Vote Health

Baseline Alignment Proposal

8 March 2010

Submitted by:
Hon Tony Ryall

Section One: Alignment to Government Priorities

1. The health and disability system faces substantial challenges especially when coupled with lower government income as a result of the global financial crisis. Budget 2010 funding allocated to Vote Health represents a significantly lower funding increase of 3.22% compared to those provided in recent Budgets, for example the Budget 2009 increase of 5.8%. Despite these challenges, it is my intention to develop a sustainable and high performing health and disability system in which resources are moved to the frontline to maintain and enhance the quality of care and support and, to live within my available funding.

Government Priorities

2. Our Government has agreed to improve state sector performance to ensure the value for money of public spending and contribute to our macroeconomic management goal of addressing imbalances in the New Zealand economy. This requires improving both the efficiency and effectiveness of spending while reducing overall state sector expenditure (fiscal consolidation), and builds on the Performance Improvement Action framework to deliver better, smarter, public services for less as agreed by Cabinet during 2009/10.

Ministerial Priorities for 2010/11

3. *[Deleted – free and frank]* the Ministerial priorities I have decided for the health and disability system in 2010/11 give effect to our Government's priority of fiscal consolidation through improved state sector performance. They are:

   - Improved financial management and sustainability across the health and disability system to move resources to frontline services and reduce forecast expenditure while maintaining per capita service coverage and quality
   - A sustainable clinical workforce which has a strong role in health and disability system leadership to facilitate improvements in quality, patient/client outcomes, and productivity
   - Bringing health services closer to home to improve the efficiency and effectiveness of health service delivery.

Delivering my priorities for 2010/11

4. The Budget 2010 package that I propose is focused on maintaining frontline service coverage and quality as a first priority and addressing risks and pressures as far as possible to ensure system sustainability and avoid problems emerging during the year. The funding increases agreed for District Health Boards (DHBs) and proposed for health and disability services managed on behalf of the Crown by the Ministry of Health are aimed at achieving this priority.

5. Given the fiscal environment, I propose a modest new initiatives package that will be funded through the reprioritisation of lower value expenditure to deliver on our key Health election commitments. I consider this fiscally prudent and aligned with my priority of ensuring system sustainability as progressing new initiatives within my available funding requires reductions in existing services in order to reprioritise funding. I will continue to drive for value for money in existing Health spending over the course of 2010/11 and leading up to Budget 2011.

6. The following parts of Section One outline how I intend to achieve my Ministerial priorities for 2010/11 and how I propose to manage any fiscal and policy risks associated with these priorities. I also provide advice on the fiscal risks over and above those pressures I am addressing within my Budget package. History has shown that not all fiscal risks materialise during the course of the financial year. However, the health and disability system is a complex system that faces foreseen and unforeseeable risks. I provide advice on known fiscal risks and how they can be managed in 2010/11 to inform Budget 2010 decisions.

7. Section Two of this proposal provides detailed information on what I intend to achieve in Vote Health in Budget 2010 and how my intentions will be funded within available funding including from savings.

Improved financial management and sustainability

8. Vote Health will face significant fiscal pressures and risks over the foreseeable future as it transitions to a lower funding growth path than previous years. To improve the financial management and sustainability of the health and disability system requires tight cost containment and effective management of demand pressures and, where appropriate, reprioritising funding to frontline services and Government priorities.

DHB-managed services

9. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]*

10. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]*

11. To build on our achievements and ensure a financially sustainable DHB sector that manages to an improving deficit track will require:

    - DHBs making productivity improvement savings of approximately *[deleted – negotiate without prejudice]* in 2010/11 to live within their available funding with any changes to service coverage as a last resort
    - DHBs meeting the full costs of renegotiated collective employment agreements expiring in 2009/10 or 2010/11 and annual step adjustments within their available funding
    - DHBs delivering on their approved Performance Improvement Actions (PIAs)
    - Establishment of a Shared Services Agency to reduce waste in the sector through joint procurement and back office functions as agreed by Cabinet

- Establishment of new institutional arrangements to support better funding and planning of services – nationally, regionally, and at the district level.

12. In my letter of expectations to DHBs I have clearly communicated that they must budget to meet Government priorities, national Health Targets, and pressures including industrial relations settlements within their 2010/11 allocations. To achieve this, DHBs will make productivity improvements through changes to models of care and service mix. In some instances, changes to service mix will require the reprioritisation of funding from some services and contracts to frontline services. This may also require DHBs to exit some contracts or to provide different types of service than they currently do to meet the health and disability needs of their communities. However, it is my expectation that these changes will not affect the overall service coverage and quality of high value frontline services.

13. I have also signalled to DHBs that I expect them to establish specific action plans to improve their financial performance year on year. I have reinforced these messages by meeting with Board Chairs and Chief Executives and have been very explicit as to their obligations to deliver to their planned budgets.

14. To support DHBs in meeting my expectations the Ministry and I have instituted some key initiatives in 2009/10 that will continue into the 2010/11 year which include:

    - Establishing a National Health Board (NHB) to oversee and engage with DHBs during the annual planning process and in-year performance against DHB plans
    - Strengthening the Monitoring and Intervention Framework including introducing an early warning system to identify any issues with DHB performance and enhanced policy tools to enable earlier intervention to improve performance over the financial year
    - Instituting new financial performance monitoring procedures in addition to the standard Monitoring and Intervention Framework.

15. Once DHB District Annual Plans (DAPs) have been approved, the NHB monitors DHBs intensely during the year depending on their level of performance against their DAPs. Where a DHB does not meet its DAP performance expectations the NHB, in consultation with me, works with a DHB to develop a recovery plan which sets out concrete steps as to how the DHB will reach its planned performance. The DHB is then monitored monthly. If a DHBs performance does not improve, I will use my statutory powers in consultation with the NHB to intervene to correct their performance, for example by appointing Crown monitors and 'turnaround teams'. These measures support my intention to close the second cheque book over time.

16. The Ministry will receive DHB DAPs on 12 March 2010 at which time the level of productivity savings required to manage within available funding will be finalised. I expect all DHBs to submit plans that align with or outperform the agreed year-end aggregate sector deficit position of $89 million for 2010/11 (an improvement of $26 million on the forecast for year-end 2009/10). As shown in table 1 above, sufficient provision *[deleted - negotiate without prejudice]* has been made in Health baselines to manage this forecast year-end position.

17. To meet the aggregate sector position for 2010/11, DHBs are required to identify in their DAPs three PIAs that will make a material difference to their performance in 2010/11 including the productivity savings they will make to live within their means. The NHB will

work with DHBs during the planning process to ensure these are achievable and align with Government priorities.

18. DHBs have been asked to focus their PIAs on:
    a. financial security – active cost management (eg industrial relations agreements that are affordable)
    b. improved productivity and quality, particularly hospital productivity – through targeted action on more efficient and productive wards, and improving day surgery and theatre utilisation
    c. regional co-operation (eg improved service configuration and delivery models as part of regional service planning, particularly to address currently vulnerable services)
    d. collective procurement and shared back-office support functions.

19. DHBs who submit unacceptable DAPs in regards to either forecast financial performance, PIAs, or delivery on Government priorities will be asked to rework their plans in consultation with the NHB.

20. For the 2010/11 year, my intention is to continue to improve the financial leadership and accountability of Board Chairs and Chief Executives. In my letter of expectations to Board Chairs, I signalled my expectation that Boards will clearly demonstrate how they will effectively take ownership of and hold their Chief Executives to account for the financial performance of their DHB. I have also signalled strongly to Board Chairs that I expect them from a governance level to involve clinicians much more closely throughout all levels of the organisation to improve the quality, productivity, and value for money of service delivery.

21. The most significant risks facing the DHB sector are the fiscal pressures arising from industrial relations settlements to be settled in the 2010/11 calendar year. Industrial relations agreements being negotiated during 2010/11 include significant portions of the health workforce (eg Nurses and Senior Doctors) both in terms of number of employees and associated costs.

22. DHBs are required under the New Zealand Public Health and Disability Act 2000 to consult with the Ministry of Health prior to entering into industrial relations negotiations. The Ministry has advised DHBs that they need to ensure they can afford the full cost of any industrial relations settlement offer, along with the cost of their existing commitments, within their overall funding package, DAP assumptions, and without recourse to extraordinary government funding as per Government expectations.

23. DHBs have entered current 2010 negotiations with tight parameters for upwards adjustments in wage rates and the timing of any adjustments. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice].*

24. In regard to the implementation of a Shared Services Agency, we have appointed a Shared Services Establishment Board which is tasked with developing options for establishing the Agency. The Establishment Board's advice will inform me of the risks associated with the proposed options and once Cabinet has agreed to an option for establishing the Agency, fiscal and policy risk management strategies will be developed to ensure successful implementation. Depending on Budget 2010 decisions outlined in Section Two of this report, there will be sufficient provision in Health baselines to manage the transition costs for establishing the Agency.

Health and disability support services managed on behalf of the Crown by the Ministry of Health

25. The Ministry of Health manages on behalf of the Crown $2.5 billion of services many of which are frontline services such as disability support, primary maternity services, national elective services, national screening services, and primary care services. A third of Ministry-managed funding is directly contracted with DHBs.

26. The Ministry has run a robust prioritisation process to assess the most critical pressures within its services that require funding under current policy settings. All Ministry-managed pressures that I propose to provide funding for in Budget 2010 are frontline care and support services. Ministry-managed frontline services face the same pressures as DHB managed services with some forecasting significant cost growth under current policy settings. If these services are not funded now through the Budget process they will either require funding during the 2010/11 financial year or changes to service coverage or quality, in many instances significant changes will be required.

27. The proposed aggregate increase of 2.2% ($59 million) to Ministry-managed non-departmental expenditure (NDE) services is significantly less than that proposed for DHB managed services of 3.6%. It is also significantly lower than forecast demographic change and economy-wide estimates of price pressure of 4.155%, with full FFT/Demo for Ministry-managed NDE being $106 million in 2010/11.

28. Given our collective Government priority of providing quality public services for less, I am proposing to push for efficiency gains in Ministry-managed services by providing a lower funding increase than calculated by top-down indicators of cost pressures in 2010/11. To manage to this funding path the Ministry will be required to make 1.955% of efficiency gains in 2010/11. The Ministry has advised me that my proposed Budget 2010 funding increase for Ministry-managed services will be tight but manageable and will enable the Ministry to maintain service coverage and quality in 2010/11.

29. However, any further reduction in funding provided for frontline Ministry-managed health and disability services would have significant impacts on service coverage and quality. These impacts would likely have consequent impacts on DHB managed services either in terms of the services the Ministry directly contracts with DHBs to provide or increased demand pressure on DHB managed services. This would make it more difficult for DHBs to manage to their deficit track requiring greater productivity improvements or potentially significant changes to service coverage and quality.

30. For instance, the Ministry contracts with DHBs to provide Assessment, Treatment, and Rehabilitation (AT&R) services for disabled people under 65. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]* . If no price adjustment is made for this service in 2010/11 the sustainability of some DHB AT&R services will be compromised *[deleted – negotiate without prejudice]* and/or access to these services for Ministry clients will likely reduce.

31. To manage within its available funding the Ministry is:

    - Managing volume growth through improved prioritisation and efficiency gains
    - Negotiating marginal or no increases to provider contracts for price pressures, which requires providers to make efficiency gains within their services and share the tighter fiscal environment

- Managing some pressures within its NDE baselines through reprioritising lower value funding to higher priority frontline services
- Improving expenditure forecasting and business planning.

32. The Ministry has also made significant savings within its NDE funding to manage its service pressures and fund Government priorities in Budget 2010. It is also making efficiency savings within its Departmental Expenditure (DE) to be reprioritised to Government priorities and frontline health and disability services. This reflects my priority of moving resources to the frontline.

33. The Budget 2009 funding increase applied to Ministry-managed NDE was also tight and prioritised towards the most critical pressures in Ministry frontline services. While these tight funding increases can be managed in the short-term, it will be important to monitor their effect on the sustainability of Ministry-managed health and disability services to avoid the need to provide significant funding catch-ups in later years and to avoid service failures. This is particularly important in the context of the proposed devolution of some Ministry-managed services to DHBs.

A sustainable clinical workforce which has a strong role in health and disability system leadership

34. The New Zealand health and disability system faces increasing demand for its services due to population aging, chronic disease, and public expectations. At the same time, workforce pressures in some services and regions are emerging and we have a very high reliance on overseas trained practitioners. For New Zealand to have a sustainable clinical workforce requires addressing these workforce issues.

35. I have established a Health Workforce Board to help set the strategic direction for workforce planning including changes to models of care and innovation in service delivery. The Board will work with the Ministry of Health to provide me with advice on how to create a sustainable workforce to ensure that the health and disability system can manage the forecast demand growth for services over the coming years.

36. An environment in which clinicians feel they are involved in decision-making and have opportunities to improve their skills will also improve recruitment and retention. Additionally, engaging clinicians in decision-making is important for improving the quality of services, patient outcomes, and productivity.

37. To deliver on this priority I propose to:
    - Fund the second tranche of the Boosting Medical Student Places initiative commenced in Budget 2009, which is intended to increase the New Zealand trained clinical workforce and reduce our reliance on foreign-trained doctors
    - Provide a one-off extension to the Voluntary Bonding Scheme initiated in Budget 2009 due to the success of the scheme, which is aimed at retaining New Zealand-trained clinicians in hard to staff areas
    - Establish a Quality Improvement Agency that will be tasked with fostering clinical engagement and leadership to drive improved sector outcomes in terms of better population health, better and safer patient care, and efficiency savings.

38. In my letter of expectations to DHBs I have also signaled my expectation that they will strengthen clinical engagement from the governance level throughout the DHB organisation to improve both clinician's job satisfaction and support productivity improvements.

39. There are no fiscal or policy risks associated with the Boosting Medical Students Places and Voluntary Bonding Scheme initiatives. In regard to the establishment of a Quality Improvement Agency, an interim board will be appointed by 1 April 2010 to provide me with expert advice on the establishment of the Quality Improvement Agency, including identifying potential risks and risk management strategies. The implementation costs for the Agency are currently being estimated but provision has been made and any associated costs will be managed within my available funding.

Bringing health services closer to home to improve the efficiency and effectiveness of health service delivery

40. As part of the drive to improve the value for money of existing Health funding and ensure system sustainability into the future, I have commenced initiatives to bring health services closer to home to improve the efficiency and effectiveness of service delivery.

41. International evidence suggests that well integrated health and disability systems in which primary care plays a major role in service delivery, prevention, and health promotion can improve health outcomes while reducing demand pressures in hospital-based services.

42. To deliver on our priority of bringing health services closer to home as part of the Government's Better, Sooner, More Convenient election commitment, I have commenced a process to develop new models of care between primary and hospital-based services. This process brings together primary and secondary care stakeholders to develop business cases to implement new models of care that will over time improve the financial sustainability of the health and disability system. This process is ongoing and will continue into the 2010/11 year.

43. I have communicated to DHBs my expectation that they work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and specify these in their 2010/11 DAPs.

44. I have also invited the primary care sector (DHB and PHO representatives) to identify significant savings within primary care funding streams to reduce forecast cost growth by reprioritising funding to the highest value frontline services. This includes identifying surplus funding in the sector that can be used to manage down forecast expenditure growth. I am also actively seeking consolidation in the primary care sector to reduce bureaucracy and waste so that more funding is prioritised to services delivered directly to the public. I have communicated this message to DHBs.

45. There are fiscal and policy risks associated with the transition to new models of care in primary and secondary services. I have asked the Ministry and sector to develop risk management strategies to ensure that the quality and financial sustainability of services is assured as new models of care are implemented. *[information deleted in order to maintain the current constitutional conventions protecting the confidentially of advice tendered by ministers and officials].*

Other Budget 2010 priorities and funding initiatives

46. Alongside the Ministerial priorities and associated initiatives I have decided for 2010/11, I propose to provide funding to advance some new initiatives that fulfill our election commitments, provide for Prime Ministerial priorities, and seek to improve population health outcomes. Additionally, I seek to provide funding to address known system pressures to ensure long term sustainability and reduce waiting lists in some services, for example Environmental Support Services for disabled people. Further information on these initiatives is provided in Section Two.

Managing fiscal risks over and above those addressed in Budget 2010

47. The health and disability system faces fiscal and policy risks over and above those earlier identified for DHB deficits and Ministry-managed NDE services. These risks will need to be monitored and managed in 2010/11.

48. In previous years, the Health risk reserve has been set at a level sufficient to provision for known fiscal risks during the Budget process and the expectation on Health was that it would manage within its available funding. However, the Budget 2010 allocation has not provided sufficient funding to increase the risk reserve above its present level given the funding required for DHBs and the Ministry to maintain the coverage and quality of their frontline care and support services.

49. Currently there is unallocated funding of *[deleted – negotiate without prejudice]* remaining in the risk reserve. While history has shown that not all fiscal risks materialise in a given year, based on the risks outlined in the table above, it is estimated that a risk reserve of between *[deleted – negotiate without prejudice]* would enable Health to manage within its available funding without recourse to the between Budget contingency.

50. To manage known Health fiscal risks during the 2010/11 year requires:
    - Addressing as many pressures now as far as possible to manage down fiscal risks during the 2010/11 year as proposed in my Budget 2010 package
    - Reprioritisation
    - Use of unallocated risk reserve funding, or
    - If risks exceed funding available, accessing the Crown between Budget contingency.

51. Given the significant reprioritisation that has already been made in Ministry-managed NDE to balance the Budget 2010 package and savings that DHBs are required to make to live within their available funding, it is likely that any further repriotisation will require changes to service coverage and quality in Ministry-managed services. Depending on the level of risk to be managed these changes may be significant and have to be made in high value services.

52. However, I am committed to managing within my available funding in the first instance and will seek Cabinet's agreement on any policy decisions that have significant implications for the health and disability system.

Priorities deferred

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

Section 2: Pressures, Commitments and Reprioritisation

Overview

54. This section details what I intend to achieve in Vote Health in Budget 2010 and how my intentions will be funded within available funding, including from savings.

55. Table 3 provides an overview of my proposed Budget 2010 package. It shows the package balances to its highest outyear with $2 billion of expenditure over the forecast period.

Table 3: Overview of Proposed Health Budget 2010 package ($ millions)*

	2010/11	2011/12	2012/13	2013/14	Highest outyear
Income					
Current Budget 2010 Allocation	400.000	400.000	400.000	400.000	400.000
Savings - On Going	31.907	33.575	34.646	35.720	33.059
Budget Allocations 08/09 Under spends	38.665	127.658	43.614	16.830	12.400
Total New Funding + Available Baseline Funding	**470.572**	**561.233**	**478.260**	**452.550**	**445.459**
Pressures and Commitments					
Demographic funding - DHBs 1.885%	182.783	182.783	182.783	182.783	182.783
Contribution for cost pressures - DHBs	167.217	167.217	167.217	167.217	167.217
Ministry Managed NDE Pressures	59.340	59.340	59.340	59.340	59.340
Government Commitments	16.789	24.235	25.306	26.380	23.719
Increase to Risk Reserve	5.778	-	-	-	-
Commitments/Pressures to be met from 08/09 underspends	38.665	127.658	43.614	16.830	12.400
Total Pressures and Commitments	**470.572**	**561.233**	**478.260**	**452.550**	**445.459**
(Deficit)/Surplus	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**

* excludes Technical Adjustments

56. As outlined in Section One, my first priority in Budget 2010 is to ensure system sustainability and to contribute to our Government priorities of improving the value for money of public spending while constraining expenditure. Reflecting this, I intend to use the majority of available funding to address pressures in DHB and Ministry-managed services to maintain frontline service coverage and quality. I have also made savings in lower value services to move resources to the frontline and to address our key Government commitments.

57. The remainder of this section provides details on each proposed use of available funding and the savings I intend to make to fund pressures and commitments.

Pressures

Proposed funding increases for DHB-managed services

58. DHBs manage over $9 billion of Vote Health funding on behalf of the Crown to deliver health and disability support services. In December 2009, joint Ministers agreed to allocate $350 million of Health's Budget 2010 allocation of $400 million to DHBs in 2010/11 and outyears. This funding is to meet pressures from demographic growth (estimated at 1.89%) and a contribution towards cost pressures (1.73%).

59. DHBs were notified of this increase in the December 2009 funding package to inform their planning for 2010/11. In the funding package, the National Director of the National Health Board Business Unit notified DHBs that they were to plan to:

- maintain core services and increase availability in line with demographic trends
- maintain funding directed to first contact patient care in real terms (requiring a funding increase of about 2%)
- improve quality in age-related residential care (an increase of around 1.7%)
- meet the full costs of renegotiated collective employment agreements expiring in 2009/10 or 2010/11 or any step adjustments
- meet the Government's commitments to increase elective services by 2000 discharges in 2010/11.

60. In February 2010 I also communicated my expectations to DHBs that, within their available funding they are to:

- focus resources on supporting frontline services. Specifically they are to:
    - increase elective surgical volumes year on year
    - improve emergency department waiting times
    - improve cancer treatment waiting times
- provide access to a wider range of services closer to home. Specifically they are to:
    - work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and to specify these in their DAPS
    - provide these services at no cost to patients, and
    - actively investigate and facilitate the opportunities that exist in their districts to consolidate Primary Health Organisations (PHOs) where appropriate, acknowledging existing provider networks
- strengthen clinical engagement from the governance level throughout the organisation
- accelerate closer collaboration with neighbouring and close DHBs, including Regional Service Plans and clinical networks.

61. I also communicated my expectation that DHBs are required to meet Government priorities, Health Targets, and pressures including industrial relations settlements within their 2010/11 allocations. To manage within their available funding DHBs will need to make productivity improvements of approximately *[deleted – negotiate without prejudice]*. This will include changes to models of care and service mix. In some instances, changes to service mix will require reprioritisation of funding from lower value services and contracts to higher value frontline services. It is my expectation that these changes will not affect the overall service coverage and quality of high value frontline services.

Pressures in Health and Disability Services managed by the Ministry of Health

62. As outlined in Section 1, significant pressures are being managed within programmes. The most pressing pressures in health and disability services budget managed by the

Ministry on behalf of the Crown are set out in Table 4. Funding of $59 million represents an effective efficiency requirement of 1.955% against top-down estimated cost pressures as advised in Section 1.

Table 4: Ministry-managed NDE pressures ($ millions)

	Disability Support Service Pressures	2010/11	2011/12	2012/13	2013/14	Highest Outyear
1	Residential Services for People with Intellectual Disabilities	5.370	5.370	5.370	5.370	5.370
2	Young Persons with Disability in Residential and Hospital Services	1.053	1.053	1.053	1.053	1.053
3	Respite Care	0.677	0.677	0.677	0.677	0.677
4	Home & Community Support Services	6.390	6.390	6.390	6.390	6.390
5	Carer Support	0.600	0.600	0.600	0.600	0.600
6	Supported Independent Living	1.980	1.980	1.980	1.980	1.980
7	NASC Management	0.177	0.177	0.177	0.177	0.177
8	Crown Funding Agreements with DHBs	0.830	0.830	0.830	0.830	0.830
9	Other Services	0.862	0.862	0.862	0.862	0.862
	National Child Health Service Pressures					
10	Well Child (Plunket Contract)	0.688	0.688	0.688	0.688	0.688
11	*[deleted – negotiate without prejudice]*					
	National Contracted Services - Other					
12	*[deleted – negotiate without prejudice]*					
13	Contact Lens volume pressure	0.094	0.094	0.094	0.094	0.094
14	*[deleted – negotiate without prejudice]*					
15	Hospital Chaplaincy	0.114	0.114	0.114	0.114	0.114
	Primary Care					
16	PHO Performance	3.772	3.772	3.772	3.772	3.772
17	Care Plus	11.182	11.182	11.182	11.182	11.182
18	Very Low Cost Access	7.500	7.500	7.500	7.500	7.500
	Screening Services					
19	Breast Screening	4.030	4.030	4.030	4.030	4.030
20	Cervical Screening	1.250	1.250	1.250	1.250	1.250
21	Antenatal & Newborn	0.288	0.288	0.288	0.288	0.288
22	Breast Screening Secondary Services	6.000	6.000	6.000	6.000	6.000
	Māori Innovations Fund					
23	Māori Innovations Fund	5.000	5.000	5.000	5.000	5.000
Pressures Total		**59.340**	**59.340**	**59.340**	**59.340**	**59.340**

Disability Support Service Pressures (proposals 1-9)

63. Ministry-managed NDE pressures include a range of services in the Disability Support Service (DSS) appropriation, such as home and community support, equipment, and residential care that are subject to price and volume pressures (Table 6).

Table 5: Disability Support Service pressures ($millions)

Service area		Price	Volume	Total
1	Residential Services for People with Intellectual Disabilities	1.790	3.580	5.370
2	Young Persons with Disability in Residential and Hospital Services	0.663	0.390	1.053
3	Respite Care	0.311	0.366	0.677
4	Home & Community Support Services	-	6.390	6.390
5	Carer Support	-	0.600	0.600
6	Supported Independent Living	-	1.980	1.980
7	NASC Management	0.177	-	0.177
8	Crown Funding Agreements with DHBs	0.830	-	0.830
9	Other Services	0.862	-	0.862
Total		4.633	13.306	***17.939***

64. My aim in managing DSS price pressures is to maintain service coverage and quality, while moving service delivery closer to home. *[Deleted – free and frank]* Cost effectiveness of care is improved by focusing on pressures in services that assist people to remain in their own home. This has allowed the service area to manage pressures within an overall funding increase of 2.1%, which is much lower than the past few years.

65. Volume pressures arise due to demographic change, people living longer with disabilities and exhibiting higher or more complex conditions. Price pressures arise due to a highly competitive labour market for support services, and the fact that the Ministry, in some instances, purchases services at a lower price than other funders. In order to maintain the quality and availability of services, the Ministry must ensure that the prices it pays for services is sufficient for providers to manage pressures within contracted funding. A large proportion of staff in home and community support services are paid at a rate only slightly higher than the minimum wage. As a result, the recent change in the minimum wage will put upward pressure on providers to manage their staff-related costs.

66. If the above pressures are unfunded, there is a risk that access to these services will be reduced resulting in higher long-term support costs if clients' needs increase more rapidly. There are also likely to be consequential impacts on DHB-managed services in terms of the services the Ministry directly contracts with DHBs to provide. An example is the Ministry contract with DHBs for Assessment, Treatment and Rehabilitation services for disabled people under 65 – where the Ministry currently pays a significantly lower price than other funders (ACC and DHBs).

Personal Health Service Pressures (proposals 10 – 15)

67. A range of personal health care services *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]* are subject to price and volume pressures. Funding these pressures aligns with my priority to maintain service coverage and quality (Table 6).

Table 6: Personal Health Services pressures ($millions)
[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]

68. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]*

69. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]*

70. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]*

71. *[information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]*

72. **InterChurch Hospital Chaplaincy services:** The multi-year contract with the InterChurch Hospital Chaplaincy service has a 4% price increase each year built into it. Exiting this contract or failing to pay the previously agreed increase carries legal and financial risks.

Primary Health Care Pressures (proposals 16-18)

73. There are pressures in the Primary Health Care Strategy appropriation in the PHO Performance Programme, Care Plus and the Very Low Cost Access (VLCA) scheme (Table 7). Funding these pressures aligns with my priority to maintain service coverage and quality. These pressures have been offset by reprioritisation within Ministry baselines in order to reduce them as far as possible.

Table 7: Primary Health Care pressures ($ millions)

Service areas		Price	Volume	Total
16	PHO Performance	-	3.772	3.772
17	Care Plus	-	11.182	11.182
18	Very Low Cost Access	7.500	-	7.500
Total		7.500	14.954	***22.454***

74. In relation to PHO performance, PHOs have exceeded forecast performance and the price paid per performance indicator was increased significantly in 2009/10, resulting in an overall increase in programme costs. The Care Plus pressures are volume driven, based on increased programme uptake.

75. The VLCA pressure is based on the funding required to address price pressures in VLCA scheme practices and maintain the relative value of the scheme compared to practices outside the scheme, given that scheme practices are not able to increase patient co-payments.

76. If unmet, the VLCA and Care Plus pressures would both compromise provider involvement in the schemes. PHO Service Agreement Amendment Protocol (PSAAP) negotiation would be required to reduce or eliminate increases in PHO Performance fees. I have considered options for scaling these pressures which will require policy decisions (including those to implement the Better Sooner More Convenient commitments for primary health care) by myself and Cabinet in consultation with DHBs and the primary care sector to implement. I will be providing a paper to Cabinet shortly seeking to make savings off up to $3 million in primary care to balance the Budget 2010 package as outlined in paragraph 144 of this proposal.

Screening Service Pressures (proposals 19-22)

77. The Ministry of Health contracts with a range of providers to screen eligible individuals for harmful conditions. This includes breast, cervical, and antenatal and newborn screening. Provider contracts face price pressures resulting from step adjustments in employment contracts, technology investment and volume pressures to reflect demographic change and to reach screening coverage targets (Table 8).

Table 8: Screening Services pressures ($ millions)

Service areas		Price	Volume	Total
19	Breast Screening	2.670	1.360	4.030
20	Cervical Screening	0.530	0.720	1.250
21	Antenatal & Newborn Screening	0.288	-	0.288
22	Breast Screening Secondary Services	3.000	3.000	6.000
Total		6.488	5.080	***11.568***

78. Investment in screening services aligns with my priority of fiscal management and sustainability, not only because it maintains service coverage, but also because effective screening programmes reduce downstream costs.

79. **Breast Screening:** Pressures in Breast Screening services are based on a 2.5% assumption for staff-related costs, and 5.7% volume growth due to demographic change. Additionally, depreciation costs of $2 million are required for the implementation of new digital mammography technologies. This investment is expected to reduce handling time by 25-30% due to improved picture archiving. As a result, future efficiencies will deliver a return on this investment.

80. There is also a $6 million pressure from the treatment costs of Breast Screening. Previously, some services were devolved to DHBs, only to be shifted back to the National Screening Unit in 2006. DHBs returned the funding at its original value, meaning that it had not been adjusted for FFT or demographic change, or the expansion of eligibility. As a result a $6 million pressure has recurred in the Breast Screen Aotearoa budget each year, which has been managed through the use of underspends. However, this strategy is no longer sustainable.

81. **Cervical Screening:** Pressures in Cervical Screening services are based on a 2.5% assumption for staff-related costs, 3% volume growth, and funding of $0.03 million required to expand coverage by 0.4% to meet the 75% target.

82. **Antenatal & Newborn Screening:** Pressures in Antenatal & Newborn Screening services are based on a 2.5% assumption for staff-related costs. No demographic funding will be passed on, due to a stable birth-rate.

Māori Innovations Fund Pressures (proposal 23)

83. The Māori Innovations Fund initiative was agreed during the 2009/10 financial year by myself and the Associate Minister of Health [HR20090805 refers]. It will invest $20 million over the next four years for the creation, implementation and modeling of innovative Whānau Ora services (Table 9). Innovations were funded during 2009/10 from one-off savings from oral health, but ongoing funding for this initiative needs to be allocated. This initiative is already fully contracted for implementation from July 2010. I propose that it should be funded as part of Budget 2010.

Table 9: Māori innovation Fund pressures ($ millions)

Māori Innovations Fund ($m)		**Price**	**Volume**	**Total**
23	Māori Innovations Fund	5.000	-	5.000
Total		5.000	-	***5.000***

Government Commitments

84. Given the fiscal environment I have identified a modest new initiatives package that is restricted to fulfilling previously announced Government commitments (Table 10). These will be funded through reprioritisation of lower value expenditure identified in the savings section.

Table 10: Government Commitments for Budget 2010 ($ millions)

		2010/11	2011/12	2012/13	2013/14	Highest Outyear
1	Boost Medical Student Places	0.589	1.635	2.706	3.780	8.719
2	Boost Medicines Funding	7.400	7.400	7.400	7.400	7.400
3	Mental Health	7.600	7.600	7.600	7.600	7.600
4	Bowel Cancer Screening	1.200	7.600	7.600	7.600	-
Total Government commitments		**16.789**	**24.235**	**25.306**	**26.380**	**23.719**
5	Increase to Risk Reserve	5.778	-	-	-	-

85. **Proposal 1. Boost Medical Student Places by 20**: This is the second tranche of the Government commitment to increase the number of fully funded medical student places by 200 over five years. This funding is for an additional 20 places on top of the 60 places funded in Budget 2009. The Tertiary Education Commission has advised that all of the 60 places have been filled. This illustrates the success of the programme. By investing in workforce development we will move towards a more sustainable workforce, which aligns with my priority of ensuring funding sustainability.

86. New Zealand has the highest percentage of international medical graduates (IMGs) of any OECD country (40% of the medical workforce). At the same time, New Zealand is the highest exporter of doctors (29%). The OECD has warned New Zealand about an over reliance on foreign practitioners. This initiative is designed to increase the number of medical graduates to reduce New Zealand's reliance on IMGs.

87. This initiative has a rising profile with a peak of $8.719 million in 2022/23 (including postgraduate and student loan costs).

88. **Proposal 2. Boost Medicines Funding**: This is the second tranche of the Government commitment to increase funding for subsidised medicines by $180 million over three years. Real public funding of medicines has declined from $158 per person per annum in 2000 to less than $140 per person per annum today.

89. DHBs are contributing $10 million from their demographic funding in Budget 2010. I am proposing an additional $7.4 million to bring the total new investment up to $17.4 million. The additional $7.4 million sought represents a scaled back option from the original commitment of $20 million. PHARMAC expects to underspend in 2009/10 and this reviewed commitment needs to be read against that.

90. New investment in medicines carries a fiscal risk in outyears for PHARMAC. This is due to the fact that the additional funding will make a range of medicines available with a total cost of $17.4 million in 2010/11. However, the 2010/11 cost is not an accurate predictor of the cost in outyears. As the new medicines become more widely known and more widely prescribed, the uptake will increase beyond that of the first year. Because PHARMAC cannot manage this demand by reducing the range of funded medicines, it means that they are committed to providing medicines in outyears that may cost more than the $17.4 million.

91. The scale of this growth is expected to exceed that accounted for by demographic adjustments. Lower funding will minimise this outyear risk as uptake from newly funded medicines increases beyond the original costings.

92. **Proposal 3. Increase Mental Health Funding**: I propose providing additional funding for a range of Mental Health initiatives in Budget 2010. A key priority for Government is

to address the drivers of crime. Additional funding for mental health and addiction services will be focused on increasing the capacity of specialist alcohol and other drug services to possibly:

- *[information deleted in order to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials]*
- *[information deleted in order to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials]*
- maintain two sites providing mental health and alcohol and other drug nurse services in police watch houses ($0.68 million per annum)
- provide additional resources for substance use and misuse prevention services for taitamariki and taioha aged 10 to 13 years ($0.405 million per annum)
- *[information deleted in order to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials]*
- *[information deleted in order to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials]*

93. If funding is not allocated, there is a risk that the sector will not be able to respond to Government priorities without significantly affecting other services.

94. **Proposal 4. Bowel Cancer Screening Pilot**: Bowel cancer is the most frequently diagnosed cancer and the second highest cause of cancer death. New Zealand has the third highest rate of bowel cancer mortality in the OECD for women, and the sixth highest for men. The research trials show a benefit in terms of reducing mortality, and reducing treatment costs in the long term through early detection of pre-cancerous growths resulting in less complex surgery.

95. Current public hospital (inpatient and outpatient) treatment costs for bowel cancer are approximately $100 million a year, with an average cost of $31,000 per person. It is estimated that bowel cancer is responsible for approximately 20% of all cancer treatment costs, while accounting for only approximately 14% of all registered cancers. Localised cancers are relatively inexpensive to treat, with public hospital costs of approximately $22,000 per patient. More advanced cancers attract between two and four times more outpatient costs than localised cancers and cost approximately $34,000 for patients with distant spread and $43,000 for patients where the cancer has spread to lymph nodes.

96. The pilot programme will run for four years, giving opportunity to assess the effectiveness and workforce capabilities required, prior to considering a national roll-out. Fully implementing the National Bowel Cancer Screening Programme (including surveillance) would cost between $24 million and $53 million per annum, depending on the age range of eligible recipients. This is in addition to capital costs which are estimated to total between $6.5 million and $14.4 million.

97. There are risks that there will be pressure to progress to a national programme after the pilot. However, time-limited funding avoids as much as possible pre-determining a later

decision. I expect to take advice to Cabinet and seek support for this pilot initiative on 12 April 2010.

98. **Proposal 4. Increase to the Risk Reserve.** The health and disability system faces fiscal and policy risks over and above those earlier identified for DHB deficits and Ministry-managed NDE services. These risks will need to be monitored and managed in 2010/11.

99. There remains a small one-off surplus of $5.778 million in the Health Budget 2010 package which I propose to transfer to the risk reserve for 2010/11.

Allocation of 2008/09 Underspend to Commitments and Pressures

100. As discussed with the Minister of Finance, I propose to use unspent funds from the 2008/09 financial year to address some commitments and pressures as outlined in Table 11.

Table 11: Commitments and Pressures funded from 2008/09 Underspends ($millions)

	Operating NDE	2010/11	2011/12	2012/13	2013/14	Highest outyear
1	Cardiac	1.500	-	-	-	-
2	Establishment Funding of shared service agency	6.000	-	-	-	-
3	Voluntary Bonding	0.000	5.128	1.368	1.094	-
4	Breast Reconstruction	2.000	2.000	2.000	2.000	2.000
5	Electives as a result of ACC changes	10.000	10.000	10.000	10.000	10.000
6	DSS Equipment waiting list	15.000	5.000	-	-	-
7	Cochlear Implants	0.400	0.400	0.400	0.400	0.400
8	Capital	-	-	3.336	3.336	0.000
	NDE Total	**34.900**	**22.528**	**17.104**	**16.830**	**12.400**
	Capital					
11	Equity for capital projects for DHBs and the New Zealand Blood Service	-	37.087	-	-	-
12	New lending for Capital Projects	-	68.043	26.510	-	-
13	Health Sector Projects	3.765	-	-	-	-
Capital Total		**3.765**	**105.130**	**26.510**	**0.000**	**0.000**
Total Commitments and Pressures from Underspends		**38.665**	**127.658**	**43.614**	**16.830**	**12.400**

Operating NDE

101. **Proposal 1. Cardiac elective surgery**: Rising demand for cardiac surgery has increased waiting lists particularly in Auckland and Christchurch. Delayed cardiac surgery results in poor outcomes for some patients, including death. This funding will assist DHBs to reduce the current waiting list to a level that can be managed within their funding path.

102. **Proposal 2. Establishment funding for the Shared Services Agency and other changes recommended by the Ministerial Review Group:** The Shared Services Agency is being funded for set up costs for the first two years, after which time it will be funded by DHBs from savings from amalgamation of back office functions. It is currently

estimated that these savings will be in the order of up to $700 million after full implementation.

103. **Proposal 3. Voluntary Bonding:** The Voluntary Bonding scheme for health workers is a Government policy introduced in 2009. Cabinet agreed to a greater than forecasted number of bond approvals in 2009. The additional funding is required to meet this commitment in outyears.

104. **Proposal 4. Breast reconstruction:** There has been considerable public interest and media coverage on the availability of post-operative breast reconstruction for women. This funding allows the DHB providing this national service to improve access and reduce the waiting list.

105. **Proposal 5. Elective services resulting from ACC changes**: Following changes to ACC determination of eligibility a significant number of people who would have previously had surgery funded by ACC are transferring to general hospital surgical lists, increasing waiting times. There is an economic benefit to the country from treating and rehabilitating these people. This funding will enable DHBs to deal with the most urgent cases on the waiting list.

106. **Proposal 6. Disability Support Services equipment (Environmental Support Services):** The DSS equipment waiting list, which also impacts on aged care recipients, has grown significantly in the last 18 months. Delays in providing suitable equipment and modifications impacts on both lifestyle and safety issues for these clients. Cabinet has recently considered this issue and has agreed to changes to the delivery of environmental support services. This funding will reduce waiting list pressures while the changes are being introduced. The Government has made a public commitment to this funding following the Cabinet decision.

107. **Proposal 7. Cochlear implants:** Cochlear implants significantly improve hearing for people with severe hearing difficulties. Funding currently in baselines has been prioritised towards children, but there is also significant pressure from adults to have greater access to cochlear implants. This funding will enable more adults to access this technology.

108. **Proposal 8. Transfer of Operating NDE to Capital:** This funding is to provide additional capital to the Health Capital Envelope. Subject to new capital processes, it could be used to fund or partially fund, commitments such as new elective surgery theatres and/or new Linac machines for cancer treatment**.**

Capital NDE (proposals 11-13)

109. Funding of $135.405 million budgeted for, but not expended in 2008/09 is required to fund projects that have already been approved by Government and are already underway. These include the Counties Manakau Towards 20/20 construction project, the New Plymouth base hospital and the Waikato service and campus redevelopment. Without this appropriation these projects would need to cease construction.

2009/10 Technical Transfers

110. I propose making a number of technical adjustments to Vote Health to carry forward and reappropriate unspent funds from 2009/10. Table 12 shows the funding to be transferred from 2009/10 and how that funding will be reappropriated.

Table 12: Funding for Technical Transfers ($millions)

		2009/10	2010/11	2011/12	2012/13	2013/14
	Risk Reserves					
1	Risk Reserve Balance	-31.015	-5.000	5.000	-	-
	Electives					
2	Electives Cardiac Initiative	4.200	-	-	-	-
3	Electives Initiative	10.000	-	-	-	-
4	Electives Services Funding	6.000	-			
	Vaccines					
5	Funding for Measles vaccine	1.500	-	-	-	-
6	Pandemic Funding	3.315	-	-	-	-
	Shared Services					
7	Shared Services and Change Costs	3.640	2.360	-	-	-
	Whānau Ora					
8	Whānau Ora Initiative Funding	-1.200	1.200	-	-	-
	Other					
9	Residential Respite Initiative	-0.173	0.173		-	-
10	Māori Health Innovation fund - Expense transfer	-2.000	1.000	1.000		-

Allocation of Technical Transfer Funding

111. **Proposal 1. Risk Reserve Expense transfer:** This is a carry-forward within the risk reserve to provide a smooth path across years. This will enable ongoing risks to be more easily managed.

112. **Proposal 2. Elective cardiac initiative:** Concern over the waiting list for cardiac procedures has led me to instruct Auckland DHB to deliver extra case weights up to a cost of $5 million. The DHB has advised that they can now deliver the required increase at a cost of $4.2 million. Delivery will be achieved by 30 June 2010.

113. **Proposal 3. Electives initiative:** This is one-off funding in 2009/10 to address waiting list pressures resulting from changes to eligibility criteria for accessing ACC funded services, and links with funding of $10 million per annum from 2008/09 underspends. This will provide additional procedures above original agreements with DHBs. I am expecting the Ministry to deliver a detailed implementation plan within the next week.

114. **Proposal 4. Electives Services funding:** As DHBs in the past under-delivering on elective services volumes, $6 million of funding in 2009/10 was held in the risk reserve to be reappropriated if contracted volumes were met. Current information indicates that contracted volumes are being met so there is an obligation on the Crown to fund to contract.

115. **Proposal 5. Funding for Measles vaccine:** Additional funding is required to refund DHBs for the additional costs of Measles/Mumps/Rubella vaccines used in response to the Christchurch measles outbreak. This outbreak was of a significant nature, well above normal levels. Additional response was also required to contain the outbreak within the identified area.

116. **Proposal 6. Pandemic funding:** During the current year the Ministry has absorbed costs of $7.5 million within baselines. Costs over the next five months are estimated to be $3.315 million above available funding. This includes vaccines for front-line workers, ordering additional vaccines at increased prices from alternative suppliers due to world-wide shortages, and a national hygiene programme.

117. **Proposal 7. Shared Services and Change costs:** To fund costs associated with establishing a Shared Services Agency (a Government commitment). Funding is split between NDE and DE appropriations.

118. **Proposal 8. Whānau Ora initiative:** To fund progress of the Whānau Ora programme with key Maori Health providers. Funding in the current year is being held, pending final decisions on the Whānau Ora direction. It is now clear that funding would have better outcomes in respect to final policy decisions if moved to 2010/11.

119. **Proposal 9. Residential respite care:** In Budget 2009 Government committed extra funding of $5 million per annum targeted at increasing residential respite beds for older people. Conditions were attached to how this funding could be used. Funding has been withheld from Southland and Otago DHBs until they have completed analysis on expanding their respite services, as the Ministry is not satisfied that these DHBs are fulfilling their obligations. Funding will be used in 2010/11 to purchase extra beds.

120. **Proposal 10. Māori Innovation Fund:** This is a new Government initiative and final policy decisions have only recently been made.

Savings

121. In order to balance my package and fund identified pressures and my commitments I propose making ongoing savings from some national services and some Departmental Expenditure. Time-limited savings have also been identified in Public Health services (Table 13). I have included savings where there is no or minimal impact on front-line services consistent with my priorities.

Table 13: Savings identified to fund Identified Pressures and Commitments

	Savings - On Going ($ millions)	2010/11	2011/12	2012/13	2013/14	Highest outyear
1	National Mental Health Information Research and Infrastructure	1.000	1.500	1.500	1.500	1.500
2	Mental Health Workforce Development	1.000	1.000	1.000	1.000	1.000
3	Mental Health National Like Minds Like Mine (LMLM) programme	0.300	0.300	0.300	0.300	0.300
4	Public Health LMLM programme	0.000	1.000	1.000	1.000	1.000
5	Mental Health Promotion	1.500	1.500	1.500	1.500	1.500
6	Public Health Alcohol and other Drugs Services	0.250	0.250	0.250	0.250	0.250
7	Mental Health Sector Advisory Services	0.050	0.050	0.050	0.050	0.050
8	Mental Health unapplied 2009/10 FFT/Demo	0.300	0.300	0.300	0.300	0.300
9	National Immunisation programme	3.000	3.000	3.000	3.000	3.000
10	Human Papilloma Virus vaccination	5.300	2.300	2.300	2.300	2.300
11	Sexual Health promotion and prevention programmes	2.000	2.000	2.000	2.000	2.000
12	Refugee and migrant interpreters	0.100	0.100	0.100	0.100	0.100
13	Environmental Health and Communicable Disease services	1.220	1.220	1.220	1.220	1.220
14	Health support services for Dioxin-exposed Paritutu residents (annual wellness checks)	0.200	0.200	0.200	0.200	0.200
15	Hepatitis C programme	2.000	2.000	2.000	2.000	2.000
16	Oral Health programme	3.797	5.656	4.127	4.127	4.149
17	National Quality Improvement Project	2.000	2.000	2.000	2.000	2.000
18	Tobacco control programme	3.000	3.000	3.000	3.000	3.000
19	Primary Care Management Fees	1.690	2.190	2.190	2.190	2.190
-	Fiscally Neutral Adjustment	-1.800	-0.991	1.609	1.183	0.000
20	Ministry of Health DE savings from Staff reductions	5.000	5.000	5.000	5.000	5.000
	Total On going savings	**31.907**	**33.575**	**34.646**	**34.220**	**33.059**
21	Oral Health Time Limited Savings	-	-	-	1.500	-
	Total savings	**31.907**	**33.575**	**34.646**	**35.720**	**33.059**

Ongoing savings

122. **Proposal 1. National Mental Health Information Research and Infrastructure**: Funds innovation in mental health service delivery and development of information systems to assist in service planning and monitoring. Savings result from foregone reinvestment of funding freed up following completion of key health information development projects. There is no risk to frontline care.

123. **Proposal 2. Mental Health Workforce Development:** Funds workforce development (health professionals and support workers) to counter shortages in alcohol and other drug, child and adolescent and adult mental health services, and reduce the imbalance between the Māori and Pacific workforce and mental health client population. Savings result from adjusting the training grants budget for mental health support worker certificate and diploma courses to reflect current take-up rates; and reconfiguring contracts for specialist workforce development to focus on components providing the most gain. There is no risk to frontline care.

124. **Proposal 3. Mental Health National Like Minds Like Mine (LMLM) programme**: Funds a national programme for reducing stigma and discrimination associated with mental illness through public relations and communications campaigns; training and education support; research and evaluation; and an 0800 helpline providing information, advice and support. Savings result from foregone reinvestment of currently uncommitted funding. There will be no reduction in current service provision or risk to frontline care.

125. **Proposal 4. Public Health LMLM programme:** Funds regional and local community-level programmes that complement the national programme (above). Savings result from:

- regionalising and reconfiguring contracts and rationalising service providers.
- disinvestment from lower value contracts (unaligned with Government policy, ineffective, or inefficient), or contracts that may no longer be viable.

126. Risk of sustainability of the overall programme and effective providers will be mitigated through the contract negotiation and strong contract management processes.

127. **Proposal 5. Mental Health Promotion**: Funds regional and local community level programmes providing: training for primary health professionals and community members; promotion of 'mentally healthy' schools, workplaces and targeted communities; resources, advice and information on mental health for primary health professionals. Savings result from:

- reconfiguration of contracts and disinvesting from contracts or components that are lower value (unaligned with Government policy, inefficient or ineffective) or low viability; and
- not reinvesting funding released from time-limited contracts.

128. Risk of sustainability of the overall programme and effective providers will be mitigated through the contract negotiation and strong contract management processes.

129. **Proposal 6. Public Health Alcohol and other Drugs Services**: Supports community-based alcohol and drug-related services including: community worker positions for Community Action on Youth and Drugs (CAYAD); projects delivered by NGOs promoting community action and collaboration with a range of agencies to support policy development on reducing access to alcohol and other drugs, promoting public discussion and debate on alcohol and other drug-related issues; promoting positive health messages for youth and their families; and regulatory and health promotion work delivered by Public Health Units (PHUs), including statutory responsibilities under the Sale of Liquor Act 1989.

130. Savings result from disinvesting in lower value contracts or components. Decisions will be based on: ongoing need for the service; alignment with Government priorities; evidence of effectiveness; impact of reprioritisation on service coverage; provider sustainability; and provider performance. Risks of sustainability of the overall programme and effective providers will be mitigated through the contract negotiation and strong contract management processes.

131. **Proposal 7. Mental Health Sector Advisory Services:** Funds sector advice to inform policy development and service performance monitoring through contracts with the Mental Health Coalition (MHAC) established by the Mental Health Foundation; Supporting Families; and the Council for Well-Being Trust. Savings result from exiting the contract with MHAC when it falls due in June 2010. The savings will have no impact on the Ministry's ability to gain sector intelligence, as it will be able to access information provided by an advisory group established by the Mental Health Commission.

132. **Proposal 8. Mental Health unapplied 2009/10 FFT/Demo:** Appropriated to manage inflationary and demographic pressures in Ministry-managed mental health contracts. Savings result from maintaining existing price and volume levels in most contracts renewed in 2009/10.

133. **Proposal 9. National Immunisation programme:** Funds promotion and provision of early childhood immunisation vaccinations. Take-up rate at end of 2009 was 83%. Savings result from: aligning the budget with current take-up target (85% by July 2010 and 95% by 2012). Historically funding has been for 100% take-up. Savings will have no impact on short-term immunisation rates and are not related to the funding pressure in the Universal Newborn Screening programme. Work is underway to improve the efficiency of immunisation services to help longer-term increase in take-up.

134. **Proposal 10. Human Papilloma Virus vaccination (HPV):** Funds vaccinations for 12 year old girls against HPV – which causes most cervical cancers. Savings result from aligning the budget with current and estimated future take-up rates, which are lower than anticipated (rising to around 70% in three years time compared to the original estimate of 80%). Savings will have no impact on short-term vaccination rates and are not related to the funding pressure in the Cervical screening programme. Any higher than anticipated increase in the longer-term will be met by reprioritisation.

135. **Proposal 11. Sexual Health promotion and prevention programmes**: Funds health promotion for sexual and reproductive health, including resources to encourage testing for Chlamydia among high risk population groups. Savings result from efficiency gains and disinvestment due to decisions already made to postpone a media campaign promoting safe sex targeting young people and to discontinue the Sexual Health Advisory Committee. There is no risk to frontline care.

136. **Proposal 12. Refugee and migrant support services:** Funds health and disability services provided under the Auckland Regional Settlement Strategy for arriving migrants and refugees. Services are delivered by the Northern DHB Support Agency and consist of: interpreters in primary health care; specialist primary health care and support for refugee children with disabilities (particularly psychological issues); and cultural competence training for medical staff in responding to migrants' special needs. Savings result from rationalising administration costs as the services move from the set-up phase into ongoing maintenance. The savings will have no impact on service levels to the target populations.

137. **Proposal 13. Environmental Health and Communicable Disease services:** Funds specialist scientific services including strategic science advice, laboratory analysis, surveillance and monitoring of environmental hazards and communicable diseases. Efficiency savings for Budget 2010 of $0.22 million have already been found during 2009/10. Review and prioritisation of the science programme will continue in 2010/11 to identify a further $1 million through efficiency savings and disinvestment. Risk of overall service and provider sustainability will be mitigated through contract negotiation and strong contract management processes.

138. **Proposal 14. Health support services for Dioxin-exposed Paritutu residents:** Funds annual wellness checks for Paritutu residents/former residents who have been exposed to dioxin. The budget also provides for possible applications from July 2010 from timber workers exposed to pentachlorophenol between 1950 and 1980s. Savings result from aligning the budget to lower than anticipated take-up of dioxin-related health support services. Savings will not impact on service delivery to the target population(s). Any future increase in take-up rates will be met within existing baselines by reprioritisation.

139. **Proposal 15. Hepatitis C programme:** Funds an enhanced treatment package for people infected by the Hepatitis C Virus (HCV), consisting of improving HCV treatment services; knowledge of HCV among primary healthcare providers; diagnosis rates; and knowledge about New Zealand HCV prevalence. The current focus is on education services for health professionals and the

community. Savings result from not applying the additional $2 million per annum appropriated for 2010/11 and outyears (which would have doubled the current budget). The additional funding would have been invested in screening and clinical services. Better value for money is being achieved through the current approach of enhancing coordination of existing services and upskilling health professionals and the community, which is currently adequately funded. The savings will have minimal impact on the enhanced treatment package outcomes.

140. **Proposal 16. Oral Health programme:** Funds the operational component of reinvestment in child and adolescent oral health services. Business cases have been received and approved for all DHBs and both capital and operating funding allocated. Savings result from being able to fund DHB business cases under budget. All remaining operational funding is relinquished apart from $0.2 million in 2012/13 and outyears to provide for additional depreciation and capital charge expenditure. If there are major price increases in the future, and demand is constant or increases, additional operating funding may be required from a general risk reserve or other sources in the future.

141. **Proposal 17. National Quality Improvement Project:** Funds initiatives under the previous national policy on improving quality and safety. The policy is in the process of changing direction with the proposed Quality and Safety Agency replacing the Quality Improvement Committee. Savings result from not reinvesting funding freed up from National Quality Improvement Programme contracts ending on June 2010, and reducing funding for health sector innovation and capability initiatives, as part of refocusing the national policy. Savings will have no impact on the establishment or functioning of the proposed Quality and Safety Agency.

142. **Proposal 18. Tobacco control programme:** Funds a comprehensive range of activities: public education; smoking cessation services; Smokefree DHB contracts; local enforcement and monitoring through PHUs; local health promotion through PHUs; funding advocacy agencies such as ASH and the Pacific Tobacco Control Service; and subsidised Nicotine Replacement Therapy. Savings result from:

- efficiency gains from refocusing current quit smoking services and devolving to DHBs
- disinvestment from lower value contracts with the Health Sponsorship Council and PHU and NGO delivered services, through the contract renewal process.

143. Risk of provider sustainability will be mitigated through contract negotiation and strong contract management processes.

144. **Proposal 19. Primary Care:** In consultation with the primary care sector (DHB and PHO representatives), the Ministry will identify savings of approximately $3 million in primary care funding streams, including the PHO Performance Programme, Careplus, and PHO Management fees. Cabinet agreement to making these savings will be required and I will seek Cabinet agreement shortly.

145. **Proposal 20. Ministry of Health Departmental Expenditure (DE)**: The Ministry will make savings of $5 million in 20101/11 and outyears in its DE from a reduction in staff numbers to 1,290 by July 2011, and a reduction in discretionary spending for consultants and overseas travel. A further $5 million of savings will be realised in Budget 2011.

Time-limited savings

Proposal 21. Oral health time limited savings:

146. Funding allocated against DHB business cases for developing new models of care for child and adolescent oral health. Savings result from some DHBs being slower than originally planned in developing and implementing business plans. These are additional savings to those identified in item 16 above.