate without prejudice]* figure is based on discussions with DHBs and the Ministry's assessment of what a reasonable level of productivity gains for Budget 2010 might be (this is an implied efficiency adjustor of approximately *[deleted – negotiate without prejudice]*).

b. it is difficult to itemise the individual items that make up the *[deleted – negotiate without prejudice]* as they reflect a mix of productivity, efficiency and reprioritisation decisions that will be specific to individual providers

c. for each scenario set out below, additional gains are required across the sector on top of the *[deleted – negotiate without prejudice]* of DHB pressures to ensure deficit positions are maintained at their forecast tracks, as well as to offset other pressures such as national health and disability services funded through the Ministry.

31. The key figures in Table 7 are the additional savings required by DHBs to achieve their current DAP forecast in 2010/11 for each scenario, ie Scenario One *[deleted – negotiate without prejudice]* and Scenario Three *[deleted – negotiate without prejudice]*. This is the implied deficit increase and/or potential service cut if other options for savings are not taken, eg achieving further productivity gains, policy changes or reprioritisation. For Scenario Two DHB productivity gains of *[deleted – negotiate without prejudice]* will be sufficient to manage within the expected forecast deficit track but the Vote would face a shortfall to fund Government commitments and pressures on national health and disability services.

1.6 Managing the Funding Gap

32. The extent to which DHBs can generate efficiency and productivity gains to manage within the current deficit track, and to ensure no service cuts are required, is critical to ensuring the sustainable management of health expenditure.

33. None of the above funding scenarios provide for any maintenance of an in-year Risk Reserve or additional deficit support. The Ministry does not recommend that additional funding is set aside to manage deficit support. Not maintaining an in-year Risk Reserve would require alternative sources of funding to manage unexpected pressures that may emerge during 2010/11 (potentially including in-year reprioritisation within the Vote) and the confirmation of ongoing arrangements to utilise any under-spends that may emerge in future.

34. Underlying pressures, such as industrial relations settlements and ongoing price pressures, can and will be managed in 2009/10, but the extent to which these pressures can continue to be restrained for future Budgets is less clear. To maintain a sustainable track in Budget 2010 and beyond will require:

    a. an ongoing focus on achieving productivity and efficiency gains across the sector, including the achievement of key Performance Improvement Actions for the Vote

    b. continuing to improve performance information so that better decisions can be made about reprioritising resource from lower-value spend in the Health system

    c. capping or reducing the proportion of spend allocated to any new initiatives for future Budgets.

1.7 Menu of Options for Achieving Savings to Address the Funding Gap

35. Depending on the funding scenario that is chosen, further gains need to be achieved to both maintain the current forecast DHB deficit track, as well as funding other pressures across the Vote (Government commitments and pressures facing national health and disability services funded through Ministry-NDE). Annex 3 provides more details on potential savings options.

36. Table 8 summarises the menu of options for the funding gap, combining a mix of managing down pressures (especially IR settlements and Government commitments) a strong deficit management strategy, DHB productivity and a variety of options for reprioritisation, productivity and policy setting changes.

Table 8: Menu of options to manage shortfall across Vote Health for Budget 2010

Scale Government Commitments

> Government commitments for Budget 2010 were originally costed at $96 million.

> Commitments can be scaled back to as little as $40.22 million.

>The table sets out examples of potential scaling options based on the highest outyear impact. The text in blue indicates the highest priority initiatives as indicated to officials in recent discussions.

Initiative	Low cost package	High cost package
Med School Places	8.72	8.72
Boost Medicines	20	20
Well Child	0	2.1
Voluntary Bonding	0 (underspends)	0 (underspends)
Electives	11.5	11.5
Whanau Ora	TBC	TBC
MRG Response	TBC	TBC
Mental Health	0	10.98
Bowel Cancer	0 (trial only)	0 (trial only)
TOTAL	40.22	53.3

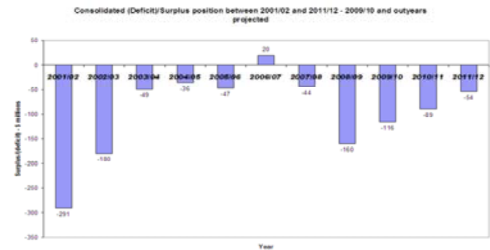
1

Deficit Management

> [deleted - negotiate without prejudice]

> [deleted - negotiate without prejudice]

> DHBs should continue to be expected to manage to the existing forecast track for deficits as set out in the chart below ($89.0 million for 2010/11).



Nb: deficits include structural and cyclical deficits. Government does not fund cyclical deficits and addresses structural deficits on the basis of cash needs with the expectations of performance improvements made by individual DHBs ie the full structural deficits are generally not fully funded. 08/09 figures provisional.

2

Industrial Relations

> IR costs are the single biggest risk facing the sector in terms of its ability to manage within a lowered funding growth path for Budget 2010 and beyond.

> [deleted - negotiate without prejudice]

> [deleted - negotiate without prejudice]

> [deleted - negotiate without prejudice]

3

Consider major policy changes – whole of system or large programmes

> The table sets out significant policy changes with indicative savings of around $100-200 million.

Policy Change Option	Indicative Potential Saving ($M) 2010/11	Outyears
Primary care		
Increase co-payments by reducing the capitation subsidy	12.3	12.3+
Allow VLCA fees to rise.	1.2-4	1.2-4+
Restrict eligibility to VLCA.	Up to 17	Up to 17+
Replace VLCA with individually-targeted subsidies.	Up to 9.4	Up to 9.4+
Remove Care Plus	46.2	53.0
Change payment formula for Care Plus	0.3	0.3
Remove all Management Fees	33.5	33.5
Change the way Management Fee levels are calculated.	6.7-13.3	6.7-13.3
Aged residential care		
Freeze asset threshold at current level of $190,000	0	2.2-36.9 over 10 years (rising profile)
Change current asset threshold to $100,000	0	37.5-45 over 4 years (rising profile)
Change current asset threshold to $50,000	0	50-60 over 4 years (rising profile)
Remove automatic matching of price uplift to ARC providers	TBC	TBC
Labs and Pharmaceuticals		
Increase co-payments on pharmaceuticals. Each $1 increase in co-payment would increase revenue by approximately $4 million	4+	4+
Remove subsidy on prescriptions for a range of pharmaceuticals that can be purchased over the counter	Up to 58	Up to 58
Remove subsidy for privately-referred lab tests	10-16	10-16

4

District Health Board productivity and reprioritisation

> [deleted - negotiate without prejudice]

> [deleted - negotiate without prejudice]

> It is difficult to itemise the types of initiatives that will lead to these gains as they are specific to individual DHBs. Initiatives set out in the Productivity Pathway will be critical to this

> Ongoing productivity and efficiency improvements from DHBs remain the key to managing cost pressures in the Health sector.

5

Managing Ministry-NDE (policy, reprioritisation and productivity options)

> The Ministry has conducted a series of NDE Indepth Reviews to identify productivity, policy and reprioritisation options to free up resources for Budget 2010 and beyond.

> These reviews have focussed on major service areas funded through NDE appropriations – Maternity, Mental Health, Disability Support and Public Health. Decisions are required to determine the savings quantum that can be applied for Budget 2010.

> In addition a second Line-by-Line Review has reviewed all other areas of Ministry-NDE not covered by the indepth review. Other savings identified for the baseline review are also included. Total potential savings for Budget 2010 from all these initiatives is $87.6 million.

> The Ministry is also working up options to manage the estimated $62 million of price and volume pressures facing health and disability services funded through Ministry-NDE.

Initiative	Low Risk	Med Risk	Total
Maternity	13.3	14.4	27.7
Mental Health	4.4	2.9	7.3
Disability	1.3	3.9	5.2
Public Health	13.6	10.8	24.4
Other Pub Health			14.52
Line by Line 2			8.504

6

1.8 Managing Beyond Budget 2010 – Longer Term System Changes

37. The advice provided in this submission focuses primarily on managing within the funding available in Budget 2010/11. However, the Ministry has also considered measures to manage within a reduced funding path from 2011/12 onwards. This longer term focus and need for ongoing improvement suggests a shift of emphasis from short term "line by line" type approaches to more fundamental change to reorient and reconfigure the health system, more effective prioritisation of health resources and effective monitoring and accountability tools to maximise opportunities for value for money.

38. A broad approach to this longer term focus was set out in Living within our Means [HR20091181] and, more recently, has been reflected in the Ministry's Performance Improvement Actions and decisions made by Cabinet following the Ministerial Review Group report.

39. Additionally, DHBs will need ongoing flexibility to ensure they can manage services as required, relative to the best value that can be achieved from health spending and the pressures they face in terms of price and volume changes. In this regard it will be important to ensure that the ability to "flex" within the system is maintained. For example, this will mean not constraining the ability of DHBs to change their service-mix and to manage prices.

1.8.1 The Ministerial Review Group

40. The Government has already accepted and started implementing several of the Ministerial Review Group recommendations:

    a. Establishing a National Health Board (NHB) as a unit within the Ministry of Health to provide more focused national supervision of the $9.7 billion spend on hospital and primary health services.

    b. Creating a Shared Services Establishment Board (SSEB) to begin consolidation of administrative functions, such as payroll and purchasing, currently spread across 21 DHBs and regional shared agencies.

    c. Strengthening regional cooperation in service planning and delivery (which will require legislation).

    d. Devolving programmes currently managed by the Ministry of Health (up to $2.5 billion), where appropriate, to DHBs.

41. These decisions will result in greater coordination of DHBs and stronger planning decisions in relation to infrastructure, especially information technology, workforce and capital.

1.8.2 Vote Health Management Arrangements

42. The Ministry would also recommend that an effective set of Vote management tools designed to maintain stability, fiscal control and a longer term planning focus is an essential component of any suite of measures. The Health system has had long-standing Vote management arrangements including:

    a. an allocation within which all pressures must be managed, including a two year indicative outyear allocation

    b. annual adjustments for price and volume pressures, including an efficiency adjustor

    c. Risk Reserves held within the Vote

    d. arrangements to access under-spends and re-allocate them across financial years

    e. deficit support mechanisms for DHBs.

43. The Vote Health arrangements enable Ministers to maintain fiscal control of the Vote. They enable the Health sector to focus on long-term planning through funding certainty, to be flexible in its service responses and to self-manage within agreed funding constraints. The arrangements also ensure that Ministers and/or the Cabinet do not have to make numerous low-level decisions on priorities and risks that could be managed more efficiently by the sector.

44. The system also needs flexibility in reallocating resources, often to respond quickly to unexpected events, e.g. the recent pandemic response. Service volumes can also fluctuate unexpectedly and the absence of mechanisms such as the Risk Reserve to manage these fluctuations would require service volumes to be lowered, potentially through service or coverage cuts or frequent funding bids to Cabinet.

45. Finally, Budget 2010/11 is the first Budget in some years where there has been insufficient new funding to provide for the automatic adjustors (even with a reasonably significant efficiency adjustor) or a risk reserve. This represents a shift in approach to the management of Vote Health that requires further discussion between Ministers about the right set of tools to manage Vote Health in the future.

1.9 DHB Funding Package

46. Following confirmation of how the operating funding will be allocated for the Vote and subsequent Cabinet approval, the next step will be to release the DHB Funding Package in December to allow DHBs to finalise planning for their 2010/11 District Annual Plans.

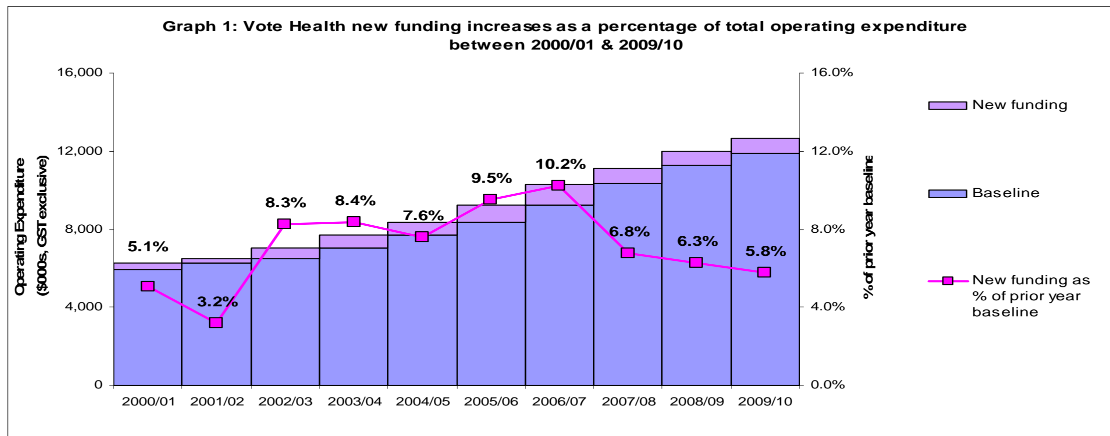
47. In order to provide a planning package overall revenue and the split between Demographic, Forecast Funding Track and new initiatives need to be known. The relative proportions impact on the implementation of population based funding.

48. If funding advice is not given to DHBs prior to Christmas there would be a reduced ability for DHBs to plan and implement initiatives to reduce expenditure. It would also increase the likelihood that Ministry-NDE (and the health and disability services funded through these appropriations) would be used to compensate for the DHB sector, if they do not have sufficient time to plan for the gains required over 2010/11.

Section 2: Vote Health Increases Since Budget 2005

2.1 Overall Operating Increases

49. Graph 1 shows that Vote Health operating expenditure, departmental and non-departmental, has increased to $12.6 billion for 2009/10 and outyears, representing around 20% of all government expenditure. Vote Health has been growing by an average of 7.7% per year since 2000/01. However, there has been a recent real decline in growth rate, with growth between Budget 2008 and Budget 2009 being 5.8%.

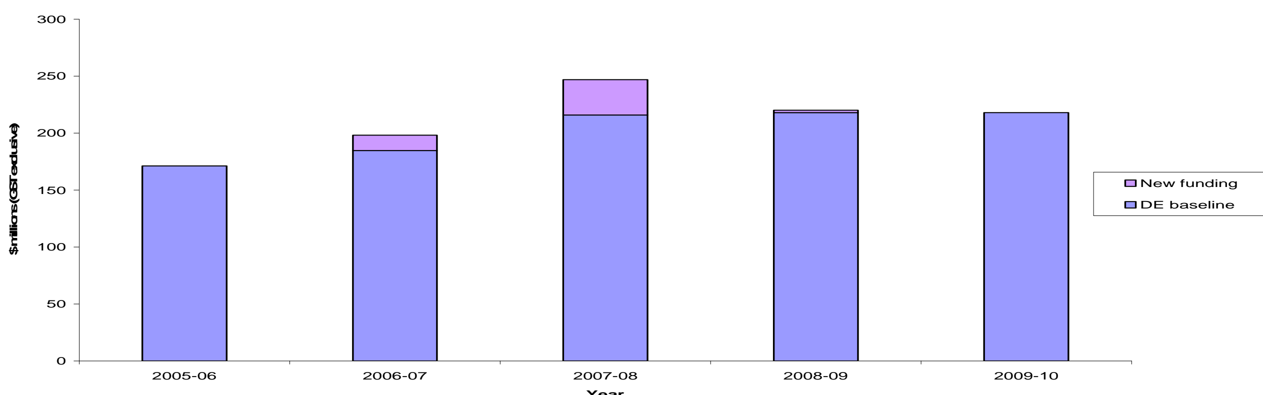


50. Annex 4 details the allocations of additional Vote Health funding since Budget 2005, grouped into high level service areas. Except for primary care and mental health blue print funding, this excludes increases in funding based on decisions made in Budgets earlier than 2005.

51. Annex 5 describes the key components of the increases detailed in Annex 4 and the value obtained from the cumulative additional funding up to 2009/10 within the different service areas. Ongoing savings that have already been realised are also noted.

2.2 Departmental Expenditure

52. Vote Health Departmental Expenditure (DE) increased between 2006/07 to 2007/08[4] to deliver on a number of Government priorities including Information Technology initiatives ($21 million), rollout of the Human Papillomavirus (HPV) vaccine ($2 million), and Antenatal Downs Syndrome screening ($2 million). Some of these priorities have since been revisited and the Ministry has reviewed its staff and other resources to deliver savings of $18 million in 2008/09 and $8 million in 2009/10. The Ministry has also committed to living within a 0% DE funding path over the next three to five years. Graph 2 shows DE expenditure has been falling since 2007/08.



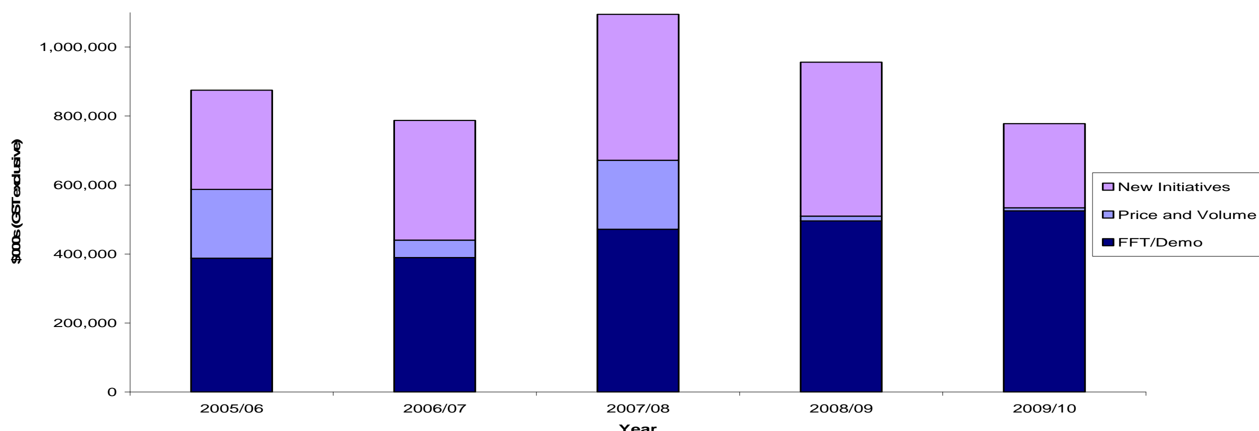
2.3 Non-Departmental Expenditure

53. Graph 3 shows new funding increases to Vote Health NDE appropriations between 2005/06 and 2009/10 split by FFT/Demo, additional price and volume funding, and new initiatives. Between 2005/06 and 2009/10 FFT Demo has on average taken up 51% of new funding while

[4] The most significant change in DE in 2007/08 was an NDE to DE transfer to progress the development of Integrated Data Management Systems.

additional price and volume funding and funding for new initiatives on average have taken up 10% and 39% of new funding respectively.

Graph 3: New funding increases to Vote Health between 2005/06 and 2009/10 split by FFT/Demo, Other Price and Volume funding, and New Initiatives



2.3.1 Future Funding Track/Demographic Funding

54. The FFT/Demo adjustors are a mechanism to automatically increase health sector funding annually to ensure that per capita service coverage and quality is maintained. The provision of FFT/Demo is not intended to increase the scope of existing services.

55. In terms of outputs, FFT/Demo ensures maintenance of existing standards across a greater number of people at a higher price, enabling the quantity and quality of health services to keep pace with price and demographic (volume) changes. The total increase for FFT/Demo over the years 2005/06 to 2009/10 was $2.27 billion.

56. As these adjustors have been automatic, reasonably predictable and transparent, their application avoids the risk of large year-on-year funding fluctuations. In the past, such fluctuations have been associated with unstable services and large deficit blow outs and subsequent large injections of funding from government. FFT/Demo are designed to smooth the funding path in Vote Health and enable the sector to plan service delivery with some certainty of funding, be flexible in service responses and to control costs by self-managing within an agreed funding constraint. There would also be a risk of greater variability in the standard of front line services provided from one year to the next and between providers.

57. Table 9 shows that overall actual volume growth in the DHB sector is estimated to have been in line with funded volume growth. Funded cost growth is estimated to have been in line with wage and Consumer Price Index (CPI) movements.

Table 9: Comparison between DHB cost and volume funding and pressure 2005/06 to 2008/09

	Funding (average annual % increase)	**Pressure (average annual % increase)**
Volume	1.78%	Approx 2.0%
Cost	FFT 3.09% Additional costs 1.34% Net change in deficits 0.35% **Total 4.78%**	Increased employment costs (staff numbers and wage increases) 5.55% CPI 2.97% **Total 4.64%** [calculated on the basis of 65% employment costs and 35% wage increases]
Total	6.56%	6.64%

Section 3: Vote Health Expenditure Reviews

58. Since November 2008 the Ministry has undertaken several reviews of areas of expenditure within Vote Health to identify any spending that is not consistent with the Government's priorities. These include:

    a. Line-by-Line review of Ministry DE and NDE funding in January/February 2009 with further opportunities for additional efficiencies being identified

    b. In-depth spending reviews of Ministry NDE funding for Maternity, Disability Support Services, Mental Health, and Public Health Services

    c. a range of programme specific reviews

    d. specific line by line reviews by individual DHBs to reduce inefficiency and ensure alignment with Government Health Targets.

59. In addition, the MRG covered provided information on the alignment of the health sector with Government priorities. They identified major areas for change to improve value for money in the health system. Many of these are already underway, including establishing a NHB, creating a SSEB, and strengthening regional cooperation in service planning and delivery.

60. The Living Within our Means (LWOM) Health Report also provided advice on how the health sector could live within a tighter funding path over the next 3-5 years [HR20091181 refers].

61. Annex 3 provides more details on the expenditure reviews with current potential options for savings. Annex 6 provides more detail on the other reviews.

Section 4: Ministry Of Health Policy Advisor Numbers and Costs

62. Table 10 demonstrates the trend for Policy Advisor numbers and costs over the period 2003-2009. Policy Advisor numbers for 2005-2009 are Full Time Equivalents (FTEs), however prior to 2005 only headcount figures were recorded.

Table 10: Policy advisor trends

Year Ended	Policy Advisor Numbers	Annual Percentage Change	Total Gross Pay ($M - salary paid employees only	Annual percentage change	% of Total DE budget
2003	265*		13.16		7.9%
2004	292*	10.2%	16.37	24.4%	9.7%
2005	297.1 FTE	1.7%	18.56	13.3%	10.9%
2006	299.1 FTE	0.7%	18.86	1.6%	12.6%
2007	308.8 FTE	3.2%	20.10	6.6%	12.8%
2008	314.6 FTE	1.9%	21.91	9.0%	10.7%
2009	303.6 FTE	-3.5%	23.18	5.8%	10.2%

* Headcounts only

63. The above policy advisor figures are a combined total of the different types of roles that contribute to giving policy advice. They include pure policy advice roles, professional leaders (such as Chief Advisors) and analysts, who may be subject matter experts and contribute to policy advice but who are not dedicated to it. They also include Policy Managers who lead policy teams and therefore contribute to policy advice. The data excludes contractors and secondees acting in permanent positions and is consistent with State Services Commission Human Resource Capability data using Australia & New Zealand Standard Classification of Occupations coding. It is consistent with data supplied for the Select Committee Review of the Ministry's expenditure for 2008/09.

64. Further detailed analysis of the 2009 data shows that 186.4 policy advisor FTEs are either dedicated to giving policy advice or contribute to it. The other 117.2 FTEs operationalise policy or provide other support, e.g. collect and analyse health sector information.

65. Policy Advisor numbers have been reducing since 2008 and are expected to decline further. Salary costs have been increasing at a higher rate than FTE changes due to reasons including market competitiveness and staff turnover.

66. The Ministry's staffing profile was considered by the MRG and decisions have been made that will ensure further reductions in Ministry staffing levels. The Director-General of Health has advised Cabinet that establishing a National Health Board Business Unit within the Ministry of Health can realistically deliver an establishment level of 1,290 FTE by 30 June 2011, a reduction of 185 FTE from the current FTE cap of 1,475.

67. Annex 7 provides more details on the Ministry's total FTE pathway since 2003 and information on the quantity of policy advice provided from 2003-2008.

Section 5: Performance Improvement Actions

68. The Ministry's Performance Improvement Actions (PIAs) are designed to achieve focussed delivery on government policy priorities and to achieve maximum value for money within the Vote Health baseline. The Director General of Health presented a paper to the Economic Cabinet Committee (ECC) on the 25 August 2009 that outlined the Ministry's proposed performance improvement actions to achieve focussed delivery on government policy priorities and to achieve maximum value for money within the Vote Health baseline.

69. Annex 8 sets out the 12 PIA objectives reported to ECC, what has been achieved to date and further work underway. Actual and potential savings from PIA objectives have directly contributed to the development of Budget 2010 advice earlier in this report.

Annex 1: Preliminary Forecast Pressures in Health and Disability services funded by the Ministry of Health in 2010/11

Service	Overview of service area	2009/10 Budget ($millions)	Price	Quantity	Funding required in 2010/11 & outyears	Consequences of no funding increase in 2010/11
Residential Services for people with Intellectual Disabilities	Residential services provided to people primarily aged under 65 with intellectual disabilities (excluding high and complex eg IDCC&R clients). The Ministry continues to fund these services after a person turns 65 until they are assessed as having an age-related disability. In residential services, the provider supplies accommodation and supports. DHBs fund similar residential services for clients over 65 with age-related disabilities and mental health conditions. Services purchased by DHBs have labour markets and some providers in common with Ministry DSS. Variances in prices paid by DHBs and the Ministry for similar services can affect the sustainability of services particularly in terms of workforce recruitment, retention and quality.	**358.000**	1% price adjustment to provider contracts in 2010/11 with additional funding *[information deleted in order to enable the Crown to negotiate without prejudice]*	Forecast demand of 1% pa of lower than in other services although there is a waitlist for these services totalling approximately $8m. People with intellectual disability living longer than previously is a factor explaining cost growth as need complexity increases with age. Analysis undertaken indicates that the proportion of high needs clients has increased by 54% between 2006 and 2009.	**8.160**	● Some providers will review/exit services including providing services for high cost clients ● It may not be possible to find alternative placements for these clients leading to client or community safety issues ●Industrial action if providers are unable to fund wage pressures ● Increase in current waitlist for residential services potentially resulting in more costly home based support services being required to meet client needs and/ or reductions in standards for clients
Young Persons with Physical and Sensory Disability Residential and Hospital Services	Residential services provided to approximately 726 clients with physical disabilities in community residential, hospital or aged residential care facilities.	**39.000**	YPD services are primarily purchased from aged residential care facilities (rest homes and dementia units), with lower numbers of people in community residential and hospital-based services. On average DSS purchases these services at a lower price than DHBs although there is regional variation. Initial estimates show that: Resthomes - DHB rate higher by 0.95% Dementia - DHB rate higher by 2.25% Hospital - DHB rate higher by 2.12%	Forecast demand is 1% lower than in other services. However, increasing complexity of clients' needs as they age may account for some demographic change pressure on cost growth.	**1.268**	● Exacerbate price relativities between the Ministry and DHBs risking some providers exiting these services or refusing to accept Ministry funded clients
Respite Care	Respite Care is a residential based service for clients with disabilities who have high support needs and require 24 hour care and supervision. Respite care is provided to clients to provide a break to caregivers so that clients can remain in the community rather than residing for a long period of time in community residential care facilities at greater cost to the Government.	**18.300**	Price increase of 2.25%. Service has not received price increase for several years.	Forecast demand pressures of 2%.	**0.778**	● Some residential service providers have signalled they may exit services if prices are not increased ● This will adversely affect the ability of some care givers supporting people with disabilities in their homes ● Potential for greater downstream costs for the Government e.g. if additional HCSS or residential services are required
Home & Community Support Services	Services provided to disabled people with generally low to medium level needs to enable them to live independently in the community rather than in Community Residential Care. Services include Household Management (general upkeep around the home) and Personal Care services (eg showering). Household management is subject to income and asset testing, while Personal Care is not.	**106.500**	Price growth in HCSS was significant between 2005 and 2008 although prices were held constant in 2009/10. Many workers in this service area are on the minimum wage or just above it with only a small proportion of nurses (5%). Any change in the minimum wage will place pressure on service providers if additional funding is not provided. For example a 5% increase in the minimum wage is estimated to increase costs by $2.8m per annum. Additionally, any funding increases for similar services purchased by DHBs and ACC will affect DSS's ability to maintain service coverage as providers may switch to providing services to higher paying funders.	The Ministry expects to be able to hold volume increases to 6%. This compares with 14% growth in HCSS services in 2008/09 and more than 10% growth in the first three months of 2009/10. Volume increases are driven by drive of a focus on providing care in the community, ageing disability population, Personal Care increasing more rapidly than Household Management following the introduction of more flexible service specifications, and the creation of waiting lists for Resdiential Care services. Personal Care client numbers are forecast to increase from 5456 in 2008/09 to 6130 in 2010/11. The average funded package is expected to increase from 8.87 hours per week to 9.22 hours per week.	**7.455**	● No funding increase is likely to exacerbate already high staff turn-over in the sector ● If the minimum wage is raised this will likely adversely affect the viability of some providers if they cannot make sufficient efficiency gains to manage the resulting increase in wages ● If price increases are not funded then service quality may be impacted, service costs may increase (such as rural services), and there is an increased risk of some form of industrial action ● If funding for volume pressures is not provided, NASCs and the Ministry will have to reassess low to medium need client service packages either reducing weekly hours of support provided or removing support entirely ● If other funders of similar services (DHBs, ACC) increase prices, this may lead to providers delivering services to other clients in preference to Ministry funded clients
Carer support	Carer support is a subsidy funded by the Ministry of Health to assist the unpaid, full-time carer of a disabled person to take a break from caring for that person. Carer support service enables low and medium need clients to live in the community at a relatively low cost by supporting their informal carers.	**30.000**	Subsidy increase of 1%. Service has not received a subsidy increase for several years. The average carer support package is $2,500 per annum.	Forecast demand pressure of 2%.	**0.900**	● If demand growth in this service is not funded it is likely that many of these clients will require more expensive disability services to enable them to live safely in the community ● If subsidy rate is not adjusted there will be less incentive for carers to support disabled people in their homes resulting further demand growth for other DSS

Service	Overview of service area	2009/10 Budget ($millions)	Price	Quantity	Funding required in 2010/11 & outyears	Consequences of no funding increase in 2010/11
Supported Independent Living	Supported independent living (SIL) provides individualised support necessary for people with higher and more complex needs to enable them to continue living in the community and meet their goals rather than having to enter residential care. Supports are configured to match changes in service users needs. Supported living services goals are to assist the person to take command of his/her life while building critical and durable relationships and networks. SIL is identified as a key area of focus in the Government policy on DSS.	**33.000**	1%. This service did not get any price increase in 2009/10. No price increase in 2010/11, is likely to impact on service quality as providers struggle to absorb inflationary cost increases. The 1% would be used on a provider by provider basis to address sustainability in areas in which service gaps are likely to eventuate (such as rural areas).	The Ministry expects to be able to manage volume pressures if funding allows for 6% growth in volumes. This contrasts with volume growth of more than 13% per annum since 2006/07. The policy direction of supporting people in the community as opposed to more expensive and restrictive residential care services is a significant contributor to growth in this service. SIL clients are forecast to increase from 1875 in 2008/09 to 2100 in 2010/11.	**2.310**	● Progress on Government priorities will be compromised ● Higher thresholds for receiving support would need to be implemented for any new clients ● Service quality may be impacted with service gaps eventuating in areas where the service costs are greater (such as rural areas) ● Providers may be unable to fund any wage increases resulting in some form of industrial action
Environmental Support Services	Environmental Support Services are a range of services funded by the Ministry of Health including: Equipment and Modifications Service (EMS) to assist with daily living, Hearing Services (eg Hearing Aid Subsidy), Vision Services (eg Children's Spectacle Subsidy) and Specialised Assessment Services.	**107.000**	1%. No price increase will force providers to reduce the quality of services delivered to live within the contract amount. A significant proportion of the equipment is imported from overseas and currency fluctuations and rising freight costs are key drivers of increasing equipment costs.	Demand pressures on ESS are forecast at 4% for 2010/11 assuming budget management initiatives advised to the Minister of Health are taken. ESS waitlist at the beginning of October 2009 was $16.6m. The waitlist is forecast to grow to between $25m and $30m by 30 June 2010 unless budget management initatives are put in place to partly offset this demand growth.	**5.350**	● Waitlist will increase significantly more than forecast ● Clients that have been assessed as requiring ESS will not be able to access them in a timely fashion
High and Complex	The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, which came into force on 1 September 2004, provides services to people with intellectual disability who offend. Funding also covers services for the intellectually disabled population with high and complex needs some of whom could potentially be subject to the Act.	**83.000**	1.00%	Funding was appropriated during Budget 2009 to manage volume pressures.	**0.830**	● High and complex services share common providers with mainstream disability services ● Giving an increase to mainstream providers and not to High and complex service providers will be difficult to justify. ● Service quality may be impacted ● Providers may also be unable manage wage pressures for this low paid workforce if the minimum wage is increased ● Risk of industrial action
NASC Management	NASC organisations are contracted to the Ministry of Health to identify disabled people's support needs. They provide options for allocating Ministry-funded support services and assist with accessing other supports.	**17.700**	1.00%	No volume pressure.	**0.177**	● NASCs play a vital role of assessing the needs and coordinating the delivery of services to eligible clients ● Their capability and capacity to enable efficient management of disability funding resources may be impacted
Crown Funding Agreements with DHBs	These are a range of disability support services provided by DHBs, including: Assessment Treatment and Rehabilitation services, Speech therapy, Social work, Occupational therapy, Child development etc.	**55.000**	1.00%	No volume pressure.	**0.550**	● DHBs are unlikely to sign the CFA agreements if no funding increases are given
Other services	These are a range of community based services provided to eligible clients with a disability. These services include: Rehabilitation services, Head injury services, Child development services, Specialist support services and Disability information and advisory services.	**86.200**	1%. Some of these providers have not had price increases for two to three years.	No volume pressure.	**0.862**	● Providers may be unable to manage wage pressures resulting in industrial action and/or provider viability will be threatened

Service	Overview of service area	2009/10 Budget ($millions)	Price	Quantity	Funding required in 2010/11 & outyears	Consequences of no funding increase in 2010/11
Electives Initiatives	Ministry-managed funding paid to DHBs to achieve Government electives targets including access to specialist assessments and diagnostics. Funding pressures dependent on Government targets, discharges delivered by DHBs, and price adjustments for hospital based services negotiated through the National Pricing Programme.	**198.000**	DHBs have planned to deliver 131,717 electives discharges in 2009/10. Maintaining this level in 2010/11 is estimated to require an additional $7.8m on top of the current planned expenditure of $198.4m (ie $206.2m), due to potential prices increases in the National Pricing Programme (averaged 7.6% over recent years).	This funding is to maintain quantity purchased in 2009/10. Funding of this level ($206.2 m) will deliver only a very small number (400) of additional discharges. Advice on funding required to meet the Government's elective target is provided under "meeting your priorities".	**7.800**	● Highly unlikely DHBs will be able to maintain 2009/10 elective volume discharges without finding further savings/producitivty improvements on top of those already identified to manage within their current deficit track ● The ability of DHBs to achieve the same volume of activity with less revenue will impact on achievement of the Government's electives target of an additional 4000 discharges on av pa
Section 88 services	The Primary Maternity Services Notice 2007 (or the 'Section 88 Notice') funds antenatal and postnatal care for up to six weeks after birth, and Lead Maternity Carers (LMCs) for eligible pregnant women in New Zealand. In addition it funds the presence of a woman's LMC at her birth (wherever it may be) and additional services such as ultrasound scans, obstetric and paediatric referrals, All other maternity services are funded by DHBs including all secondary and tertiary services and birthing facilities.	**128.576**	No price pressures as prices under Sec 88 are fixed. Pressure from LMCs for fee increases may emerge.	Fee for service subject to demand pressures in some services but with quantity guidelines. Birthrate relatively stable over the long term but subject to short term fluctuations and significant increases have been applied to this appropriation in recent years to manage increases in birthrate. However, ultra sound volumes have been increasing at an average of 7% pa. If this trend continues in 2010/11 the fiscal pressure is approximately $1m. There are also anticipated pressures in increase in NT scan volumes under s.88 Primary Maternity Services Notice due to roll-out of NSU guidelines and availability of first trimester blood testing associated with screening for Down Syndrome - approximately $1.2m.	**2.229**	● If the birth rate and claiming patterns remain relatively stable, and the fees in the s.88 Primary Maternity Services Notice are not increased, adverse consequences would be minimal ● Pressure from LMCs for fee increases may emerge
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Contact Lens (Northern region)	This subsidy covers contact lens supply and fitting for persons whose vision cannot be corrected by spectacle lenses.	**0.782**	No price pressure.	Forecast 15% growth for 2010/11 based on historical demand growth. Service area is forecasting a $250k overspend in 2009/10 due to increased demand which will be managed within current baselines.	**0.094**	● In the absence of policy and eligibility changes, this would require reprioritisation from elsewhere as this is currently an entitlement based service

Service	Overview of service area	2009/10 Budget ($millions)	Price	Quantity	Funding required in 2010/11 & outyears	Consequences of no funding increase in 2010/11
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PHO Performance	The PHO Performance Programme is a quality improvement programme focused on improving the health of enrolled populations and reducing health inequalities by supporting clinical governance and continuous quality improvement processes with PHOs and general practice providers.	**28.000**	No price pressure	Volume pressure forecast of up to 5% due to PHOs meeting more performance targets and an increasing number of people being enrolled with PHOs.	**UQ**	• No direct service consequences, however, the PHO Agreement between the PHOs and DHBs sets the requirement for funding
Care Plus	Care Plus provides a structured care planning approach to people with high and complex health needs in the community. The PHO agreement enables Care Plus to be delivered to 5% of the total NZ population with currently 3.7% of the enrolled population recieving Care Plus.	**39.500**	No advised price pressure.	Volume pressure forecast at 16% due to continued uptake of the programme.	**6.700**	• New patients (who have been clinically assessed as requiring structured planning approach to long term care) will not have access to programme • Inequities of access across PHOs will continue if current funding is not reallocated more equitably
Very Low Cost Access & Under Sixes	VLCA is a voluntary PHO/practice scheme to reduce copayments for high needs communities. Under Sixes is provided to practices that commit each quarter to providing free standard consultations to children under six. It is a voluntary opt in (and opt out) scheme similar to the Very Low Cost Access initiative.	**28.000**	Price pressures dependent on LECG calculation of reasonable increase in primary care co-payments for practices outside the scheme.	No volume pressure forecast for the VLCA programme as entry to the scheme has been capped.	**UQ**	• Ongoing participation in the scheme may be unviable for some practices • If practices opt out of the scheme, patient co-payments for people aged over six years enrolled in those practices would increase, with the likelihood that fees for children aged under six would be introduced • Practices offering the Under Sixes scheme may make up for a perceived shortfall in government funding by increasing fees charged to other age groups where fees are not capped
Breast Screening Services	Screening services are demand driven services generally with targeted coverage for a defined population. Changes in the size of the defined population (ie population growth) plus ensuring coverage targets are achieved places cost pressure on service budgets. Within screening programmes technological developments that improve the effectiveness and cost effectiveness of screening can place cost pressure on service budgets in the short term. Screening services are purchased from DHBs.	**41.491**	Annual salary steps, negotiated settlements and other related staff pressures are forecast to contribute 3% price pressure to provider costs (staffing component of budget approximately 65%). Analogue x-ray equipment used by BSA Lead Providers is reaching obsolescence. BSA Lead Providers are in the process of implementing new digital mammography technologies (DMT). Alongside joint procurement and national systems, these changes are estimated to generate 25-30% increase in workforce productivity while improving service quality. An assumption of $2m has been made to fund Lead Provider depreciation charge on new investment.	Breast Screening services are primarily provided to women in the 50-69 age group. The proportion of women in this age group is increasing due to population ageing. This is estimated at 5.7% pa	**4.160**	• Reduction in service coverage • Some women will not be identified with breast cancer, affecting their health outcomes and in some instances leading to preventable deaths • Will affect workforce recruitment, retention, and quality potentially also impacting on service coverage • Improving coverage rates for Maori and Pacific women will be harder • Current ad hoc process of implmenting technology is likely to continue rather than realising the full value-for-money benefits.

Service	Overview of service area	2009/10 Budget ($millions)	Price	Quantity	Funding required in 2010/11 & outyears	Consequences of no funding increase in 2010/11
Cervical Screening Services	Screening services are demand driven services generally with targeted coverage for a defined population. Changes in the size of the defined population (ie population growth) plus ensuring coverage targets are achieved places cost pressure on service budgets. Screening services are purchased from DHBs. Cervical screening aims to identify lesions before they become cancerous thereby enabling early intervention to improve a given woman's health outcomes including morbidity.	**35.126**	Annual salary steps, negotiated settlements and other related staff pressures are forecast to contribute 3% price pressure to provider costs (staffing component of budget approximately 60%)	Cervical screening services are primarily provided to women in the 20-69 age group. The proportion of women in this age group is increasing due to population ageing. This is estimated at 3% pa. Targets are set for screening service coverage of eligible populations. The NCSP has a 75% coverage target. Overall coverage is currently 74.6%. An additional $0.03m is estimated to be required to achieve the 75% coverage target.	**1.350**	• Reduction in service coverage • Some women will not be identified with precancerous lesions, affecting their health outcomes and in some instances leading to preventable deaths • Based on initial estimates no funding growth for this programme could lead to up to 6 more deaths pa by 2014/15 than would otherwise have been the case • Will affect workforce recruitment, retention, and quality potentially also impacting service coverage • Improving coverage rates for Maori and Pacific women will be harder
Antenatal & Newborn Screening Services	Screening services are demand driven services generally with targeted coverage for a defined population. Changes in the size of the defined population (ie population growth) plus ensuring coverage targets are achieved places cost pressure on service budgets. Screening services are purchased from DHBs.	**13.859**	Annual salary steps, negotiated settlements and other related staff pressures are forecast to contribute 3% price pressure to provider costs (staffing component of budget approximately 60%)	Given the birthrate is relatively stable there is no demand pressure forecast for these services. Funding will be required for the Universal Newborn Hearing Screening system ($500k). Assuming currently appropriated funding of $2m for Antenatal Down Syndrome Screening quality improvement is maintained in outyears. If this funding is reprioritised the quality improvements sought in service are unlikely to be made.	**0.800**	• Will affect workforce recruitment, retention, and quality • Delay roll out of Universal Newborn Hearing Screening system
Public Health Unit (PHU) Services	Regional public health services are delivered by 12 District Health Board-owned public health units and various non-governmental organisations. DHB-based services and NGOs each deliver around half of these services. Public health units focus on 'core public health services' such as environmental health and tobacco control. Many of these services include a regulatory component performed by officers appointed under statutes.	**61.729**	PHU employ a wide range of staff some of who will be subject to annual salary adjustments and settlements.	PHUs have been advised to manage any volume pressures within their current budget.	**3.000**	• Some services will need to be scaled back • Capacity to respond to emergencies(Eg: disease pandemic) and delivering regulatory responsibilities for managing communicable disease and environmental health may be impacted
Workforce Training	This service funds training places in DHBs and other providers (eg GP primary care). Training funded includes Nursing, GPs, Midwifery, and post-graduate Medical specialities.	**124.597**	Price pressure estimated by application of FFT adjustor. No FFT applied to this service area in 2009/10. FFT funding has been used to maintain purchasing power of funding to ensure that DHBs and other providers remain incentivised to take on workforce trainees.	Volume pressure estimated by application of demographic adjustor as per previous years practice - 1.855%. No demo applied to this service area in 2009/10. Demographic funding has previously been used to increase the volume of trainees to meet future workforce demand or fund new types of training in line with Government priorities and future workforce needs.	**5.177**	• Impact on Ministry's ability to ensure trainee volumes are delivered • Will likely impact on the Ministry's ability to maintain contracted volumes and will mean that additional volumes on top of 2009/10 cannot be contracted for 2010/11 •The Ministry estimates that with no additional funding in 2010/11 training places may have to be reduced by up to 110 places.
	TOTAL Min NDE Budget under consideration	**1,633.36**		**TOTAL**	**59.949**	
	Total Min NDE	**2593**		**TOTAL Min NDE Budget under consideration**	**1,633.36**	
	% of Total Min NDE	**63%**		**% of TOTAL Min NDE under cons**	**3.67%**	

Annex Two: Scaling Options

	Initiative ($millions)	2010/11	2011/12	2012/13	2013/14	Highest Out-year	Description
Full Cost Package (no scaling)	Boost Med School Places	0.6	2.8	7.1	13.4	55.5	Fund remaining 140 medical places in Budget 2010, rather than over the next four years. This includes both undergrad and post-grad costs, as noted in HR20091922
	Boost Medicines funding	20	20	20	20	20	Phase Two of Manifesto commitment
	[deleted - negotiate without prejudice]						
	Voluntary Bonding	0	5.13	1.37	1.09	0	One-off increase to the number of applicants accepted to the programme
	Whānau Ora	TBC	TBC	TBC	TBC	TBC	The Whānau Ora Taskforce may seek to advance new initiatives for funding against Budget 2010. These are unknown at this stage.
	[deleted - negotiate without prejudice]						
	MRG Responses	TBC	TBC	TBC	TBC	TBC	Any one-off costs are currently tagged against 08/09 underspends. Any ongoing financial implications not yet known
	Mental Health	20	20	20	20	20	Second phase of Budget 2009 commitment to increase coverage of mental health services
	Bowel Cancer	1.2	3.8	3.8	3.8	0	Development of four demo sites for four years. Note: There is an additional cost of $0.52m to $1.125m of capital in year one for an IT system
	Full Cost Package Total	**41.8**	**51.73**	**52.27**	**58.29**	**95.5**	
High Cost Scaled Package	Boost Med School Places	0.59	1.64	2.71	3.78	8.72	Only fund 20 additional places. This aligns with the phasing indicated in the Budget 09 commitment
	Boosting Medicines	20	20	20	20	20	No scaling options
	[deleted - negotiate without prejudice]						
	Voluntary Bonding	0	0	0	0	0	Seek reappropriation of 08/09 underspends to meet this cost as no ongoing funding is required (HR20092026 refers)
	Whānau Ora	TBC	TBC	TBC	TBC	TBC	Costs unknown at this stage. **(See above)**
	[deleted - negotiate without prejudice]						
	MRG Responses	TBC	TBC	TBC	TBC	TBC	Ongoing costs unknown at this stage. **(See above)**
	Mental Health	13.44	10.98	10.98	10.98	10.98	The Ministry of Health has recently agreed to fund the 'Tackling Methamphetamine' Action Plan (HR20091891 refers) from the Budget 2009 Risk Reserve. You could deduct this amount from the $20 million committed to for mental health in Budget 2010
	Bowel Cancer	1.2	3.8	3.8	3.8	0	No scaling options. Note: There is an additional cost of $0.52m to $1.125m of capital in year one for an IT system
	Total High Cost Package	**35.23**	**36.42**	**37.49**	**38.56**	**39.7**	
	Initiative ($millions)	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**Highest Out-year**	**Description**
Low Cost Scaled Package	Boost Med School Places	0.59	1.64	2.71	3.78	8.72	**(Only fund 20 places. See above)**
	Boosting Medicines	20	20	20	20	20	No scaling options
	[deleted - negotiate without prejudice]						
	Voluntary Bonding	0	0	0	0	0	Seek reappropriation of underspends from 08/09. **(See above)**
	Whānau Ora	TBC	TBC	TBC	TBC	TBC	Costs unknown at this stage. **(See above)**
	[deleted - negotiate without prejudice]						
	MRG Responses	TBC	TBC	TBC	TBC	TBC	Ongoing costs unknown at this stage. **(See above)**
	Mental Health	0	0	0	0	0	The Ministry of Health has recently agreed to fund the 'Tackling Methamphetamine' Action Plan (HR20091891 refers) from the Budget 2009 Risk Reserve. You could choose to advance this initiative alone, and not allocate any additional funding to mental health in Budget 2010
	Bowel Cancer	1.2	3.8	3.8	3.8	0	No scaling options. Note: There is an additional cost of $0.52m to $1.125m of capital in year one for an IT system
	Total Low Cost Package	**21.79**	**25.44**	**26.51**	**27.58**	**28.72**	

Annex 3: Potential Savings Options

[information deleted in order to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials]

Annex 4: Vote Health additional funding since Budget 2005

Initiative	Purpose / Objectives	Budget year	Operating expenses $millions 2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Aged Care									
Health of Older People	Funding to DHBs for price increases to maintain viability of the sector.	2005	32.52	32.52	32.52	32.52	32.52	32.52	32.52
Income & Asset Testing	Reduction in income and asset testing by increasing thresholds by $10k per annum to reduce personal cost of residential care.	2005	93.24	93.24	93.24	93.24	93.24	93.24	93.24
Aged Residential Care: price increase	Funding for price increases to support the viability and safety of the sector.	2006		17.00	17.00	17.00	17.00	17.00	17.00
		2007			37.50	37.50	37.50	37.50	37.50
Boosting Hospice Care	Boost funding for hospices, to expand the care and services provided by hospices, and meet their current financial challenges.	2009					15.00	15.00	15.00
Home-based support services for older people	Price increases to address stability issues in the sector (high turnover, growth in demand).	2006		14.50	14.50	14.50	14.50	14.50	14.50
Home-based support services: DHB contracted services	Increase in HBSS worker hourly wage rate of $1.70 per hour. To maintain a safe and sustainable sector (low wages causing high turnovers and risks to the safe supply of core services).	2007			20.30	20.30	20.30	20.30	20.30
National Implementation of InterRAI Assessment Tool - New Initiative	Funding for implementation of a needs assessment tool to assist targeting of services for elderly in aged care.	2008				1.51	3.00	4.00	4.00
Total Aged Care			**125.76**	**157.26**	**215.06**	**216.57**	**233.06**	**234.06**	**234.06**
Disability Support Services									
Residential Services For Disabled People (Under 65)	Funding to recompense service providers for a rise in the minimum wage, including supported independent living & residential respite.	2007			11.00	11.00	11.00	11.00	11.00
Younger People's Residential Care	Funding for price pressures & sector sustainability.	2007		18.00	18.00	18.00	18.00	18.00	18.00
Home-based support services (HBSS) for MoH DSS	To reduce significant staff turnover amongst home based support staff by increasing the hourly wage rate by $1.25.	2007			7.50	7.50	7.50	7.50	7.50
Stabilise Home-Based Disability Support Services	Additional funding to providers to enhance sustainability. Expected to enable providers to address recruitment, training and retention issues.	2007			8.00	8.00	8.00	8.00	8.00
DSS Price Increases - Home Based Support	Price increase for providers	2006	6.20	6.20	6.20	6.20	6.20	6.20	6.20
Kimberley Deinstitutionalisation - New Initiative	Funding to help transition those residents who were institutionalised at the Kimberley facility, to other residential care, and for specialist services to support individuals and assist the residential and day service provider to support people who have high and complex behavioural needs, and those who have high medical/health needs	2005	14.26	14.26	14.26	14.26	14.26	14.26	14.26
Doubtless Bay Rest home	Transfer to Northland DHB for part of the costs of building the Doubtless Bay resthome. This is due to its part use for use by disabled people, which is funded through the MoH DSS budget.	2009				0.58	0.58	0.58	0.58
High and Complex Needs (IDCC&R Act)	To provide for workforce development initiatives for statutory functionaries; the management of volume growth of those individuals who have received ID(CC&R) court orders; and the development of Community Secure services in Regional Intellectual Disability Supported Accommodation Services (RIDSAS).	2007		8.00	8.00	8.00	8.00	8.00	8.00
		2008				3.00	3.00	3.00	3.00
		2009				0.00	7.80	9.80	9.80
Huntington's Disease - Christchurch	Used to fund a specialist facility in Christchurch due to a higher than equitable number of sufferers there. These few individuals exhibit very high needs and were putting undue pressure on other disability services, restricting their capacity	2009				0.23	1.20	1.20	1.20
Environmental Disability Support Services (ESS) - New Initiative	Further response to the ESS review of 2005 enhancing scope of ESS services supplied to clients. Enhanced access to equipment and modifications to housing and vehicles for different groups of disabled people will mean that more disabled people will be able to live safely in their homes, communicate effectively, have housing modifications completed in their homes, and have their vehicles modified.	2008				0.00	0.99	1.50	1.50
Environmental Support Services: funding for increased volume	To increase the range of home modification and support services available to disabled people.	2007			14.00	11.00	11.00	11.00	11.00
Cochlear Implant Services - Adults and Newborns - New Initiative	To increase baseline funding for additional cochlear implants per year to ensure funding for those deaf adults who have the greatest need of a cochlear implant. Ensures newborns identified as deaf through a universal newborn screening programme, and subsequently determined to benefit from a cochlear implant, will receive cochlear implants within a reasonable timeframe.	2007			2.25	2.85	1.80	1.30	1.30
Hearing Aids For Super Gold Card Holders - New Initiative	Increases the subsidy available to the 11,000 Super Gold Card holders for the purchase of hearing aids. Based on evidence of unaffordability of hearing aids or many elderly people	2008				4.50	4.50	4.50	4.50
Provide Support For Family Caregivers - New Initiative	Funding to develop and implement a Support for Families Framework. Responding to immediate demands for respite care and to begin to broaden support options for families and whanau.	2007			1.50	1.50	1.50	1.50	1.50
Autism Spectrum Disorder Work Programme - New Initiative	To fund the expansion of the following programmes: • Existing early intervention services to reach 120 families in 4 regions • Brightsparks family support programme to 300 families in 4 regions • Family/whanau outreach service to 332 families in 4 regions • Spell services (knowledge skills and confidence for parents, family, professionals and support workers) to reach 80 families.	2007			2.50	2.50	2.50	2.50	2.50
		2008				2.50	2.50	2.50	2.50
DSS NASC Capability/Systems	Funding was used to increase the capacity, training and develop information systems for the NASC process	2006	5.41	5.37	5.37	5.37	5.37	5.37	5.37
DSS NASC Training		2006	0.31	0.31	0.31	0.31	0.31	0.31	0.31
Disability Support Services - Respite Care	Provided increased 'time out'/respite care for unpaid care givers and family from their caring responsibilities Funding will go towards funding respite services to approximately 120 clients in 2008/09 increasing to 240 clients in 2009/10 and out years	2009				1.50	3.00	3.00	3.00
DSS Price Increases - Community Residential Care	The volume had been increasing at a greater rate than demographic funding. FFT had been supporting funding, which left unmet demand for price increases.	2006	8.44	8.44	8.44	8.44	8.44	8.44	8.44
Total Disability Support Services			**34.62**	**60.58**	**107.33**	**117.24**	**127.46**	**129.47**	**129.47**
Primary Care									
PHO Capitation	Successive extension of low cost access to age groups 18-24 and 25-44.	2005	111.56	206.40	266.49	266.49	266.49	266.49	266.49

Initiative	Purpose / Objectives	Budget year	Operating expenses $millions 2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
PHO Capitation	Additional Capitation	2006	14.26	42.86	62.46	68.66	68.66	68.66	68.66
PHO price increase	Increase in subsidy rates.	2005	3.11	3.11	3.11	3.11	3.11	3.11	3.11
Migrant Health Initiative	Improve access to primary care and DSS for non-English speakers. DHBs are not funded for refugees and migrants. Migrants therefore cannot access GP services, increasing inequalities and reliance upon more costly emergency services. This is supported by evidence from audits.	2008				1.92	1.90	1.90	1.90
Care Plus Preparatory Services HSF - DHBs	To fund Care Plus - a 'priority patient' initiative which aims to provide proactive management, and low cost services, for the 5% of enrolees with the greatest need for primary health care. Care Plus will replace the High User Health Card as the means of targeting this high need group of patients The funding was devolved to DHBs in 2004/05.	2005	4.13	4.13	4.13	4.13	4.13	4.13	4.13
Strengthen Primary Mental H/C Response to Mental Illness/Addiction	Funding 14 PHOs for increased packages of care, coordinators, practitioner services to manage mild to moderate mental illness and workforce capability. This will fund small increase in volumes for existing PHO initiatives. Funds developing internet based therapy programmes and e-therapy tools, implementing treatment guidelines for practitioners.	2007			5.10	7.60	4.40	4.40	4.40
Transition Funding For Primary Healthcare Initiatives - New Initiative	To fund 10 sites (DHB or PHOs) to profile innovative ways of fostering improvements in primary health care delivery with a focus on reducing inequalities and improved outcomes in relation to chronic disease. Support initiatives funded in mental health and support better co-ordinated care practices. The Ministry will undertake a formative and intermediate health and organisational outcomes evaluation with a focus on looking at why processes within PHOs work or do not work.	2007			2.90	2.90	0.00	0.00	0.00
Funding for primary maternity services via the Section 88 notice	Used to fund the higher volume of maternity claims resulting from higher birthrate and price changes in the Primary Maternity Services Notice	2006	8.40	8.40	8.40	8.40	8.40	8.40	8.40
		2009					10.00	10.00	10.00
		2009				10.00	0.00	0.00	0.00
		2009				17.00	17.00	17.00	17.00
Rural Support For Primary Maternity Care - New Initiative	Rural Midwifery Recruitment & Retention Service. Aims at addressing a number of concerns by Rural midwives with regard to locum support, cover and ongoing education opportunities. Aims to avert an imminent crisis in rural midwifery. Contract about to be signed with NZCOM following tendering process.	2007			2.00	2.00	2.00	2.00	2.00
Pacific Health Provider and Workforce Development	Pacific providers are the key enabler for reducing Pacific Health inequalities.	2008				2.40	2.40	2.40	2.40
Plunket Well Child Contacts (Telephone Delivery)	To fund additional contacts to be provided to selected families with assessed need. This will give Plunket the opportunity to provide part of its 'non core' contact service commitment under the Well Child Framework by telephone	2007			1.50	1.50	1.50	1.50	1.50
Plunket Well Child - Reprioritisation Paper	To maintain the specified per capita level of Well Child contacts which are delivered by Plunket.	2009				1.93	1.93	1.93	1.93
Primary Health Care IImplementation	Funding to increase access to low cost after hours primary care, extend Careplus, maintain value of VLCA and Under 6s, further expansion and roll out of primary mental health initiatives, implement policy consistency of $3 co-payments charges for scripts issued by hospital.	2008				19.49	19.49	19.49	19.49
Primary Care Chronic Disease Nursing Education	To fund two additional papers for Nurses to study chronic disease management. Objective is to enable a greater array of conditions to be managed in primary care	2008			1.70	2.20	2.20	2.20	2.20
GP/Lead Maternity Carer Optional Visit	An optional meeting each trimester for "at-risk" women with her General Practitioner and her Lead Maternity Carer. Aimed at improving the management of ancilliary conditions that endanger the pregnancy	2009					1.41	2.82	2.82
PHO Emergency Funding	To fund emergency management for PHOs	2009				0.68	0.68	0.68	0.68
Funding Refugee Primary Health Care	There has been a cumulative increase in the number of refugees. They generally feature very high health needs. The associated costs are disproportionately incurred by a small number of PHOs	2006			1.12	1.12	1.12	1.12	1.12
Total Primary Care			**141.45**	**264.89**	**358.90**	**421.52**	**416.81**	**418.22**	**418.22**
Electives									
Electives initiatives	Increase cataract procedures to reduce waiting list.	2006	8.32	6.37	6.37	6.37	6.37	6.37	6.37
	Increase orthopaedic procedure volumes to reduce waiting list.	2006	26.67	26.67	26.67	26.67	26.67	26.67	26.67
	One-off increase	2007		29.50	0.00	0.00	0.00	0.00	0.00
	Increase elective procedures to reduce waiting lists and meet price increases.	2007			59.00	59.00	59.00	59.00	59.00
		2008				50.00	40.00	35.00	35.00
Total Electives			**34.99**	**62.53**	**92.03**	**142.03**	**132.03**	**127.03**	**127.03**
Mental Health									
Alcohol and Other Drug Treatment Service Directory	Focus on alcohol & drug issues of offenders - opportunities to improve offenders' health that will also benefit their families and general community.	2005	0.02	0.02	0.02	0.02	0.02	0.02	0.02
Mental health Blueprint funding	To meet access targets for mental health services for the 3% of people with the most severe mental health conditions by increasing volumes in a range of specialist services including in-patient, community residential and community mental health services.	2005	22.22	22.22	22.22	22.22	22.22	22.22	22.22
		2006		22.22	22.22	22.22	22.22	22.22	22.22
		2007			22.22	22.22	22.22	22.22	22.22
		2008				22.22	22.22	22.22	22.22
		2009					20.00	20.00	20.00
Suicide Prevention/National Depression - New Initiative	To fund an integrated package of interventions to prevent suicidal behaviour, focusing on improving the after care of people who have made suicide attempts and improving the responsiveness of the community and primary care sector to people with depression. This includes: 1. Evaluated pilots for intensive care after suicide attempt 2. Continued roll out of the Emergency Department Guidelines on suicide prevention to all DHBs 3. Evaluated intensive demonstration sites providing training/support to General Practitioners/Primary Health Organisations on the assessment and management of depression 4. Additional investment and ongoing roll out for the National Depression Initiative.	2007			4.27	5.59	1.95	1.95	1.95
		2008				2.23	2.83	3.03	3.03
National Drug Policy - Online Data/Info System	To fund the creation of an information environment that supports and validates effective and evidence based drug policies. This includes website development and collection and updating of new data and evidence essential for the maintenance of drug policy.	2007			0.05	0.20	0.20	0.20	0.20

Initiative	Purpose / Objectives	Budget year	Operating expenses $millions 2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
National Depression Awareness - New Initiative	To fund television advertisements to link the depression campaign conceptually with the Like Minds Like Mine (LMLM) campaign. In particular to de-stigmatise mental illness, through awareness.	2005	0.29	0.29	1.50	2.20	2.08	2.08	2.08
Mental Health Holidays Act	Contract variations to a small number of providers in response to the legislative change	2006	0.50	0.50	0.50	0.50	0.50	0.50	0.50
Effective Interventions	A programme to promote the interface between the criminal justice system and mental health, drug and alcohol services	2008			4.84	0.00	0.00	0.00	0.00
Total Mental Health			**23.04**	**45.26**	**77.85**	**99.62**	**116.46**	**116.66**	**116.66**
Public Health									
Public Health: Immunisation									
Human Papilloma Virus (HPV) Vaccine	Role out HPV programme to reduce cervical cancer by immunising girls aged 11-13years, and a catch-up programme for 12-15yr old girls.	2008				43.52	45.63	39.64	25.51
Meningococcal Vaccine Transition - New Initiative	Preventing diseases and reducing the burden of disease by providing free vaccinations for a range of communicable diseases.	2006		7.73	6.77	6.63	0.00	0.00	0.00
Pneumococcal Vaccine	Include the pneumococcal vaccine in the National Immunisation Schedule (3 doses of the pneumococcal vaccine Prevenar for infants).	2007			17.00	17.00	17.00	17.00	17.00
		2008				10.00	10.00	10.00	10.00
Public Health: Nutrition and Physical Activity									
HEHA	Funding for developing leadership & community action; delivery of school-based nutrition & physical activities; green prescriptions; breastfeeding; information campaigns; and monitoring & evaluation.	2006		19.03	19.03	19.03	19.03	19.03	19.03
	Expansion of 2006 initiatives including expansion of the Mission On and Feeding our Futures campaigns.	2007			12.45	12.75	12.75	12.75	12.75
Extend "Get Checked" To Include Cardiovascular Disease - New Initiative	Funding to increase the number of diabetics currently enrolled in the 'Get Checked' scheme from approximately 80,000 to 100 000. Improve 'Get Checked' to enable the data to track a person with diabetes over time. Investigate how to integrate people at risk of CVD into a programme similar to 'Get Check' and make provision for recording and reporting on CVD data from the programme.	2007			3.30	3.30	3.30	3.30	3.30
Response To Select Committee Into Obesity/Type 2 Diabetes	Increased emphasis on monitoring & research and diabetes management; expansion of Fruit in Schools; breastfeeding; working with the food industry on healthy food options; and strengthening infrastructure.	2008				11.67	11.79	11.79	11.79
Public Health:Tobacco									
Smoking Cessation - New Pharmaceutical/Improved DHB Services	To reduce smoking rates through: increased nicotine replacement therapy (NRT); plans for four DHBs (Lakes, Northland, Tairawhiti, Whanganui) with higher levels of inequalities; education and training for primary care practitioners; reducing smoking initiation; enhancement of smoking cessation; and a mass media campaign.	2007			10.60	10.60	10.60	10.60	10.60
Smoking Cessation Programmes	To support DHB initiatives to increase smoking cessation rates (focus on primary care) plus fund Varenicline (new pharmaceutical) to help smokers quit.	2008				8.00	8.00	8.00	8.00
Public Health: Screening									
Breast Screening Age Extension	To extend the breast screening programme to 45-49 & 65-69 year olds.	2006	11.46	11.46	11.46	11.46	11.46	11.46	11.46
		2006		7.30	7.30	7.30	7.30	7.30	7.30
Improve the Newborn Metabolic Screening Programme - New Initiative	The programme screens all NZ newborns for a range of treatable metabolic disorders. Improved tracking monitoring and tracking of samples to ensure early detection and treatment. Improved education material for midwives and updated parental information.	2007			0.50	0.50	0.50	0.50	0.50
Universal Newborn Hearing Screening	To fund program to screen for congenital hearing deficiencies. Early detection increases options for treatment, or techniques for managing the condition	2008			1.60	3.35	3.50	3.40	3.05
Antenatal HIV Screening	Implementation of screening program to detect HIV and prevent transmission from mother to child during pregnancy	2006	1.59	1.30	1.30	1.30	1.30	1.30	1.30
Antenatal Down Syndrome screening	Funding to update screening procedures and develop a nationally-organised screening programme to achieve a >75% detection rate and <3% false positive rate.	2007			2.90	2.90	2.90	2.90	2.90
		2008				0.69	5.20	8.03	8.03
Public Health: Health Promotion									
Youth Pregnancy and Parenting Action Pla	One off funding in 2008/09 to develop priorities for action and for the development of some youth friendly information on services for youth who are pregnant or parenting	2009				0.21	0.00	0.00	0.00
Sexual Health Education/Reduce Sexually Transmitted Infection	Funding for a repeat/ follow-up public health education/ media campaign on safe sex. Targeted at young adults age 15-25 years. A Sexual Health Advisory group was established to provide advice for public health education and professional education. Development of resources and advice to public and professionals was used to encourage testing for chlamydia in specific groups at risk of an STI at primary health care services	2007			2.50	3.90	3.40	3.40	3.40
		2008				1.10	1.10	1.10	1.10
Problem Gambling Levy	Development and delivery of media campaign	2007			6.76	7.19	6.98	0.00	0.00
Programmes To Prevent Family Violence - New Initiative	Funding for programmes to prevent family violence, including, further support DHBs family violence intervention programmes, audit DHB performance, provide family violence intervention training in primary care (well child, sexual health, maternity, PHO), maintain the community based NGO family violence prevention programme (replaced existing time-limited funding), provide Ministry leadership through contract management, inter-sectoral collaboration and policy support	2007			2.64	2.64	2.64	2.64	2.64
Community Action on Youth and Drugs - New Initiative	Funding for five new sites for the Community Action On Youth and Drugs Programme. This programme aims to improve the health and wellbeing of the Auckland City youth by reducing methamphetamine, cannabis, alcohol and other drug related harm and increasing community ownership and capacity to address these health issues	2005	0.80	0.80	0.72	0.74	0.75	0.75	0.75
Rebranding of Rockquest - New Initiative	Funding for the Sponsorship of Rockquest	2005	0.20	0.20	0.20	0.20	0.20	0.20	0.20
National Drug Policy - Media Campaign On Illicit Drugs - New Initiative	To fund a social marketing and information campaign to provide messages for target groups about the risks of taking drugs and what action can be taken by family, whanau, friends and communities to help. Work programme included a stocktake of existing information resources, identification of gaps, and review of quality of messages.	2007			0.25	0.25	0.25	0.25	0.25
		2008				1.25	1.25	1.25	1.25
Public Health: Other									

Initiative	Purpose / Objectives	Budget year	Operating expenses $millions 2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Youth Access to Health Services - New Initiative	Funds of public health services for young people to address lower outcomes from underpresentation for primary care, sexual health and mental health. Delivered in a targeted manner to lower decile schools. Aims to improve outcomes and reduce preventable diseases.	2008				1.84	3.81	5.58	5.58
Drinking-water Assistance Programme - New Initiative	Funding contributes to upgrading small drinking-water supplies to provide safe water to their communities	2005	2.22	2.22	15.56	22.22	28.89	0.00	0.00
National Rollout of Healthline	Increase to funding for operating Healthline. Previous funding was only for 4 regions, rather than a full national service	2005		4.64	4.64	4.64	4.64	4.64	4.64
Funding PlunketLine	Funding of PlunketLine in terms of Government's 100-day plan commitment. Currently PlunketLine is privately funded. The funding of PlunketLine will ensure the continued availability of PlunketLine to parents and caregivers of children less than five years of age.	2009				1.75	0.00	0.00	0.00
		2009					3.50	3.50	3.50
Enhancing Surveillance/Control Of Anti-Microbial Resistance - New Initiative	Resistance to antimicrobial drugs (ie antibiotics) is a WHO-directed issue of international concern. Funding went to ESR, Food Safety NZ, and other bodies to advance a range of initiatives to improve monitoring and surveilance of resistance in diseases.	2008				1.00	1.00	1.00	1.00
		2009				1.00	1.00	1.00	1.00
Sanitary Works Subsidy Scheme (SWSS)	Subsidy for the capital costs of upgrading sewage schemes to reduce the health risks associated with inadequate sewerage schemes in small rural communities.	2008				15.22	12.05	7.25	2.98
Trans-Tasman Therapeutics	Additional funding for the joint regulatory organisation for pharmaceuticals. It was in response to unanticipated set up costs ($1m) and additional work volumes in early years ($2.5m). Funding is not ongoing	2007		2.50	0.00	0.00	0.00	0.00	0.00
		2007		1.00	0.00	0.00	0.00	0.00	0.00
EnergyWise Home Grants Scheme - New Initiative	Funding for improved insulation and weather proofing of low cost housing.	2007			1.80	1.80	1.80	0.00	0.00
Healthy Housing Programme	Funding to retrofit old houses with insulation. Targeted at low income families to improve outcomes and reduce inequalities. Funding is not ongoing	2008			0.00	7.50	7.50	0.00	0.00
B4 School Checks	Funding to increase the availability of B4 school checks services	2008			2.64	0.00	0.00	0.00	0.00
		2009				4.40	3.41	3.41	3.41
		2009				5.50	6.00	6.00	6.00
AIMHI Healthy Schools - Nurse Component/Evaluation - New Initiative	Nurses to be employed in 9 AIMHI decile-1 secondary schools from 2007. Evaluation (with MSD) of the health components of the AIMHI project 2007/08. Nurses will work in 17 Counties/Manukau schools from 2008/09. Scoping study for inclusion of Alternative Education	2007			1.01	1.01	1.01	1.01	1.01
		2008				0.56	1.13	1.13	1.13
Emergency Planning	To fund and establish greater emergency planning and preparedness in the Ministry	2009				2.73	2.73	2.73	2.73
Total Public Health			**16.27**	**58.18**	**132.93**	**258.65**	**265.31**	**213.85**	**195.10**
Workforce									
Workforce: Wages, Recruitment & Retention									
Improve Terms/Conditions For Low-Paid DHB Workforce - New Initiative	Partial funding to DHBs for settlement of negotiations with Service & Food Workers Union.	2007			10.00	10.00	10.00	10.00	10.00
DSS Holidays Act	Funding used to address wage pressures arising from the legislative change	2006	6.00	6.00	6.00	6.00	6.00	6.00	6.00
Holidays Act wage pressures	Funding to pay time and a half for public holidays to meet requirements of Public Holidays Amendment Act 2004.	2005	7.90	7.90	7.90	7.90	7.90	7.90	7.90
DHB Holidays Act wage pressures	Funding to pay time and a half for public holidays to meet requirements of Public Holidays Amendment Act 2004.	2005	44.72	44.72	44.72	44.72	44.72	44.72	44.72
Maori Nursing Workforce Development - New Initiative	A shortage of Maori health workers is contributing to inequalities in Maori Health. Maori health workers are expected to be able to delvier more effective care. This initiative is to fund a host of iniatives aimed at training and recruiting Maori nurses.	2008				3.00	3.00	3.00	3.00
Stabilisation of the Ambulance Sector - New Initiative	Additional funding for Ambulance providers to meet price, volume and wage pressures. Objective is to avoid service failure	2008				6.90	6.90	6.90	6.90
DHB industrial settlements funding	Nurses pay parity with police and teachers	2005	102.01	102.01	149.17	149.17	149.17	149.17	149.17
Nurse Practitioner Employment Working Party	One-off funding for the working party which investigated options surrounding the use of Nurse practitioners for more efficient prescribing	2007		0.30	0.00	0.00	0.00	0.00	0.00
Registration of Overseas Doctors	Supervision of overseas doctors during their first year of provisional registration. Aims to increase the size of the workforce.	2008			0.90	0.90	0.90	0.90	0.90
Safe Staffing Support Unit	Time limited funding for the establishment of the Safe Staff Support Unit to implement the recommendations of the Report of the Safe Staffing/Healthy Workplace Committee of Inquiry .	2008			0.40	0.40	0.40	0.00	0.00
Disability Support Services - Wage Rates -	Used to assist providers of disability support care facing wage pressures to move towards a minimum wage rate of $14.20 by June 2009	2009				6.17	6.17	6.17	6.17
Pilot Midwifery Entry To Practice Programme	Used to fund support for new midwives. In response to the aging midwifery workforce and shortage of new graduates	2007		1.00	2.00	1.00	0.00	0.00	0.00
Rural Midwife Recruitment and Retention	One-off bonus payment to rural midwives	2007		1.00	0.00	0.00	0.00	0.00	0.00
Voluntary Bonding Scheme - New Initiative	Student loan debt write-offs, or payments to graduates who agree to work in hard to staff communities or specialities for 3-5 years	2009					0.00	0.00	6.73
Workforce: Training									
Increasing GP Registrar Trainee Numbers	Boost the number of funded general practice registrar training places by 50 places in 2009 (increasae in funded GP registrar training places from 104 to 154)	2008			1.70	1.70	0.00	0.00	0.00
		2009					2.50	5.00	5.00
GP Training/Upskilling In Primary Maternity	To assist with the costs of training for GPs to undertake a Diploma of Obstetrics, or other relevant courses to enable them to work in, or return to, primary maternity care	2009					0.15	0.30	0.30
Training 800 Health Professionals For Elec	Funding for the appropriate number and mix of approximately 800 new staff to support planned new elective surgery theatres	2009					10.00	20.00	20.00
Workforce development: increased CTA funding for training places	Increase CTA training services in response to workforce pressures. This includes continued provision of Nursing Entry to Practice and Midwifery First Year of Practice programmes and increasing trainee places on the General Practice training	2008				7.61	10.00	10.00	10.00
Encourage More Training In Rural/Provincia	To increase the number of health training opportunities in rural locations/communities and the number of accredited training sites and students in rural locations	2009					0.50	1.50	1.00

Initiative	Purpose / Objectives	Budget year	Operating expenses $millions 2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
CTA - New Medical Registrations	Funding for an additional 40 post graduate medical students from December 2008	2009				0.72	1.24	2.06	3.40
Disability Support - Workforce Developmen	Funding to developing a disability career framework, and additional training at level 2 and 3 National Certificate in Community Support Services, foundation skills and core competencies	2009				1.00	2.00	3.00	3.00
Post Graduate Nurse Training from 2007	Transfer of responsibility for post-graduate nursing training from the Health Services Funding NDE to the Clinical Training Agency to reduce fragmentation of training schemes	2008			0.57	0.71	0.71	0.71	0.71
Total Workforce			**160.63**	**162.93**	**223.35**	**247.90**	**262.26**	**277.33**	**284.90**
Performance Improvement									
Support For Health Sector To Build Capability/Innovate	Sponsor innovation, awards, collaboration, research. Create infrastructure for performance improvement actions and research.	2008				7.00	7.00	7.00	7.00
Financial incentives to improve DHB performance	Funding to incentivise DHBs to implement Quality Improvement Programme (QIP) priorities and increase procurement efficiency.	2008				43.07	43.07	43.07	43.07
Service Planning/New Health Intervention (SPNIA)	Funding for DHBs to effectively use the SPNIA Framework for prioritising funding for new initiatives. Funding supports DHB staff to focus on cost-benefit analysis in order to improve SPNIA.	2008				1.34	1.46	1.58	1.58
3 Quality Improvement Projects	Management of Healthcare Incidents, Infection Prevention and Control	2008			1.19	1.56	0.57	0.57	0.57
Quality Improvement Committee Project	To fund the establishment of a new adult peri-operative mortality committee	2008			1.85	1.45	1.45	1.45	1.45
Innovations - HSF to National Contracted Services - Other		2009				4.50	7.00	7.00	7.00
Total Performance Improvement			**0.00**	**0.00**	**3.04**	**58.91**	**60.54**	**60.66**	**60.66**
Pharmaceuticals									
DHB increases for community pharmaceuticals pressures	To address PHARMAC price and volume pressures	2007			20.00	20.00	20.00	20.00	20.00
Boost Funding For Subsidised Medicines	Increased the availability of subsidised medicines. The 12 months supply of herceptin has been netted off this original total	2009					8.90	11.20	13.00
Investing In Medicines Sector Infrastructure - New Initiative	Funding to implement key steps in Actioning Medicine NZ strategy. Including developing a NZ Medicines Formulary. Ongoing funding for small initiatives aimed at promoting better prescribing practices and pharmacovigilance.	2008				2.20	2.20	2.20	2.20
Improve Patient Safety - Bedside Verification of Drugs	Introduce to DHB hospitals a system that checks that the right drug is given to the right person at the right dose, at the right time by the right route. The system verifies drug and patient information at the bedside using bar-coded unit dose pharmaceuticals at the point of patient care (BPOC).	2007			3.50	3.50	2.10	1.10	1.10
		2008				2.30	3.20	3.20	3.20
		2009				5.80	5.30	4.30	4.20
Total Pharmaceuticals			**0.00**	**0.00**	**23.50**	**33.80**	**41.70**	**42.00**	**43.70**
Oral Health									
Child and Adolescent Oral Health Services	Improve access to oral health services for preschool children and adolescents by increasing the dentist/dental therapist ratio and cover the costs of capital investment projects (i.e. new fixed facilities, mobile clinics, and refurbishing existing clinics).	2008				14.00	15.00	20.00	30.00
		2009				6.60	14.15	18.09	19.57
Child/Adolescent Oral Health (Lakes)	Funding for operating associated with the approved child and adolescent oral health business case for Lakes	2009				0.34	0.80	1.10	0.83
Dental Data Collection Business Case	HSF to National Services	2005	0.06	0.06	0.06	0.06	0.06	0.06	0.06
Total Oral Health			**0.06**	**0.06**	**0.06**	**20.99**	**30.01**	**39.25**	**50.46**
Cancer									
Cancer control strategy	Funding for the following specific objectives as part of the New Zealand Cancer Control Strategy Action Plan 2005-2010: (1) Scope and pilot national programmes to develop the colorectal cancer surveillance and treatment workforce. (2) Implement national service specifications for palliative care in all DHBs. (3) Develop further business case and initial implementation stages of a National Cancer Management Dataview (NCMD). (4) Develop and implement a national education and training framework for cancer and palliative care nursing. Includes funding for obesity related cancers ($0.7m)	2006	14.40	14.40	14.40	14.40	14.40	14.40	14.40
		2007			6.50	6.50	6.50	6.50	6.50
		2008			0.00	5.63	5.63	5.63	5.63
Familial Bowel Cancer Registry -	Registry to track and manage a specific subset of bowel cancer to reduce morbidity and reduce cost	2007		0.33	0.62	0.62	0.62	0.62	0.62
Funding For Cancer Control -	One-off funding	2007		3.38	5.63	0.00	0.00	0.00	0.00
Guidelines For Cancer Control	One-off funding to develop guidelines	2007		0.53	0.25	0.00	0.00	0.00	0.00
Total Cancer Control			**14.40**	**18.63**	**27.40**	**27.15**	**27.15**	**27.15**	**27.15**
Chronic Diseases									
Interim Funding Pool	Provide long-term support services for people with chronic health conditions who do not meet the eligibility criteria for DSS, DHB or ACC funding	2007		6.20	16.00	16.00	16.00	16.00	16.00
		2008				6.55	10.00	10.00	10.00
Total Chronic Diseases			**0.00**	**6.20**	**16.00**	**22.55**	**26.00**	**26.00**	**26.00**
DHB FFT/Demo									
Additional Demo Funding		2005	8.02	8.02	8.02	8.02	8.02	8.02	8.02
Additional FFT Funding			64.80	64.80	64.80	64.80	64.80	64.80	64.80
FFT/Demo			250.92	250.92	250.92	250.92	250.92	250.92	250.92
Demo	National Services to DHBs	2006		106.94	106.94	106.94	106.94	106.94	106.94
FFT	National Services to DHBs			209.46	209.46	209.46	209.46	209.46	209.46
Demo		2007			137.43	137.43	137.43	137.43	137.43
FFT					250.40	250.40	250.40	250.40	250.40
Demo		2008				156.60	156.60	156.60	156.60
FFT						240.56	240.56	240.56	240.56
Demographics - New Initiative		Bud 09					153.80	153.80	153.80
Forecast Funding Track - New Initiative							285.73	285.73	285.73
Total DHB FFT/Demo			**323.73**	**640.13**	**1027.96**	**1425.12**	**1957.95**	**1957.95**	**1957.95**
MoH FFT/Demo									
FFT/Demo		2005	63.99	63.99	63.99	63.99	63.99	63.99	63.99
FFT/Demo		2006		73.40	73.40	73.40	73.40	73.40	
Demo - New Initiative		2007			27.96	27.96	27.96	27.96	27.96

Initiative	Purpose / Objectives	Budget year	Operating expenses $millions						
			2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
FFT		2007			55.79	55.79	55.79	55.79	55.79
Demo		2008				37.94	37.94	37.94	37.94
FFT						60.85	60.85	60.85	60.85
FFT/Demo		2009					85.84	83.84	83.84
Total MoH FFT/Demo			**63.99**	**137.39**	**221.13**	**319.93**	**405.77**	**403.77**	**330.37**
Other									
Health/Disability Commissioner - Expand Advocacy Services	Funding to expand the advocacy service to meet the demand from consumers. Increase FTE advocates to 41, thereby: addressing regional disparities; increasing access for vulnerable consumers; increasing number of education sessions; improving service quality and timeliness.	2007			0.55	0.55	0.55	0.55	0.55
		2008				0.28	0.55	0.55	0.55
Extreme Complex Burns	Complex Burns involve very high cost treatments due to long ICU stays and expensive cosmetic surgery. Additional funding is supplied by the Ministry & ACC to DHBs based on the number of cases treated	2008				6.80	6.80	6.80	6.80
National Maternal Fetal Medicine Centre	The establishment of a National Maternal Fetal Medicine Service at National Women's Hospital in the Auckland DHB	2009				0.25	0.40	0.40	0.40
Hepatitis C enhanced treatment	Funding for an enhanced treatment package as part of the no-fault package is a programme of work to resolve the concerns of those who became infected with HCV through the New Zealand blood supply, before screening of donor blood was introduced	2009				4.00	4.00	4.00	4.00
Ambulance Services	Lowering provider part charges incurred when using St John's ambulances and targeted funding for areas where there is single crewing of ambulances	2009				7.00	10.00	10.00	10.00
		2009				0.00	2.00	2.00	2.00
Financial Reporting Standards 3 change - revaluation of assets	Fiscally neutral funding for DHBs for increased capital charge & depreciation resulting from FRS3 asset revaluations. Covers: 2005/06 Revaluation - Capital Charge $38.397M & Depreciation $12.499M; 2004/05 Revaluation - Capital Charge $11.827M; 2003/04 Revaluation - Capital Charge $1.700M.	2007			64.42	64.42	64.42	64.42	64.42
Financial Reporting Standards 3 change	Management costs	2005	0.44	0.44	0.44	0.44	0.44	0.44	0.44
Train the Trainer Courses	Training for hospital staff to spot victims of domestic abuse.	2005	0.04	0.04	0.01	0.00	0.00	0.00	0.00
Akld DHB - Additional Costs of Servces		2007			15.00				
Transitional Payment	HSF to National Services	2005	1.50	1.50	1.50	1.50	1.50	1.50	1.50
NNPAC Operational Funding	Funding for the National Non-admitted Patient Collection project. This project will collect and collate nationally consistent data on non-admitted patient activity.	2006	2.14	2.14	2.14	2.14	2.14	2.14	2.14
Diabetes/Cardiovascular Disease	Quality improvement plan to review national outcomes and prioritise evidence based interventions to make the best use of resoruces. A three year plan will be developed to advance priorities with DHB consenus	2007		0.24	0.00	0.00	0.00	0.00	0.00
Diabetes/Cardiovascular Quality Improvement		2007		0.16	0.00	0.00	0.00	0.00	0.00
Setting NZ Superannuation and Veterans Pension Rates	Cabinet Decision	2007		0.38	1.50	1.50	1.50	1.50	1.50
Treatment services for Victims of Sexual Abuse and Assault	Services to address the acute and non-acute medical (including injury), psychological, and forensic (where indicated) requirements of the victim in a developmentally appropriate way. Jointly between Accident Compensation Corporation (ACC), Police, and Health.	2007			1.00	2.00	2.00	2.00	2.00
DHB Deficit Support - New Initiative		2009					53.33	38.33	23.33
Funding For Price Pressures/Government Commitments - New Initiative		2009					93.31	93.31	93.31
DHB Emergency Funding - HSF to Public Health Service Purchasing		2009				3.27	3.27	3.27	3.27
Rephasing of Baselines For Sector Risk Management		2008				12.30	13.66	1.13	1.13
Sector Risk Management 2008	Funding to provision for risks & pressures in Vote Health over 2008/09 as per Vote arrangements. Note that some of these initiatives are noted separately and therefore double-counted with the funding allocated here	2008	0.00	0.00	0.00	18.20	16.12	27.25	0.52
Sector Risk Management 2005	Funding to provision for risks & pressures in Vote Health over 2005/06 as per Vote arrangements. Note that some of these initiatives are noted separately and therefore double-counted with the funding allocated here	2005	-3.90	-3.90	16.18	55.75	88.42	88.42	88.42
Sector Risk Management 2007	Funding to ensure the Minister is able to manage risks that require funding, main ones being - PHCS pharmaceuticals co-payment; implementation of National Ambulance Standards; National Air Ambulance Service; Funding for National Tertiary Services at ADHB*; Prostate cancer screening policy development*; HEHA response to the Obesity Inquiry*; Infant nutrition; Laboratory funding of cervical cytology test; Sanitary Works Subsidy Scheme* and Universal newborn hearing screening* **Note that some of these initiatives are noted separately and therefore double-counted with the funding allocated here**	2007	0.00	0.00	81.00	81.00	81.00	81.00	81.00
Total Other			**0.22**	**0.99**	**183.74**	**261.40**	**445.41**	**429.02**	**387.29**
GRAND TOTAL			**939.15**	**1726.73**	**2821.98**	**3785.07**	**4566.31**	**4520.81**	**4480.80**

Please Note: This spreadsheet does not function as a dollar-by-dollar account of changes to Vote Health since 2005. Such an account would be extremely complicated to present, due to the number of transfers between appropriations, between years and to DHBs. The figures presented here detail the budgeted costs for all new initiatives and additional funding to increase the scope of existing initiatives. In addition, there will be some double counting present as some initiatives (newborn hearing screening for example) are listed individually, with a cost beside them even though they were funded through the Risk Reserve, whose total cost is also accounted. Likewise, there are a number of fiscally-neutral transfers included. In order to give a clear picture of the increases funded through the Budget, we have not netted off these costs.

Annex 5: Value Obtained From New Initiatives and Other Price and Volume Increases Since Budget 2005

1. This Annex describes the key components of the increases detailed in Annex 4 and the value obtained from the cumulative additional funding up to 2009/10 within the different service areas. These figures below do not reflect whole of baseline spend for each area – rather all new spending since Budget 2005 until 2009/10, ie the ongoing marginal increase in baselines as at 2009/10. Ongoing savings that have already been realised are also noted.

2. ***Aged Care*** has received additional funding of $233.06 million since Budget 2005. Funding was largely used to address price pressures in the sector, many of which were legislative minimum wage changes and to phase out asset testing. Funding to implement a needs assessment tool is expected to provide better targeting of services. Funding increases in this area were intended to ensure a sustainable sector that can cope with the increasing demand pressures from the ageing population.

3. ***Disability Support Services*** (DSS) has received additional funding of $127.46 million since Budget 2005. DSS funding has been applied to demand driven pressures due to an increasing number of clients (many with more complex bundles of care, eg recently deinstitutionalised clients from Kimberley and the Intellectual Disability – Compulsory Care and Rehabilitation Act court ordered care packages) and expanded services for under 65 year olds. A large proportion of the increased funding in DSS was to meet to price and wage pressures in the sector driven by legislative changes to the minimum wage. Value is expected from a focus on living in the community through increased levels of outcomes for clients.

4. ***Primary Healthcare*** has received additional funding of $416.81 million since Budget 2005. Ongoing savings of $7.5 million have already been realised in the PHO performance programme, through unallocated funds and within Men's Health. Opportunities for further savings are being considered, including through rationalisation of management fees.

5. Funding in this area has been targeted to increase low cost access and promote early intervention. Key initiatives have included extending the age groups for low cost access, the Care Plus priority patient initiative, primary mental health interventions, migrant health and to implement consistency of $3 co-payments charges for scripts issued by hospitals. Funding has also been applied to maintain the value of Very Low Cost Access and Under 6s, increase for maternity funding due to the spike in the birth rate, funding for GP/lead maternity carer optional visits, and to increase access to low cost after hours primary care.

6. The reduction in co-payment charges for primary care over this period resulted in a significant decrease in reported unmet need (fewer people saying they cannot access services, particularly due to cost) and increases in the number of consultations (particularly for older adults). Fees have fallen by a higher percentage for patients in practices serving high needs, and Maori, Pacific peoples and people from lower socio-economic areas have lower fees. There were also increases in the number of pharmaceuticals prescribed and lab tests ordered.

7. In terms of health outcomes, there has been a small reduction in ambulatory sensitive hospitalisations, especially for children. There have been improvements in cardiovascular risk management in men and significant increases in diabetes checks. A review of Care Plus in 2006 found that it was reaching patients with chronic high need, particularly those with diabetes and cardiovascular disease. Most of the patients surveyed felt their care had improved under Care Plus.

8. ***Elective Services*** has received additional funding of $132.03 million since Budget 2005. Funding was provided to increase the numbers of elective surgeries, to reduce waiting lists and meet price increases. Specific funding was initially targeted at cataract and orthopaedic surgery and later expanded more generally. These additional elective procedures reduced waiting times and numbers on waiting lists. Patients waiting longer than six months for their first specialist assessment have decreased from 4164 in October 2008 to 3165 in September 2009 – a decrease in waiting lists of 23%. During 2008/09 there has been an increase of 11,800 elective surgical discharges over 2007/08.

9. ***Mental Health*** has received additional funding of $116.46 million since Budget 2005. Of this funding, $88 million was allocated toward the Mental Health Commission's Blueprint. The Blueprint describes the service components and resources estimated to be needed to meet the needs of the 3% requiring specialist services. Ongoing savings of $4.2 million have already been realised from Blueprint funding in the February 2009 Line-by-Line review. Performance monitoring is primarily focused on progress towards 3% of the population accessing specialist services and the level of funding estimated is needed to meet this access target. Currently, funding for the mental health sector is at 81.6% of the funding target, up from 75.3% in 2004/05.

10. Several programmes have been funded including the depression initiatives, alcohol and drug treatments and suicide prevention. Promotion programmes in mental health are effective in providing information, early intervention and referral pathways for people with mild to severe mental health conditions, particularly depression, and helping them to seek help at an early stage. The effectiveness of the suicide prevention programme is demonstrated by a reduction in the overall suicide rate over the last decade of 19 percent and 31 percent for young people. In the Evaluation of Primary Mental Health Initiatives (PMHI) 2009, PMHIs were able to demonstrate significant clinical improvements, with up to 80% of service users benefiting from a variety of interventions offered to them

11. ***Public Health*** has received additional funding of $265.31 million since Budget 2005. Ongoing savings of $26.387 million have already been realised by reducing health promotion (including vaccination campaigns, Healthy Eating Healthy Action, mental health and well child), the Get Checked programme and smoking cessation programmes. In addition, a number of one-off savings have been made, eg delayed PHARMAC drug approval of Varenicline.

12. The largest funding increases in the public health area included:
   - funding for additional immunisation coverage (introduction of the HPV, meningococcal and pneumococcal vaccines) to reduce the incidence of cervical cancer, meningitis and whooping cough
   - extending the age-range for eligibility for breast cancer screening to increase early detection and intervention
   - advertising around safe sex/sexual health promotion to reduce the incidence of sexually transmitted infections
   - smoking cessation, including the drug Varenicline to support the continued downward trend over the last 25 years, and a reduction in the uptake in youth
   - the Healthy Eating, Healthy Action programme to reduce the incidence of obesity and related chronic diseases. Although it is too early to see significant changes in behaviour, research indicates that it is cost effective and early evidence suggests that Body Mass Indexes may be decreasing.

13. ***Workforce*** has received additional funding of $262.26 million since Budget 2005. Ongoing savings of $0.03 million have already been realised within the Maori Nursing Workforce Development programme.

14. Workforce funding has predominantly been applied to wage pressures for pay parity for nurses with police and teachers ($149 million), industrial settlements and legislative change relating to the Holidays Act ($44 million). The value from this funding is a stable workforce and an increased ability of the New Zealand health sector to compete within a scarce global labour market. Workforce has also received a funding injection in 2009 for an additional 800 health professionals to staff extra elective surgeries, up-skilling in primary maternity care, as well as funding boost to GP training. The intended value to be gained from these initiatives includes reducing waiting times, and improving the current skilled workforce shortages in the health sector.

15. ***Performance Improvement*** has received additional funding of $60.54 million since Budget 2005. Performance improvement funding sponsored innovation, awards, collaboration, and research, as well as created infrastructure for performance improvement actions and research.

16. Funding was provided for financial incentives to improve DHB efficiency and service quality – DHBs received some funding after demonstrating in their DAPS how they would progress priority quality improvements developed by the Quality Improvement Committee. DHBs received more funding by partially achieving a procurement efficiency target by December 2007. Some funding was for better DHB prioritisation through SPNIA. These initiatives were from Budget 2008 and have yet to be evaluated.

17. ***Pharmaceuticals*** have received additional funding of $41.70 million since Budget 2005. Ongoing savings of $0.2 million have already been made within this area. This funding was provided to fund Pharmac to increase the range of subsidised medicines, for initiatives to increase the accuracy (dose verification) of medicine supply and for coordination between General Practitioners (GPs) and Pharmac. These initiatives increased the range of medicines available to patients, increased patient safety and supported decision making by Pharmac and better prescribing from GPs.

18. ***Oral Health*** has received additional funding of $30.01 million since Budget 2005. This funding was to support the update/rebuild of dental facilities and to increase the numbers of dentists/dental therapists to address declining levels of child and adolescent oral health. This initiative is being rolled out following the development of DHB business cases for implementation. Outcomes expected from this initiative are increased oral health status among children and adolescents and increased equality of oral health outcomes nationally. Increasing numbers of adolescents are accessing oral health services.

19. ***Cancer Services*** have received additional funding of $27.15 million since Budget 2005. Funding increases were for the creation of a Cancer Strategy and implementation of this through the Cancer Action Plan to ensure more effective cancer prevention, detection, surveillance, diagnosis, treatment and service delivery for cancer patients and their families. The cost effectiveness of individual interventions is currently being modelled by the Ministry in the Aotearoa Burden of Cancer and Comparative Benefit Assessment study. Five year relative survival rates for the five most common cancers (Colorectum, Lung, Female breast, Cervix, Prostate) are increasing.

20. ***Chronic Disease*** has received additional funding of $26.0 million through an Interim Funding Pool (IFP) million since Budget 2005. The IFP provides long-term support services for people with chronic health conditions who do not meet the eligibility criteria for DSS, DHB or ACC support. Eligibility has been tightened in recent years to ensure the right applicants are selected.

21. ***FFT/Demo***. $1,865 million for DHBs and $406 million for Ministry NDE.]

22. ***Other Funding.*** Other additional funding since Budget 2005 totals around $352.10 million (where identifiable, some of the risk management funding has also been included in the relevant service areas above). The largest residual funding areas include:
- Risk Reserve funding ($263.62 million). This included an increase to the capital charge funding for DHBs resulting from a change to the International Financial Reporting Standard 3 (IFRS3) accounting method.
- demand driven/volume funding for the treatment of extreme/complex burns in conjunction with ACC
- Hepatitis C funding for improved treatment services, extending the no-faults package to those with the disease who were not contaminated with untested blood ($4 million per annum).

Annex 6: Vote Health Expenditure and Other Reviews

Line-by-Line Review of Ministry DE and NDE

1. During January/February 2009 the Ministry undertook a line-by-line review of all Ministry of Health Departmental Expenditure (DE) and NDE to identify:
   a. Immediate savings to create headroom to manage pressures within Vote Health as part of preparation for Budget 2009
   b. programmes that may not align with Government priorities or be value for money.

2. The review identified significant savings. The DE savings were achieved by capping Full-Time Equivalents (FTEs), efficiency gains and programme delays. NDE savings were released from realigning programmes with Government priorities by either scaling back or stopping them (e.g. HEHA and a primary health care men's initiative) or re-phasing expenditure (eg, ambulance services and introduction of a new information system for Diabetes Get Checked). The savings also included a reduction in the sector risk reserve (of $51.226 million in 2009/10)

Line-by Line Review Savings Realised

Savings realised	2008/09	2009/10	2010/11	2011/12	2012/13
	$ M	$ M	$ M	$ M	$ M
DE	18.758	8.471	1.838	1.508	1.508
Ministry NDE	84.507	77.206	69.306	57.172	39.234
Total	**103.265**	**85.677**	**71.144**	**58.680**	**40.742**

Programme Specific Reviews

3. The Ministry has also undertaken several reviews of specific programmes for consistency with the Government's priorities:
   a. The HEHA suite of initiatives. The Mission On and Feeding Our Futures campaigns were discontinued in February 2009 and the HEHA programme subsequently disestablished. The administrative component of Fruit in Schools was recently discontinued and future strategy in this area is currently under Ministerial consideration.
   b. Social marketing advertising campaigns (sexual health, Like Minds Like Mine, Feeding our Future, Breastfeeding, Sun Smart, Healthline & well child, problem gambling, tobacco control, HPV immunisation, and cervical and breast screening).
   c. Sanitary Works Subsidy Scheme (SWSS) and the Drinking Water Assistance Programme – both currently under Ministerial consideration.
   d. B4 School Checks (the eighth Well Child check), which, following MRG comment, is being reviewed and will be subject to ministerial decision in January 2010.
   e. Smoking cessation, including a review of the Quitline services, Aukati Kaipaipa quit smoking services, Pacific and pregnancy quit smoking services; and development of a purchasing framework for national quit smoking services (due for completion by the end of November).

f. *[information deleted to enable the Crown to negotiate without disadvantage or prejudice]*

g. Achieving the goal of Whanau Ora and improving outcomes for Maori. The Ministry is in the process of developing a set of headline indicators for measuring progress in maximising the health and wellbeing of Maori.

h. Ministry of Health corporate value for money 2009/10 work programme. So far reviews of vehicles and taxies have been completed; and reviews of Ministry stationary, video conferencing, Corporate Express/RAPS interface, and print stationary are underway. Reviews of reprographics and office equipment have been started, but put on hold and reviews of catering and postal purchasing have yet to start.

i. Capital asset management and decision-making processes to develop a national asset management strategy that better reflects national priorities.

The Ministerial Review Group (MRG) report

4. The Government has already accepted and started implementing several of the MRG recommendations:

   a. establishing a National Health Board (NHB), as a unit within the Ministry of Health (the Ministry) to provide more focused national supervision of the $9.7 billion spend on hospital and primary health services

   b. creating a Shared Services Establishment Board to begin consolidation of administrative functions such as payroll and purchasing currently spread across 21 District Health Boards (DHBs) and regional shared agencies

   c. strengthening regional cooperation in service planning and delivery (which will require legislation)

   d. devolving programmes of funding of up to $2.5 billion, currently managed by the Ministry, where appropriate, to DHBs.

5. These decisions will result in greater coordination of DHBs and stronger planning decisions in relation to infrastructure, especially IT, workforce and capital. Other significant work underway includes:

   a. re orientating the National Health Committee to focus on improving value for money and prioritising new health technology and interventions

   b. the Ministry of Health, in consultation with the Treasury and State Services Commission, reporting by the end of the year on:

      i. expanding the remits of PHARMAC and MEDSAFE to include the prioritisation and procurement of medical devices

      ii. establishing a separate Quality Improvement Agency

   c. reviewing funding and pricing systems to ensure they support national, regional and local services in order to improve the efficiency of the health care system including national, tertiary, secondary, community and primary care services.

   d. Improving value for money and fiscal control in the health care system through tight prioritisation of new health technology and interventions, including assessment of the MRG proposal that such prioritisation be implemented through the National Health Committee.

e. Progressing MRG recommendations on increasing clinical leadership and clinical networks.

6. Cabinet noted that after consolidation of back office functions and collective procurement has been fully implemented (which might take up to four years) there might be up to $700 million reduction in the rate of growth of health spending over a five year period (this does not take into account set up costs).

Living Within Our Means

7. Living Within Our Means (LWOM) provided the Ministry's advice to the Minister of Health on how the health sector can live within a tighter funding path over the next 3-5 years [HR20091181 refers]. In particular, LWOM responded to the likely scale of the funding path (including scenarios) and the options for controlling spending for Budget 2010.

8. LWOM illustrated that living within a lower growth path, will require a mix of immediate actions along with medium term, more fundamental changes to some key system settings.

9. A reduction in the rate of growth of new funding will have to be matched by reductions in new spending. Supporting the sector to live within this budget constraint requires improvements in productivity, performance and quality; improved prioritisation at every level; and changes to policy settings and service configuration designed to deliver improved value for money. The LWOM report identified the need for:
   a. productivity gains through a reasonable efficiency adjustor applied to Future Funding Track and Demographic growth (FFT/Demo) from 2010/11
   b. improved system performance including: controlling the growth of labour costs, reducing the growth of spending on clinical and non-clinical consumables and devices, improving hospital productivity, improving clinical quality and reducing errors, improving business practices, including further reduction in losses from fraud, and enhanced clinical involvement in decisions, and using performance management and incentives to promote fiscal probity and productivity improvement.
   c. improved prioritisation throughout the sector. This includes improving the use of economic analysis in prioritisation decisions through the Budget process, reviewing the Service Planning and New Health Intervention Assessment (SPNIA) process, and providing DHBs with the tools, support, information and incentives to prioritise properly.
   d. further prioritisation exercises by conducting in-depth service reviews (starting with services funded from Ministry NDE) and by continuing line by line reviews.
   e. reviewing broader system policy settings, including strengthening primary care, considering further devolution of Ministry Non-Departmental Expenditure (NDE), accelerating changes in service reconfiguration and new models of care, considering how best to leverage gains from integrating purchasing and providing functions, and other policy options such as selectively increasing excise taxes.
   f. targeting new operating investment in Budget 2010 strategically to areas which can produce downstream savings, or accelerate step changes in models of care which will create long-term benefit.
   g. using capital investment as a key driver of improved models of care. Work is underway to improve Capital and Asset Management (CAM) processes. LWOM

recommended only considering capital improvements that are critical for legislative or safety reasons, or which demonstrate they support improved regional and national service reconfiguration to meet population needs, and which prove a clear role for the life of the asset.

Annex 7: Additional Policy Advice Information

1. The following outlines the Ministry's overall FTE pathway since 2003:
   - Growth in Ministry FTE in 2003 was attributable to the merger of the Health Funding Authority into the Ministry of Health and incremental growth occurred in 2004
   - Additions to the services the Ministry was funded to deliver led to FTE increases in 2005 – 2007. This included changes in HealthPAC processing and systems changes; and the establishment of a national drug policy secretariat (both 2005); the establishment of the Health Eating Healthy Action work programme; additional funding for elective surgery; the establishment of the Cancer Control Council and implementation of the Cancer Control Strategy (all 2006); and the development of the National Systems Development Programme (NSDP) (2007).
   - Ongoing additional programme and policy requirements were addressed when the Ministry's new structure came into effect on 1 July 2007. These expectations led to continued systems development (NSDP and the NZ Health Information Strategy; national Health Targets; and increased programme delivery within the national cervical screening programme. There were also a range of other activities including B4 schools checks (free health checks for 4 year olds); effective interventions in the criminal justice system; Quality Improvement Committee related projects; and increased health sector-focused capacity to deliver to Government outcomes.
   - This saw an establishment level agreed at 1675 for the 2008/2009 year. In the course of this year the Ministry has reviewed all staffing and output areas. This has seen the Ministry's FTE cap drop 200FTE to 1475FTE (as at 30 June 2009) with an additional undertaking, as part of establishing a National Health Board Business Unit within the Ministry of Health, to drop to 1290FTE by 30 June 2011.
   - In November 2009 the Ministry took action to ensure that only critical vacancies are recruited to and any new staff are to be employed on fixed term employment agreements (with an end date of 30 June 2010) while the Ministry undergoes the organisational change programme.

2. With a reduction in FTE, the Ministry is focused on ensuring that it is still able to deliver on the priorities set by Government and on increasing the capability of a reducing staff base, including policy staff. To that end, the following initiatives are being undertaken to develop the Ministry's policy capability:
   a. Review and enhancement of the Ministry's Policy Analysis programme.
   b. Focus being placed on building culture and capability within policy directorates.
   c. Implementation of workshops to equip managers with skills to lead staff more effectively.
   d. Building engagement so that staff are clear about what is expected of them and that they are working in an environment which enables them to perform more effectively.

3. The following table shows the quantity of policy advice that the Ministry measured and reported on from 2003 to 2008. These figures do not reflect the amount of work required to produce a piece of policy advice.

Year ended	Written Parliamentary Questions	Ministerial Correspondence	Health Reports
2003	1420	5456	2131
2004	1993	5032	2323
2005	2111	4138	2162
2006	2807	4692	2862
2007	2486	4703	2736
2008	1043	4373	2545

4. The NZIER review in December 2008 outlined the Ministry's policy advice as varied in quality. Whilst papers audited were brief, had appropriate attachments and were written by subject matter experts, they also required further work to ensure that they were written with the reader in mind, were polished and contained impact and risk analysis.

5. The following table shows the cost of policy advisors as a proportion of Vote Health and shows a reducing trend since 2007:

Year ended	Total Gross Pay ($m - salary paid employees only*)	Vote Health Operating Expenditure	% of Total Vote Health operating expenditure
	($m)	($m)	
2003	13.16	6946.90	0.1894%
2004	16.37	7641.40	0.2142%
2005	18.56	9366.32	0.1982%
2006	18.86	9099.59	0.2073%
2007	20.10	9557.60	0.2103%
2008	21.91	10772.20	0.2034%
2009	23.18	11621.22	0.1995%

* excludes overheads

Annex 8: Performance Improvement Actions

Vote Health Performance Improvement Actions

PIA Objective	Achievements to Date and further work
Short-term - across Vote Health	
1. Stronger funding framework to drive improvements across Vote Health	Explicit productivity expectations are set out in Budget 2010, including consideration of applying an efficiency adjustor to any increase in FFT or funding only for demographic growth (either fully or partially) (HR200921543 refers)
2. Improved purchasing and prioritisation identified by rolling In-depth Reviews, including options for funding devolution options that optimise purchasing power	The first phase of In-depth Reviews and the second phase Ministry NDE Line-by-Line Review have identified potential savings for Budget 2010. Work is progressing on developing criteria to determine which services should be planned and funded at national, regional or local level and on opportunities for devolution.
3. Stronger accountability with monitoring and enforcement based on supported plans, streamlined reporting and rapid intervention when performance issues arise	The Ministry is developing a stronger accountability and monitoring framework that explicitly focuses on DHB performance along four dimensions: ownership (focusing on provider arm performance), system integration, outputs and outcomes. Ownership productivity will be monitored against a national set of key performance indicators. These include monitoring DHB performance on improving hospital throughput as measured by: • the average length of stay (ALOS) for elective and arranged inpatients, and acute inpatients • the proportion of elective and arranged surgery undertaken as day cases • percentage of inpatient elective and arranged surgery cases admitted on the day of surgery (target of 90 percent) • rates of unplanned acute readmissions within 28 days of discharge (as a counter measure to ALOS) • potential excess bed days relative to total bed days. To mediate any risk of a focus on hospital productivity resulting in reduced quality, DHBs will also be monitored on mortality rates within 30 days of admission. Monitoring DHBs against these productivity and quality indicators will provide a basis for identifying low performers and instituting an agreed plan to bring them into line with higher performing DHBs. This strategy is highly dependent upon good quality data. For this reason DHBs will also be monitored on their submission of patient events to the National Minimum Dataset (NMDS) national collection.

Short-term - DHB focus	
4. Improved hospital productivity – focus on hospital wards, theatre utilisation and emergency departments	The Ministry has an extensive work programme to improve hospital productivity so that resources can be released to improve front-line patient care. Work is being progressed through five workstreams: • More efficient and productive wards. • Improving day surgery and theatre utilisation. • Improving workforce productivity. • Better use of joint procurement. • Reduced costs of back office functions. Any identified savings targets from the 20 November Productivity Summit will be taken into account in Budget 2010.
5. Primary Care Implementation Action Plan – strengthen focus on chronic disease management and reducing avoidable hospitalisation	Work to improve the efficiency and effectiveness of primary health care is underway as part of the *Better, Sooner, More Convenient* primary health care project. This includes policy work focusing on new settings for performance management, contracting, devolution of services from secondary care, and managing demand for secondary care services. The nine primary care groupings participating in this project will have a focus on the devolution of services from secondary care as well as managing demand for acute secondary services. Ambulatory sensitive hospital admissions are one of the indicators of DHB performance.
6. Working with the sector to improve purchasing – including: smarter contracting, collective procurement and shared back-office services	A National Health Board has been established within the Ministry to provide focused national supervision of spending on hospital and primary care services. A national Shared Services Establishment Board has been established and work has commenced on extracting greater value for money from expenditure on back office functions and to take forward collective procurement, as directed by Cabinet. Policy work and implementation planning is also well advanced to advise Cabinet on how to improve value for money and fiscal control through strengthened prioritisation of new health technology and interventions.
7. Contain rate of employment cost growth	A strong signal has been given to DHBs that industrial relations settlements will need to be met within baseline funding.
8. Maximum use of settings to enforce plans and deliver improved value against	Work is currently being scoped for analysing price/quantity performance trends to inform purchasing practices across major service areas (DHB and Ministry–managed NDE). The aim is to identify targeted purchasing and monitoring improvement opportunities leading to medium-term efficiency savings. Also, policy work and implementation planning is well underway, in close consultation with the sector, toward advising Cabinet on organisational options for strengthening Quality Improvement

price, quantity and standards	functions in the sector.
Medium-term – across Vote Health	
9. Support sector to achieve all Government Health Targets on time	Advice for Budget 2010 is based on the assumption that service funders and providers will meet their agreed performance targets and these will, in turn, deliver the Health Target improvements specified in the Ministry Statement of Intent for 2009/2012.
10. New models of care, focus on innovative use of the work force	The Clinical Training Agency Board work plan was agreed in September 2009. This includes identifying legislative and non-legislative barriers to workforce innovation to improve flexibility and remove workplace silos in the existing health workforce. Developing more innovative workforce models will reduce ongoing administrative costs and generate potential cost savings in the medium-term.
11. Service planning to define national and regional services	One of the roles of the recently established Health Services Planning Unit (now part of the National Health Board) in the Ministry is to provide a national overview of service planning, decision-making and capacity at national, regional and local levels to guide comprehensive long-term service planning. This is intended to support decisions being made at the right level in the health sector; better prioritisation nationally; and more efficient and effective use of resources, in particular, a more optimal service configuration across DHBs. This is expected to achieve efficiency savings in the medium-term. The Ministry has developed a draft National Asset Management Plan which has resulted in improved information for Budget 2010. The Ministry is also redrafting the Capital Guidelines to improve decision-making processes and to ensure a greater emphasis on the inter-relation between system-wide service planning and asset management. The purpose of the plan and guidelines is to maximise value for money from capital investment and to help configure the health system to meet the future health needs.
12. Accelerated Quality Improvements, including reductions in, and then elimination of, avoidable admissions, variations and adverse events	The Ministry is progressing advice on an implementation pathway for establishing clinical networks. The Ministry is collaborating with the NHS Institute in the UK to develop capability and capacity in building a continuously improving health care system which will help the development and diffusion of improvements and innovations. This includes the productive ward (focusing on improving ward processes and environments to enable nurses and therapists to spend more time on patient care, thereby improving safety, efficiency and productivity); the productive operating theatre (focusing on nurses, surgeons and anaesthetists); and the productive community programme (to help build continuity between care providers and work at integrating services across all aspects of the patient's journey). This work is expected to deliver efficiency savings in the medium-term.