

# **Vote Health**

Report in relation to  
selected non-departmental  
appropriations for the year  
ended 30 June 2017

---

Citation: Minister of Health. 2017. *Vote Health: Report in relation to selected non-departmental appropriations for the year ended 30 June 2017*.

Wellington: Ministry of Health.

Published in October 2017  
by the Ministry of Health  
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-1-98-853902-7 (print)  
ISBN 978-1-98-853903-4 (online)  
HP 6708

This document is available at [health.govt.nz](http://health.govt.nz)



This work is licensed under the Creative Commons Attribution 4.0 International licence. In essence, you are free to: share ie, copy and redistribute the material in any medium or format; adapt ie, remix, transform and build upon the material. You must give appropriate credit, provide a link to the licence and indicate if changes were made.

# Minister's foreword

As Minister of Health, I purchase advisory and support services from a number of organisations working in the health and disability sector. A significant number of those service providers do not report to Parliament directly.

In accordance with section 19 of the Public Finance Act 1989, the purpose of this report is to articulate the service performance of those outputs delivered by third-party service providers funded directly by the Ministry of Health (the Ministry) and not covered by other reporting to Parliament.

A handwritten signature in black ink, appearing to read 'Coleman', with a stylized, cursive script.

Hon Dr Jonathan Coleman

Minister of Health

# Contents

<b>Minister's foreword</b>	<b>iii</b>
<b>Statement of performance</b>	<b>1</b>
Introduction	1
<b>Non-departmental expenses</b>	<b>2</b>
Health sector projects operating expenses	2
Health workforce training and development	3
Monitoring and protecting health and disability consumer interests	7
National child health services	9
National contracted services – other	11
National disability support services	12
National elective services	15
National emergency services	17
National health information systems	19
National Māori health services	21
National maternity services	22
National mental health services	25
National personal health services	29
Primary Health Care Strategy	34
Problem gambling services	36
Public health service purchasing	38
<b>Non-departmental other expenses</b>	<b>48</b>
Provider development	48
<b>Non-departmental capital expenditure</b>	<b>52</b>
Deficit support for DHBs	52
Equity for capital projects for DHBs and health sector Crown agencies	52
Health sector projects	53
Loans for capital projects	53
Refinance of Crown loans	53
Residential care loans – payments	54

# Statement of performance

## Introduction

This report is prepared under section 19 of the Public Finance Act 1989 and covers the Vote Health appropriations used for purchasing outputs supplied by third-party service providers that do not report to Parliament directly on that expenditure.

# Non-departmental expenses

## Health sector projects operating expenses

This appropriation is limited to operating expenses associated with the governance, planning and development of health sector capital projects.

### Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
N/A	The key project milestones for the Southern Partnership Group are delivered within one month of scheduled time frames	Achieved	Achieved

### Comments

These expenses predominantly relate to the Southern Partnership Group's operating expenses for overseeing the Dunedin hospital redevelopment project which is progressing through the Indicative Business Case and is expected to be built on a green site rather than re-developing the old building due to cost and clinical benefits.

### Summary of financial performance

Actual 30/06/2016 \$000	Health Sector Projects Operating Expenses	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
–	Total appropriation	2,561	–	6,252

# Health workforce training and development

This appropriation is for the provision of clinical training for doctors, nurses, dentists and other health professionals, and Voluntary Bonding Scheme claims. This appropriation is intended to ensure the New Zealand health sector is supported to develop a sustainable, flexible, and fit-for-purpose workforce through the funding of clinical training and other initiatives

## Summary of output performance

Actual 30/06/2016 <sup>1</sup>	Measure Description	Actual 30/06/2017 <sup>2</sup>	Budget Standard 30/06/2017
<b>Workforce Investment Programmes – the number of funded trainees</b>			
2,331	Medical workforce	2,204	2,204
100%	Sufficient numbers: the percentage of uptake nationally compared to contract volumes	100%	100%
3,609	Nursing workforce – see note 1	3,610	3,064
100%	Sufficient numbers: the percentage of uptake nationally compared to contract volumes – see note 1	118%	100%
175	Allied health workforce	384	362
100%	Sufficient numbers: the percentage of uptake nationally compared to contract volumes	106%	100%
280	Midwifery workforce	126	170
100%	Sufficient numbers: the percentage of uptake nationally compared to contract volumes – see note 2	74%	100%
249	Kaiāwhina workforce	743	706
100%	Sufficient numbers: the percentage of uptake nationally compared to contract volumes	105%	100%
718	Multi-disciplinary workforce – see note 1	694	300
100%	Sufficient numbers: the percentage of uptake nationally compared to contract volumes – see note 1	231%	100%
<b>Voluntary Bonding Scheme</b>			
333	New graduates are successfully being brought into the scheme: The total number of enrolees per annum	364	350
75%	People are being retained in the scheme: The percentage of registrants who applied for payment in the previous year who applied for payment in the current academic year, where this is allowable under the terms of the scheme	78%	75%
3	Ministry is actively managing the scheme: The number of bulk contracts with Voluntary Bonding Scheme participants	3	3

Note 1: Course costs for these programmes have changed enabling a greater number of trainees to be supported.

Note 2: The midwifery programme takes place over 18 months and one further intake still to occur under this contract to meet the expected budget standard.

<sup>1</sup> Figures relate to the 2015 academic year.

<sup>2</sup> Figures relate to the 2016 academic year.

## Comments

The Ministry, through Health Workforce New Zealand (HWNZ), invests \$185m annually in training and development of the health and disability workforce. This funding:

- supports new graduate nurses, midwives, pharmacists and doctors to transition into the workforce in their first year of practice
- subsidises the costs of vocational (specialist) training for doctors including general practice trainees in their first year of vocational (specialist) training
- supports the postgraduate training of nurses, dentists, midwives and a range of allied health and scientific workers such as psychologist interns, anaesthetic technicians, sonographers and medical physicists.

Around 63% of the funding for 2016/17 supported medical vocational training, 12% supported nursing workforce development, 12% supported the mental health and addictions workforce and the remainder supported midwifery, allied health, science and technical professions, disability support training, and workforce development support for Maori and Pacific health practitioners.

The Ministry also funded the operating costs of the Health Practitioners Disciplinary Tribunal, Regional Directors of Workforce Development and the provision of data to support workforce planning and development.

### Voluntary Bonding Scheme

The Voluntary Bonding Scheme continues to provide incentives for new graduates to work in hard-to-staff professions and/or specialties and hard-to-staff communities to improve recruitment and retention. There were 364 new registrants in 2016 (up 31 on the previous year): doctors, nurses, midwives and sonographers, with dentists registering for the first time.

### Nurse Entry to Practice (NETP)

The NETP programme provides funding for new nursing graduates in their first year of practice. The expected outcome of participating in the programme is that trainees meet the criteria to achieve competency Level Two on the Professional Development and Recognition Programme. In the 2016 academic year, 1135 NETP trainees were supported in 20 DHBs.

### Postgraduate Nursing Training

The Ministry invested in postgraduate training for 2459 nurses and 20 nurse practitioners in 2016. This investment will also support some registered nurses to qualify as prescribers.

### Midwifery First Year of Practice (MFYP)

The MFYP programme is a fully funded national programme aimed at providing a framework of support for newly graduated midwives during their first year of practice. MFYP was introduced in response to identified workforce issues, such as support for new midwives, quality assurance in clinical practice and recruitment and retention of new midwives. In 2016, 125 midwives were supported through contracts with New Zealand College of Midwives.

### Post Graduate Year 1 and Year 2 Medical Vocational Training (PGY1 and PGY2)

This is the first 2 years of training for RMOs (Resident Medical Officers) after the completion of training at Medical School. After PGY1 the RMOs gain general registration with the Medical Council of New Zealand. In the 2016 academic year, a total of 437 PGY1 and 376 PGY2 trainees were supported through contracts with 20 DHBs.



## **General Practice Education Programme (GPEP)**

GPEP provides pathways to a specialist career as a general practitioner. In the 2016 academic year we funded 187 eligible registrars in the first year of the programme. This programme increases the numbers of General Practitioners practising in the New Zealand health sector, ensuring a viable and sustainable workforce. GPEP includes an intensive first year of training in the work environment, placement outside the main centres where possible and subsequent years of supervised practice and additional learning. This provides experience and increases competence.

## **Disability Sector**

Workforce development services for the disability sector increase the skills of the disability workforce, increase the skills of people with disabilities, improve learning option for carers and family/whānau who support people with disabilities, improve information about the disability workforce and improve the integration of the disability workforce development.

## **Mental Health and Addictions**

Investment in workforce development, education and training services for the mental health and addiction workforce is targeted to ensure that the services delivered continue to meet the changing needs of the public and are consistent with the priorities outlined in *Rising to the Challenge, The Mental Health and Addiction Service Development Plan 2012-2017*, *Let's Get Real: Real skills for people working in mental health and addiction* (2008) and the *Mental Health and Addiction Workforce Development Plan 2017-2021*.

This Ministry's investment in four workforce centres ensures a comprehensive range of workforce development nationally, with each centre having a specific area of focus. One of the main programmes is the Skills Matter Programme, delivered by Te Pou. Skills Matter provides funding for postgraduate training for new graduates and existing practitioners, including nurses, social workers, occupational therapists, psychologists and addiction practitioners working in DHB, NGO and primary care settings. All programmes combine academic and workplace learning, and are at postgraduate level (levels 8 and 9 in the New Zealand Qualifications Framework).

New Entry to Specialist Practice (NESP) – Nursing, a Skills Matter programme, has over 50% of the total programme numbers. NESP is for new graduate nurses entering mental health and addiction nursing. The programme combines theory, supported clinical experience, clinical preceptorship and supervision. Nurses on this programme develop their professional practice and mental health and addiction nursing skills. Nurses receive a Postgraduate Certificate in Mental Health and Addiction Nursing. In 2016 we funded 163 places.

HWNZ and Massey University have made a commitment to increasing the professionalism of the Māori Mental Health Workforce. Each year the Te Rau Puawai Workforce Programme provides bursaries and learning support for students who are seeking to commence or complete a Massey University qualification in the field of Māori mental health.

We also continue to support Careerforce, the Industry Training Organisation (ITO) for the health, wellbeing, social and community sectors by providing training grants for Certificates and Diplomas in Mental Health for support workers.

## **Hauora Māori**

In addition, the Hauora Māori training fund supports the non-regulated Māori workforce to develop formal competencies in their current roles, and develop their potential to move into other health sector roles. Funding covers tuition fees and backfill, travel and accommodation, and course related costs. HWNZ has contracts with 19 DHBs for 2017. Annual workshops for programme

coordinators provide an opportunity to share best practice ideas, assist in planning and promotion for the following calendar year, and strengthen stakeholder relationships.

## Regional Workforce Development

We fund regional directors of workforce development in four hubs across New Zealand to support the workforce development and training of health professionals to meet local community needs and make better use of resources. The hubs, covering the four DHB regions, are a collaboration between the Ministry, regional shared services agencies, DHBs, the broader health sector, education providers and professional associations. The regional directors of workforce development maintain oversight of regional workforce related activities, including workforce development plans developed under Regional Service Plans

## Summary of financial performance

<b>Actual</b>	<b>Health Workforce training and development</b>	<b>Actual</b>	<b>Main estimates</b>	<b>Voted</b>
<b>30/06/2016</b>		<b>30/06/2017</b>	<b>30/06/2017</b>	<b>appropriation</b>
<b>\$000</b>		<b>\$000</b>	<b>\$000</b>	<b>30/06/2017</b>
				<b>\$000</b>
109,701	DHBs	115,734	117,032	120,532
3,031	The University of Auckland	2,388	—	—
2,084	University of Otago	1,438	—	—
517	Massey University	675	—	—
60,919	Non-government organisations	64,422	62,982	64,482
176,252	Total appropriation	184,657	180,014	185,014

# Monitoring and protecting health and disability consumer interests

The scope of the appropriation is the provision of services to monitor and protect health consumer interests by the Health and Disability Commissioner, District Mental Health Inspectors and Review Tribunals, and the Mental Health Commission. This appropriation is intended to ensure the rights of people using health and disability services are protected. This includes addressing the concerns of whānau and appropriately investigating alleged breaches of patients' rights.

Parts of this appropriation are reported to Parliament by the Health and Disability Commissioner, the Mental Health Commission and the Health Quality and Safety Commission. Their annual reports are framed in relation to the performance measures contained in their current Statements of Intent. This report covers the part of the appropriation that funds mental health reviews and enquiries, and it includes the work of district inspectors, the Director of Mental Health and the Mental Health Review Tribunal.

## Summary of output performance

### Health and Disability Commissioner

The performance measures are those contained in the Crown entity's Statement of Intent.

### Health Quality and Safety Commission

The performance measures are those contained in the Crown entity's Statement of Intent.

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Mental health reviews and inquiries</b>			
73%	The percentage of District Mental Health Inspectors' monthly reports, on their duties undertaken, sent to the Director of Mental Health within one month after completion – see note 1	79%	90%
11 <sup>th</sup> Sept 2015	The annual report by the Mental Health Review Tribunal, on their duties undertaken, to the Director of Mental Health by the due date	31 <sup>st</sup> Oct 2016	31 <sup>st</sup> Oct 2016
	The six-monthly reports, administered by the Tribunal's secretariat, to the Director of Mental Health by the due dates		
Achieved	– Report one	Achieved	20 <sup>th</sup> Nov 2016 [Achieved]
Achieved	– Report two	Achieved	20 <sup>th</sup> May 2017 [Achieved]
55%	The start of the Mental Health Tribunal review held within 28 days of the receipt of the application	79%	75%

Note 1: Performance in this area has improved and the Ministry has implemented changes to the reporting process to further improve timeliness of District Inspector reporting.

## Comments

### District inspectors

District inspectors are lawyers appointed by the Minister of Health to uphold the rights of patients as set out in the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental

Health Act). District Inspectors are responsible for visiting hospitals and services and reporting on these visits to the Director of Mental Health as required by section 98. They also investigate complaints of breaches of patient rights under section 75 and carry out inquiries into matters relating to patients, services where required by the Director (section 95). The District Inspector's primary accountability relationship is with the Director, who is responsible for the operation of the Act. Complaints about breaches of rights are addressed between the district inspectors and the Director.

### **Mental Health Review Tribunal**

Mental Health Review Tribunal's (MHRT) primary function is to consider whether patients subject to compulsory treatment orders are mentally disordered as defined by the Mental Health Act. Under the Act, a patient may apply to MHRT for a review of his or her condition. Other interested persons, such as the Director, a district inspector, a patient's welfare guardian or a GP, may also apply for a review. In 2016/17 there were 134 applications received. Since MHRT has been in operation the number of applications per year has ranged from 118 to 226.

In 2016/17, MHRT published decisions to assist the legal profession and public to understand mental health law and practices. To ensure privacy and confidentiality, only a selection of anonymised cases is released.

A detailed report of MHRT's activities is published each year as part of the Annual Report of the Office of the Director of Mental Health and is available on the Ministry's website.

### **Summary of financial performance**

<b>Actual</b>	<b>Monitoring and protecting health and disability consumer interests</b>	<b>Actual</b>	<b>Main estimates</b>	<b>Voted</b>
<b>30/06/2016</b>		<b>30/06/2017</b>	<b>30/06/2017</b>	<b>30/06/2017</b>
<b>\$000</b>		<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
27,510	Total appropriation	28,642	27,596	28,746

# National child health services

The scope of National Child Health appropriation is the funding and purchase of child health services. The appropriation is intended to ensure services are provided which support the development of New Zealand children and establish a foundation for children to live longer, healthier and more independent lives.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Infants receive their full Well Child/Tamariki Ora (WCTO) entitlement</b>			
85%	Percent of enrolled infants (0–12 months) who receive all core WCTO contacts (see Note 1)	77%	85%
<b>Plunketline telephone information and advisory services to support the Well Child/Tamaki Ora framework are delivered</b>			
100%	Phone line service is available 24/7	100%	99%
9%	Call abandonment rate (percentage of calls 'less than)	8%	less than 10%
<b>B4 School Checks (B4SC)</b>			
92%	Percentage of the eligible population delivered B4SCs	94%	90%
93%	Percentage of high-deprivation population delivered B4SCs	92%	90%
19	DHBs that provide the volumes of checks as specified in funding arrangements	20	20

Note 1: Enrolling with a WCTO provider at birth or as soon as possible thereafter allows sufficient time for WCTO providers to deliver the first core contact on time at around 6 weeks and therefore meet the quality indicator of delivering the full entitlement to children in the first year of life (if core 1 is missed, they are unable to meet the full entitlement measure).

## Comments

### Well Child/Tamariki Ora

Services are provided in conjunction with the Well Child / Tamariki Ora (WCTO) national schedule (June 2013), which outlines the assessment, intervention and health education activities.

These services are provided to a child and their whānau when the child reaches between four and six weeks of age, and services continue until the child reaches five years old.

The schedule divides the care into core screening, surveillance, and education & support, and these services are delivered in parallel as an integrated package of care for each child and their family.

All children enrolled with the national WCTO schedule are entitled to seven core contacts (excluding the B4 School Check, which is delivered separately). These services include core contacts provided from the time of hand-over from the lead maternity carer through to five years, with additional contacts being provided if there is an assessed need, for example first-time parents, postnatal depression, infant feeding or behaviour concerns.

Enrolling with a WCTO provider at birth, or as soon as possible thereafter, allows sufficient time for the provider to deliver the first core contact between four and six weeks of age, therefore providing

the best opportunity to meet the quality indicator of delivering the full entitlement to children in the first year of life (if core 1 is missed, the provider will be unable to meet the full entitlement measure).

The Ministry is responsible for funding comprehensive WCTO service coverage in each DHB district via the Plunket National Contract and DHB's WCTO Crown funding agreement. The agreements are designed to drive Plunket and DHB collaboration and collective responsibility to achieve the universal coverage of all contacts to improve health outcomes for all children and especially high-need and vulnerable children.

The national service provides for approximately 85 percent of service coverage for children up to four years. The balance of service coverage is the responsibility of local providers who are contracted via DHBs but funded via a Crown funding agreement (CFA).

## PlunketLine

PlunketLine provides telephone advice and information about parenting, child development and behaviour, nutrition and other Well Child topics. PlunketLine supports the family of children enrolled with all WCTO providers. Calls about sick or symptomatic children are transferred from PlunketLine to the national Healthline free advice service. Changes to call handling with the addition of a Plunket General Enquiry Line have enabled an increase in PlunketLine's capacity to deliver follow-up call backs to PlunketLine callers in appropriate cases.

## B4 School Check

DHBs are accountable (through a Crown funding agreement variation) for ensuring B4 School Check (B4SC) are delivered to a high quality and are nationally consistent in accordance with service requirements. The B4SC is the final core contact in the WCTO programme and takes place when a child turns four. WCTO services have a primary objective of supporting whānau and caregivers to maximise the child's developmental potential and health status from birth to five years of age, establishing a strong foundation for ongoing healthy development.

DHBs engage a B4SC coordinator to ensure the success of the programme and its sustainability. Coordinators are responsible for monitoring the completion of checks, actioning and tracking referrals, and ensuring that a high-quality service is provided, including the management of the consent process. In a number of regions, the DHB will contract a lead provider to deliver and manage the service (primary-care led, Plunket led or through the public health nursing workforce).

A total of 58,642 children were checked during 2016/17 with a coverage of 94 percent of the total population and 92 percent of the high-deprivation population. DHBs are currently funded to reach 90 percent of both the total and high-deprivation populations. Coverage for Māori and Pacific children was 95 and 89 percent respectively. The Ministry provides DHBs with feedback on trends in national service provision and areas of focus for quality improvements to the B4SC programme.

## Summary of financial performance

Actual	National child health services	Actual	Main estimates	Voted appropriation
30/06/2016		30/06/2017	30/06/2017	30/06/2017
\$000		\$000	\$000	\$000
83,559	Total appropriation	81,764	85,001	81,841

# National contracted services – other

The scope of this appropriation is limited to the Crown purchasing other services directly to support the health and disability services sector, including the national management of pharmaceuticals and health research.

Parts of this appropriation are reported to Parliament by PHARMAC and the Health Research Council of New Zealand. Their annual reports are against the performance measures in their Statements of Intent.

This report covers the part of the appropriation that funds other health services. The Pacific Innovation Fund recognises the need to design responsive services across health, education, housing, justice, social services, employment and lifestyle. The fund, to be invested over four years, is aligned to the vision of Whānau Ora for Pacific peoples and will support Pacific peoples to develop Pacific solutions to the issues they face as distinct communities.

## Summary of output performance

### PHARMAC

The performance measures are those contained in the Crown entity's Statement of Intent.

### Health Research Council of New Zealand

The performance measures are those contained in the Crown entity's Statement of Intent.

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Pacific Innovation Fund</b>			
100%	All Pacific Innovation contracts deliver an evaluation of their project to the Ministry	100%	100%

## Comments

### Pacific Innovation Fund

Eleven Pacific Innovation projects started or were extended in the 2016/17 financial year. The projects are spread across the country and are with community, church and provider-led groups delivering services to address diabetes prevention, obesity, health literacy, oral health, antenatal care and suicide prevention.

Five projects are an extension of previously funded projects. Projects were selected for extension on the basis that they were able to demonstrate how additional benefits could be delivered with the extra funding and longer timeframes. The remaining six projects are new.

## Summary of financial performance

Actual 30/06/2016 \$000	National contracted services - other	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
24,518	Total appropriation	25,880	37,155	25,907

# National disability support services

Annually disability support services funds support for approximately 34,000 people for regular ongoing support, and approximately an additional 80,000 people of all ages for one-off equipment and environmental support (including people with sensory loss) across all age groups.

The appropriation is directed at providing services to people with a long-term impairment to support them in achieving a good life. These services include personal care, household management, residential services, supported living and funded family care. In addition, early intervention services such as behaviour support and child development are also funded in order to increase independence.

The aims of the appropriation include:

- disabled people have choice and control over the way they are supported
- disabled people are supported through the delivery of high quality, person-directed supports from providers and carers
- information and advisory services are delivered in a way that is understandable, reliable and in accessible formats
- the process of assessing needs and ensuring the delivery of appropriate support is efficient and effective
- compulsory care and rehabilitation services are provided for people subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- services are developed and monitored to ensure capacity meets demand.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Needs assessment and service coordination (NASC)</b>			
89%	All new eligible Disability Support Services clients are assessed within 20 days of referral – see note 1	80%	80%
90%	All new clients assessed as being eligible for Ministry-funded support are provided with their support options within 20 days of assessment – see note 1	85%	80%
<b>Home and community services</b>			
67%	Percentage of disability support service clients receiving community support – see note 2	77%	65%
2,968	The number of individualised funding arrangements to improve client and family choice and control	3,566	3,700
69	Enabling Good Lives – the Hamilton demonstration increase number of participants to at least 155 by 30 June 2017	240	155–245
<b>Residential care</b>			
95%	Residential services support people to have an everyday life: the percentage of clients and families satisfied with the service, as demonstrated through the developmental evaluations	98%	80%
241	The number of clients in very high-cost services (High and Complex Services) will be maintained at a sustainable level	257	Under 500



Environmental support			
84%	The percentage of equipment supplied from the Ministry of Health equipment list is greater than	80%	75%
38%	The percentage of equipment items supplied that are refurbished and reissued is greater than – see note 3	39%	45%
<hr/>			
Note 1:	The results remain above budget standard. However, time required to assess and deliver support has increased slightly in 2016/17 due to more complex support needs of disability support clients.		
Note 2:	The increase in result is due more options being offered for how community support can be delivered to disabled people including paying resident family members for specific services.		
Note 3:	The result reflects clients retaining equipment for longer periods of time which reduces the frequency of re-issue required.		

## Comments

### Needs Assessment Service Co-ordination Organisations

The Ministry contracts Needs Assessment Service Co-ordination organisations to provide information to disabled people about eligibility for disability support, assessment of disability needs, and coordination of relevant support via a range of channels including external providers, individualised funding and funded family care. The goal is to enable disabled people to have more choice and control over the way they are supported.

### Home and Community Services

Community based services provide support to enable people with disabilities to live in their own homes. These services include personal care, household management, caregiver support, supported living and respite. In certain circumstances funding is provided to enable a resident family member to provide some of these services.

The increase in the number of disabled people being supported in the community is a significant achievement as a result of more support options outside of residential being offered.

The increase in the number of disabled people opting for individualised funding demonstrates a preference for this type of support.

### Residential Care

Residential care enables approximately 7,500 disabled people the choice to live in a home-like setting, such as a group home(ideally with three other people), or a range of residential options including aged care, hospital level care and secure high and complex environments.

An initiative called Choice in Community Living looks to support disabled people moving from a residential option into a group home (with other people of their choosing).

### Environmental Support

Environmental support services provide equipment and modifications for people of all ages who have a long-term disability.

As the population ages, more people are requiring equipment support to continue to live independently in their own home. In addition to standard equipment, support is also provided through housing and vehicle modifications, hearing aid subsidies, cochlear implants and spectacle subsidies.

In order to manage this growing cost, a list of 'standard' equipment is aimed at delivering cost effective solutions to the greatest number of people. In addition, there is a focus on refurbishing and reissuing equipment to gain the greatest value for money.

## Summary of financial performance

Actual National disability support services		Actual	Main estimates	Voted appropriation
30/06/2016		30/06/2017	30/06/2017	30/06/2017
\$000		\$000	\$000	\$000
1,167,483	Total appropriation	1,187,988	1,165,888	1,188,334

# National elective services

The scope of this appropriation is limited to provision, purchase and support of elective surgery services. This appropriation is intended to improve access to elective procedures by funding more procedures and improvements to how elective procedures are provided or supported. The 2016/17 budget standards are based on the 2015/16 Crown funding agreements.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Electives and Ambulatory initiative - see note 1</b>			
5,048	Auckland DHB	4,713	5,298
1,629	Bay of Plenty DHB	2,065	1,994
5,513	Canterbury DHB	5,852	5,605
2,550	Capital & Coast DHB	2,494	2,623
3,897	Counties Manukau DHB	4,409	3,986
1,504	Hawke's Bay DHB	1,660	1,588
1,179	Hutt Valley DHB	1,354	1,192
894	Lakes DHB	945	966
1,711	MidCentral DHB	1,896	1,812
1,335	Nelson Marlborough DHB	1,407	1,335
1,725	Northland DHB	1,917	1,796
449	South Canterbury DHB	479	449
2,452	Southern DHB	2,466	2,591
349	Tairāwhiti DHB	371	349
1,067	Taranaki DHB	1,122	1,067
3,692	Waikato DHB	4,195	4,076
374	Wairarapa DHB	396	374
5,503	Waitemata DHB	5,976	5,770
255	West Coast DHB	272	255
559	Whanganui DHB	592	559
41,685	Total electives and ambulatory initiative	44,581	43,685
<b>Bariatric initiative</b>			
127	All 20 DHBs total bariatric initiative	127	126
<b>Quality initiative</b>			
20	All 20 DHBs	20	20
<b>Mobile surgical services</b>			
650	The elective day surgery target of case-weights (approximately 1,500 operations per annum)	650	650
100%	Rural health professional development and remote collaboration services volume targets met	100%	100%

Note 1: Budget standards for the Electives and Ambulatory initiatives were set based on previous year quantities and are indicative. The actual results differ from budget standards because contracts for elective and ambulatory initiative quantities required are renewed with the DHBs after budget standards have been set.

## Comments

The output is the agreed number of discharges, above the base funding for each DHB, which are funded through non-departmental expenditure. This is only a proportion of each DHB's total health target and includes:

- the elective initiative supports agreed levels of delivery of surgical discharges
- the ambulatory initiative supports agreed levels of surgical and medical first-specialist assessments, community referred tests and some non-admitted procedures
- the bariatric initiative supports agreed levels of bariatric surgery discharges above DHB base levels
- the quality initiative is targeted funding to support DHBs in maintaining timely access, implementing system change or new models of care to create capacity to elective surgery.

## Mobile Surgical Services

Mobile surgical services continue to provide elective day surgeries to many rural communities throughout New Zealand.

## Summary of financial performance

Actual National elective services		Actual	Main estimates	Voted
30/06/2016		30/06/2017	30/06/2017	30/06/2017
\$000		\$000	\$000	\$000
323,180	Total appropriation	350,577	355,517	356,205

# National emergency services

The scope of this appropriation is for the funding and purchase of health emergency services directly by the Crown. This appropriation is intended to ensure emergency services are provided to people who require urgent acute health care (air and road ambulances).

This appropriation provides funding contributions for the following services:

- emergency road and air ambulance service;
- emergency ambulance communications centre services for the whole of the country;
- Primary Response in Medical Emergencies (PRIME);
- disaster preparedness for all regions; and;
- project funding as set out in New Zealand Ambulance Service Strategy (2009).

Emergency Ambulance services (EAS) are part of the first line in the continuum of health care. EAS operate 24 hours a day, seven days a week, and respond to medical emergencies and accidents. They work closely with other pre-hospital acute and urgent services, including primary care, Clinical Hub and Healthline.

They provide clinical assessment via 'hear and treat' (telehealth) 'see and treat' (where a responder assesses patient but does not transport) and 'treat and transport' when the patient requires transport to a medical facility or hospital. EAS aim to have a positive impact on patient outcomes by providing the right care, at the right time, in the right place, delivered to the right person.

They determine the level of patient need through a telephone triage system and authorise and dispatch the most appropriate and available EAS resource.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Emergency calls are triaged and services dispatched effectively and efficiently:</b>			
94%	Call response times – percentage of calls answered in 15 seconds	94%	95%
75%	Calls reach compliance with the medical priority dispatch system performance indicators	100%	100%
<b>Ambulance Response Times – for immediately life-threatening incidents an ambulance reaches the scene within:</b>			
59%	Urban reached in 8 minutes	52%	50%
96%	Urban reached in 20 minutes	95%	95%
54%	Rural reached in 12 minutes	51%	50%
93%	Rural reached in 30 minutes	93%	95%
<b>Air Ambulance</b>			
58%	Percentage of air ambulance activations that are within the target times	58%	50%
<b>Emergency Services</b>			
100%	Percentage of Reportable Events that providers manage in accordance with the HQSC guidelines – see note 1	69%	100%

Note 1: Providers are working to improve reporting of adverse events by focusing on having efficient systems and adequate resources to support these reporting requirements.

## Comments

The ambulance service continues to work with the Health sector to develop or integrate service pathways. These pathways are being introduced to ensure the most appropriate and expedient path to care for the patient. The pathways are:

- stroke
- major trauma
- spinal cord impairment
- ST segment elevation myocardial infarction (STEMI)

The Ministry contracts with:

- two emergency road ambulance providers
- two ambulance clinical control/communications centre providers
- 13 emergency air ambulance providers

Key service performance metrics are published on the National Ambulance Sector Office (NASO) website, together with summaries of ambulance services' serious and sentinel events. Ambulance services adverse event reporting systems are maturing against an increased workload, with the ambulance service providers finding new ways to develop their systems.

The Horn report <sup>3</sup>findings have been integrated into the service provision of ambulance and communication centres. New funding arrangements, which include increased funding and a pathway to support new funding have been included in the 2017/18 agreements.

The 'Clinical Hub' service has been rolled out nationally. This increases the ability of the communication centres to provide clinical phone advice without the need to dispatch an ambulance, resulting in more ambulances being available to respond to life-threatening incidents.

The PRIME (Primary Response in Medical Emergencies) review has been completed and the findings published in July 2017. The review identified a number of key changes to the funding and governance of the PRIME providers. St John will continue to administrate this group and have developed a work plan to align with the PRIME review for the 2017/18 year.

## Summary of financial performance

Actual 30/06/2016 \$000	National emergency services	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
95,540	Total appropriation	101,033	99,946	101,050

<sup>3</sup> Dr Murray Horn led the independent review of funding arrangements for emergency road ambulances services. The findings of the review were published in June 2016.

# National health information systems

This appropriation is limited to the provision of information technology services for the New Zealand health and social sectors. The appropriation is intended to ensure the Ministry is able to fund or purchase health information systems on behalf of the health and social sectors, ensuring that procurement is more efficient and effective.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>E-prescription Tool</b>			
Achieved	E-prescription Tool implemented over three years	Achieved	Achieved
<b>Whānau Ora Information System</b>			
Achieved	Whānau Ora Information System implementation into collectives' trial sites (38 providers) by December 2016 – see note 1	Not Achieved	Achieved
<b>National implementation of InterRAI assessment tool</b>			
20	DHBs implement the InterRAI Home Care and Contact Assessments tools for assessing the needs of older people to access long-term support services in the community or residential care	20	20

Note 1: In total, 33 providers were trained to use the system and 31 providers have implemented the system. Two providers that were trained have not implemented the system due to changes in their organisational structure. The remaining 5 providers, (originally included in the measure) have withdrawn from using the system.

## Comments

### E-prescription Tool

Technology and enabling standards to support ePrescribing, and facilitation and support to advise on its implementation in hospitals has been established by the Ministry. District health boards are contracting with the selected hospital prescribing supplier and are implementing the tool in line with their own budget and clinical change priorities. A national user group is in place to review and prioritise ongoing enhancements to the vendor product, and an Health Quality and Safety Commission (HQSC) Expert Advisory Group guides national priorities and clinical process.

The Ministry monitors implementation progress and reports regularly to the Ministry of Health and HQSC.

### Whānau Ora

The Ministry works with Te Puni Kōkiri (lead) and the Ministries of Finance, Education, Social Development the Ministry of Business, Innovation and Employment (MBIE) to deliver the Whānau Ora approach among service providers and to progress achievement of Whānau Ora's short-term outcomes as part of the Whānau Ora Outcomes Framework.

### InterRAI

New Zealand is the first country in the world where interRAI tools are used nationwide in the home and community setting, as well as in aged residential care. interRAI tools utilise common clinical assessment outcomes to enable clinicians and providers in different care settings to improve care planning, and to integrate the care and support needed for each individual. The objectives of

interRAI are to continuously improve health outcomes for New Zealanders as they age with interRAI data contributing to the effectiveness and efficiency of our health system.

Comprehensive Clinical assessment for Aged Care (interRAI). This system is used in all 20 DHBs, and as at 30 June 2017, there are now:

- 762 organisations enrolled
- 4,257 registered clinical users

In 2016/17 there were 118,153 clinical assessments undertaken by clinicians and providers.

## Summary of financial performance

Actual National health information systems		Actual	Main estimates	Voted appropriation
30/06/2016		30/06/2017	30/06/2017	30/06/2017
\$000		\$000	\$000	\$000
10,534	Total appropriation	4,369	13,065	5,418



# National Māori health services

The National Māori Health Services appropriation funds and facilitates the procurement of services that are either for Maori or by Maori, ensuring Maori health is supported and encouraged.

Services procured to support Māori health and disability providers include:

- implementation of Taonga Tuku Iho; rongoā Māori traditional healing services and the development of national standards for rongoā
- implementation of He Korowai Oranga; Māori Health Strategy to achieve whānau ora
- statistical data to inform good planning to improve Māori health outcomes
- development of research projects in target areas.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Rongoā (traditional Māori healing) services</b>			
19	The number of rongoā providers delivering between 425 and 1,500 client contacts – see note 1	14	19
<b>Provision and funding to support the delivery of health services for Māori (excl. Rongoā services)</b>			
98%	The percentage of providers who deliver services in accordance with their provider contracts with the Ministry of Health	100%	100%

Note 1: The decrease against budget standard reflects one terminated contract and four providers which delivered less than their contracted volumes by less than 10%. The Ministry is working with these providers to make up the shortfall over the remainder of their contracts.

## Comments

### Māori Health

Rongoā, traditional Māori health and wellbeing services, deliver mirimiri (massage), karakia (prayer, including pastoral support), and whitiwhiti kōrero (cultural support).

### Māori Research

Te Puāwaitanga O Ngā Tapuwae Kia Ora Tonu: Life and Living in Advanced Age: a Cohort Study in New Zealand (LiLACS-NZ) examines a wide range of aspects of living in advanced age and provide comparisons between the life experiences of Māori and non-Māori.

Te Ohonga Ake: Māori Child Health Report provides an evidence base to assist the Ministry and DHBs in developing programmes and interventions focused on addressing the needs of Māori children and young people.

## Summary of financial performance

Actual 30/06/2016 \$000	National Māori health services	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
4,066	Total appropriation	3,010	6,828	3,328

# National maternity services

The scope of this appropriation is for direct Crown funding and purchase of maternity services. The appropriation funds community-based Lead Maternity Carers (LMCs) and other health professionals to provide primary maternity care.

Most pregnancy and childbirth services are 'primary maternity services' delivered in the community by an LMC. The majority of LMCs are registered midwives (approximately 96 percent), about 3 percent are private obstetricians, and around 1 percent are general practitioners with Diplomas of Obstetrics. LMCs are responsible for a woman's maternity care from the time she registers and must provide continuity of care where possible throughout pregnancy, labour and birth and until six weeks after the birth. Services are provided in clinics, maternity facilities, and the woman's home.

Primary maternity services are funded under section 88 of the New Zealand Public Health and Disability Act 2000 via the Primary Maternity Services Notice 2007 (the Notice). The Notice sets out the terms and conditions for authorised health professionals to provide and claim for primary maternity services. The objectives of primary maternity services are to:

- provide each woman, her partner and her whānau primary maternity services that are safe, informed by evidence and based on partnership, information and choice
- recognise that pregnancy and childbirth are a normal life-stage for most women
- facilitate the provision of appropriate additional care for women and babies who need it.

Radiology services and non-LMC services for specified care provided by health professionals during pregnancy and childbirth are also funded through this appropriation. Primary maternity services are also delivered outside this appropriation by DHBs, along with secondary and tertiary maternity services (Caesarean sections, terminations for foetal abnormality).

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Lead Maternity Carer</b> Lead maternity carers (LMCs) delivery quality maternity services in compliance with Section 88 Primary Maternity Services Notice 2007 (excludes DHB primary maternity services) Women giving birth in the year who receive primary maternity services through the Section 88 Primary Maternity Services Notice <sup>4</sup>			
67% <sup>5</sup>	Percentage of women – see note 1	92%	70% <sup>6</sup>
45,025 <sup>7</sup>	Number of women based on birth data for the year – see note 1	54,713	40,069 <sup>8</sup>

Note 1: The 2016/17 results has been sourced from the National Maternity Collection which is continuously refreshed based on live data entered through the DHB National Minimal Dataset and LMC system. The prior year 2015/16 results and budget standard was set based on historical data (such as data from December 2014) from the sources such as the claims database which has been superseded by the National Maternity Collection.

## Comments

### Total number of deliveries, number and percentage of deliveries where mother received antenatal Lead Maternity Carers (LMC) care by financial year of delivery, 1 July 2009–30 June 2017

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Number of deliveries involving antenatal LMC care	52,891	53,837	53,258	53,545	53,174	53,926	54,401	54,713
Total number of deliveries	64,947	63,514	61,930	60,932	59,108	59,204	59,121	59,768
Deliveries involving antenatal LMC care as % of total deliveries	81%	85%	86%	88%	90%	91%	92%	92%

The percentage of women who give births receive primary maternity services under the Notice has continued to increase and is significantly above the performance standard of 70 percent.

There is a co-design process underway with the New Zealand College of Midwives to develop a new funding and payment model for community midwives.

<sup>4</sup> Source: National Maternity Collection (MAT), 2017, Ministry of Health. The numbers for 2016/17 may be incomplete due to data lag and should be treated as provisional (as extracted on 15 Sep 2017). Deliveries involving antenatal LMC care are defined as deliveries with antenatal registrations with LMCs excluding deliveries with postnatal LMC registrations, where antenatal care was provided through DHB primary maternity services or where there was no antenatal care from LMCs or DHBs. The total number of deliveries does not make any exclusions based on LMC or DHB primary maternity services registrations.

<sup>5</sup> The prior year 2015/16 results were based on historical data from the sources such as the claims database which has been superseded by the National Maternity Collection and is not directly comparable with the 2016/17 results.

<sup>6</sup> This budget standard was based on outdated data source from December 2014 and is not directly comparable with the 2016/17 results.

<sup>7</sup> The prior year 2015/16 results were based on historical data from the sources such as the claims database which has been superseded by the National Maternity Collection and is not directly comparable with the 2016/17 results.

<sup>8</sup> This budget standard was based on outdated data source from December 2014 and is not directly comparable with the 2016/17 results.

## Summary of financial performance

Actual National maternity services 30/06/2016 \$000		Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
144,589	Total appropriation	154,047	146,767	154,100

# National mental health services

The scope of this appropriation is for the funding and purchase of mental health services directly by the Crown. The appropriation is intended to ensure people with mental health issues, including addiction, are supported and work is undertaken to respond to suicidal behaviour and reduce its impact on communities.

The appropriation supports the delivery of Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health 2012). Rising to the Challenge sets the direction for mental health and addiction service delivery across the health sector. The mental health services appropriation addresses key health priorities aimed at achieving further system-wide change to make service provision more consistent and to improve outcomes both for people who use primary and specialist services and for their families/whānau. Mental health promotion, prevention and de-stigmatisation are critical to achieving the vision, and for this reason, Rising to the Challenge also includes actions in these areas. This appropriation funds service level contracts with non-governmental organisation (NGO) providers, non-devolved funding for DHBs, and infrastructure initiatives for:

- mental health services including inpatient services at Ashburn Clinic, youth forensic services, cross-agency conduct problems work streams, the implementation of an adolescent e-therapy tool as part of the Prime Minister's Youth Mental Health Project, and perinatal and infant mental health services
- research and development which includes a service line of the Te Pou o Te Whakaaro Nui agreement which is dedicated to mental health research development and service modelling
- alcohol and other drug services including services to implement the Tackling Methamphetamine Action Plan, and youth addiction treatment services for the Prime Minister's Youth Mental Health Project
- services for Māori youth aged 10–13 years and a mental health and addiction literacy programme
- suicide prevention programmes including skills training and the Travellers programme.

A range of other services are also funded under this appropriation, including:

- the implementation of contracts in North Island DHBs to deliver services for women who are pregnant or in the first 12 months postpartum who are experiencing acute mental illness
- a key performance indicator framework for mental health and addiction services, which is now being used by DHBs and NGOs in all DHB areas
- contracts for methamphetamine treatment programmes.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Mental Health Programmes</b>			
80%	Inpatient Mental Health Services; national specialist Ashburn clinic: the percentage of occupied bed days – see note 1	81%	95%
<b>Mental Health Services</b>			
73%	Mother/Baby unit: percentage of occupied day beds – see note 2	64%	80%
<b>Addictions</b>			
<b>Deliver on the Tackling Methamphetamine Action Plan:</b>			
220	The number of people receiving residential treatment	336	150
<b>Deliver on the Drivers of Crime Action Plan:</b>			
92 participants 85 graduates	Drug Court: the number of participants	93 participants 109 graduates	100
N/A	Alcohol Brief Intervention and Screening: the percentage of people older than 12 years of age who receive Primary Mental Health Initiative (PMHI) who are screened – see note 4	51,400 adults 4,100 youth	50%
51	Triple P Parenting Programme: the number of practitioners trained – see note 5	40	800
1,759	Triple P parenting programme: the number of families receiving an intervention – see note 6	1,400	1,800

Note 1: Occupancy for inpatient mental health services are demand driven.

Note 2: Fluctuating demand and home leave is impacting occupancy levels along with beds also being held for regional patients with scheduled admissions. The practice of home leave has also impacted on occupancy levels

Note 3: The results reflect increased demand due to services becoming more established in communities compared with prior year results and when the budget standard was set.

Note 4: The result is unable to be expressed as a percentage of the number of eligible people seen in primary care due to data limitations. In 2016/17, approximately 51,400 adults and 4,100 youth accessed alcohol brief intervention services. However, this does not isolate unique clients and counts each time a client is seen by providers. This measure will be removed and a more meaningful option for measuring will be introduced for 2017/18.

Note 5: The budget standard of 800 was incorrectly transposed during the drafting of the budget standard for this measure and reflects intervention numbers rather than the number of practitioners trained. The correct budget standards for the number of practitioners is 40 – 60 per annum.

Note 6: The Triple P parenting programme is a pilot service and uptake numbers for training provisions and interventions were estimated when it was unclear how the interventions would be delivered. For instance, if the number of one-on-one interventions were high, the number of families would be lower, whereas if the number of group interventions were high, the number of families would be high. The budget standard was increased in the Supplementary Estimates for Vote Health from 800 to 1,800 in anticipation of the roll out of the pilot service. Also, the year end result of 1,400 is below budget standard due to some limitations in the data collection process and only includes information provided to Lead Primary Care Providers. Families also receive intervention from other providers (NGOs) which not included in the result.

## Comments

### Mental health

The 25 bed inpatient psychiatric treatment service provided at Ashburn Clinic in Dunedin is a national service within a therapeutic community model of care. It specialises in eating disorders,

borderline personality disorder, mood disorders and alcohol and drug issues. It also caters for impaired professionals who are unable to receive treatment in their own or neighbouring DHBs for privacy reasons.

### **Addictions**

A range of addiction treatment service types have been maintained, including helpline information and advice services; brief interventions through primary care settings; specialised addiction treatment community-based care and residential programmes.

Addiction treatment services saw 47,867 clients between 1 April 2016 and 31 March 2017. This includes 8,687 young people (aged 0-19). The Substance Addiction (Compulsory Assessment and Treatment) Act was passed by Parliament in February 2017 and will come into force during the 2017/18 financial year.

### **Reviewing and re-contracting methamphetamine treatment services**

A review of the methamphetamine treatment services contracted by the Ministry concluded that there is still a high demand for such services. Adult residential methamphetamine-related treatment services were re-contracted. Residential treatment services for young people were consolidated with one provider, instead of three. Funding for the withdrawal management services will be devolved to DHBs once they have revised the model of care for such services.

### **Multi-level approach to conduct problems**

Conduct problems is one of four work streams that make up the cross-government initiative, addressing the Drivers of Crime focus on effective programmes to reduce conduct problems in three to seven year-old children. One of the Drivers of Crime health-led deliverables is implementation of the Multi-level Approach to Conduct Problems in four participating DHBs through delivery of the Triple P and Incredible Years programmes.

Triple P (positive parenting programme) and Incredible Years (are being delivered through Counties Manukau, Bay of Plenty, MidCentral and Waitemata DHBs. Triple P and Incredible Years are delivered by a skilled workforce in both primary health care and specialist settings.

### **Alcohol brief intervention and screening**

*2616 Alcohol Brief Interventions (ABI) were carried out for young people, out of a total of 29,426 undertaken between 1 July 2016 and 30 December 2016 (the latest available data). Please note that the Ministry does not collect the number of unique clients receiving an ABI. Triple P parenting programme: the number of practitioners trained*

The number of practitioners trained in Triple P for the 2016/17 year is 40, the likely reason for the small variance is that as the pilot reaches its later stages the training requirement reduces and is likely to be driven by staff turnover numbers in the four DHB areas.

### **Triple P parenting programme: the number of practitioners trained**

The number of practitioners trained in Triple P for the 2016/17 year is 40. The likely reason for the small variance is that as the pilot reaches its later stages the training requirement reduces and is likely to be driven by staff turnover numbers in the four DHB areas.

### **Triple P parenting programme: the number of families receiving an intervention**

The number of carers/families receiving an intervention in 2016/17 was 1193, against the target of 800. The reason for the large variance is due to the fact that when the contract was established it was recognised that the service was a pilot service and it was unclear how the interventions would be delivered. For instance, if the number of one-on-one interventions were high, the number of

families would be low, whereas if the number of group interventions were high, the number of families would be high. This number is subject to change as the service demand changes.

There is increasing coverage of family/carers receiving Triple P promotion of the 'TipPaper' by Triple P New Zealand (TPNZ), and this has contributed to raising awareness of the service. Lead providers are working with some iwi to raise awareness with Māori whānau.

## Other mental health services

*Supporting Parents Healthy Children guidelines (for children of parents with mental illness and/or addictions, COPMIA)*

In February 2016, four regional DHB-focused workshops were delivered across the country. Post workshop feedback was positive: a survey of resource needs showed an adequate 24 percent response rate with a good spread of respondents identifying the resources they most needed. The national workforce centres reviewed their January to July 2016 work-plans. Implementation support for DHBs and other key stakeholders is on track.

### *Rural Mental Health*

On 17 June 2016, the government (Ministry for Primary Industries and Ministry of Health) announced joint funding of \$600,000 for rural mental health initiatives, including the development of a Rural Mental Health and Addiction Framework.

- **Rural Mental Health and Addiction Framework:** development of a longer term strategic approach to improving rural mental health outcomes to inform future service and funding decisions.
- **Additional rural mental health initiatives:** The Ministry of Health funded the delivery of ten suicide prevention workshops for health professionals in rural areas not covered in 2015, the development and delivery of a new workshop entitled 'Safe Hands, Safe Plans' (managing suicidal patients in rural situations), and the continued funding of the 15 Clinical Champions and Medical Director.

### *Youth forensic mental health services*

Nga Taiohi Secure Youth Forensic Inpatient Mental Health Service was launched on 21 April 2016 by the Hon Hekia Parata on behalf of the Minister of Health, Hon Dr Jonathan Coleman.

Admissions commenced from 26 April 2016. Monitoring and reporting requirements of ongoing service delivery will be covered in the contract management process with support from the project oversight group. Youth forensic community services continue to be delivered within the DHBs, and more adequate monitoring mechanisms are being explored.

## Summary of financial performance

Actual 30/06/2016 \$000	National mental health services	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
18,835	DHBs	31,555	23,330	30,810
7,078	Health Promotion Agency (HPA)	7,078	7,078	7,078
1,677	The Institute of Environmental Science and Research (ESR)	1,688	1,698	1,698
58	Health Sponsorship Agency	0	0	0
25,465	Non-government organisations	24,526	26,856	30,082
53,114	Total appropriation	64,848	58,962	69,669



# National personal health services

This appropriation is limited to personal health care and support services purchased directly by the Crown, including mobile surgical services, telephone and online advice services, hospice services, sexual and reproductive health services, and services associated with implementing the oral health and cancer control strategies.

The national personal health services appropriation is intended to achieve a number of outcomes for personal health services, including:

- health information and recommendations of appropriate care for telephone callers with symptoms
- comprehensive, quality services for people living in rural areas
- an improvement across the cancer pathway, which will contribute to better overall cancer outcomes
- identifying and continuing to improve cardiac-related services in New Zealand
- sustainable growth in transplants and
- the promotion of good oral health outcomes for young children and the development of an electronic oral health register.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>National Telehealth Services</b>			
99%	Phone line service is available 24/7	99%	99%
7%	Call abandonment rate (percentage less than)	7%	less than 10%
78%	Percentage of calls answered within 20 seconds	79%	greater than 80%
N/A	Percentage of surveyed callers satisfied or very satisfied with the Healthline service – see note 1	N/A	greater than 95%
<b>Cancer Services</b>			
4	Six-monthly progress reports on regional implementation of national priorities are received from the four Regional Cancer Networks (RCNs)	4	4
100%	Boost hospice funding passed on to all hospices – see note 2	100%	100%
100%	DHBs who receive funding from the Faster cancer treatment service improvement fund implement service improvements to support achievement of the new health target for cancer and implement the tumour standards	100%	100%
100%	DHBs maintain performance against the Shorter waits for cancer treatment health target – radiotherapy and chemotherapy	100%	85%
<b>Colonoscopy Wait Times</b>			
100%	Monthly monitoring of colonoscopy waiting times	100%	100%

<b>High-cost Treatment Pool</b>			
100%	The percentage of completed applications managed within three weeks	100%	100%
<b>Cardiac Services</b>			
5	The number of DHBs with cardiac facilities using the Licensing and Development of Cardiac Surgery Registry	5	Up to 5
20	The number of DHBs using the Acute Coronary Syndrome Registry	20	20
<b>Additional Organ Donations</b>			
<b>Deceased Organ Donors</b>			
Achieved	Quarterly and annual reports about deceased organ donors	Reports received	Reports received
<b>Live Organ Donations</b>			
Reports received	Quarterly and annual reports about live organ donations	Reports received	Reports received
<b>Diabetes</b>			
100%	DHBs report quarterly on implementation of Diabetes care improvement packages	100%	100%
<b>Long-Term Conditions</b>			
N/a	Implementation of programme	Achieved	Achieved
<b>Stroke Services Improvement</b>			
4 [100%]	Percentage of DHBs that report quarterly on implementation of stroke services improvement – see note 3	100%	100%
<b>Oral Health</b>			
N/A	Oral Health promotion campaign	Achieved	Achieved
N/A	Electronic Oral Health Register	Achieved	Achieved

Note 1: The survey data collection process was not available for 2016/17. The survey collection process has commenced 1 July 2017 for reporting in 2017/18.

Note 2: All Boost Hospice funding has been devolved to DHBs.

Note 3: The measure changed from counting four regional reports to using percentages in 2016/17

## Comments

### National telehealth services

The National Telehealth Service was launched on 1 November 2015 to consolidate a range of Health-funded helplines onto one technology and clinically-supported platform. The services provided for include Healthline, Quitline, immunisation and poisons advice to the public, the Depression helpline and other mental health lines.

A professional workforce provides phone and online advice, support, assessment of symptoms, triage and referral advice across a range of health domains. The integrated platform ensures every person who makes contact, no matter what phone line or digital channel they choose, is provided with care by a health professional who can best assist with their needs.

In addition to the Vote Health appropriations the Accident Compensation Corporation, Department of Corrections, and Health Promotion Agency contribute funding to the service. From 1 July 2017 the Ministry of Social Development and Ministry for Vulnerable Children, Oranga Tamariki will also contribute funds.

New performance measures are in development from 2017/18 to reflect the consolidated service model. Service user survey data will be reported from 2017/18.

## Cancer Services

Work continues to implement the New Zealand Cancer Plan 2015–2018 to ensure all people have timely access to excellent cancer services that enable them to live better and longer. Crown funding agreements (CFAs) are in place with all DHBs until June 2018 to implement the cancer nurse coordinator roles funded in Budget 2012. CFAs were also implemented with all DHBs during 2015/16 in relation to the Budget 2014 cancer psychological and social support initiative.

Contracts are in place with four regional cancer networks to implement service improvement projects that support the 'Faster cancer treatment' health target. There was 100 percent compliance with all quarterly reporting on the delivery of those services.

## Colonoscopy Wait Times

The number of colonoscopies performed has increased every year since 2012/13. In 2016/17 over 40,000 colonoscopies were performed, an increase of 33 percent.

The increase in colonoscopies has enabled a reduction in the number of patients waiting longer than recommended for a colonoscopy, which in June 2017 was down approximately 56 per cent compared to June 2014. Ninety-two per cent of urgent colonoscopies were performed within 14 days compared to 55 per cent in June 2014 as shown in the table below:

Category	June 2014	June 2017
Urgent colonoscopy within 14 days or less	55%	92%
Non-urgent colonoscopy within 42 days or less	38%	66%
Surveillance colonoscopy within 84 days or less	39%	72%

The Ministry continues to work with DHBs to ensure colonoscopies are performed in a timely manner, and where performance is variable the Ministry takes the appropriate steps to support performance improvement.

## High-cost Treatment Pool

The high-cost treatment pool is funding for one-off treatments not otherwise funded by the public health system. Only people who are New Zealand citizens or permanent residents may be considered for treatment funded under the high-cost treatment pool.

High-cost treatments include medical treatments with proven efficacy that are only available in the private sector in New Zealand or overseas. Applications are only accepted from District Health Board specialists with recommendations for treatment. Specialists provide supporting documentation and evidence for why a particular patient would benefit from the requested treatment

In 2016/17 there were a total of 18 applications received, and of those seven were approved, two were declined and nine were placed on the waiting list for gender reassignment surgery.

## Cardiac Services

The four Regional Cardiac Networks are proactively supporting the district health boards to implement locally appropriate initiatives, improve services and support the use of cardiac registers.

## **Additional organ donations**

Sustainable increases in the rate of live and deceased organ transplant are supported through the continued investment in the National Renal Transplant Service, donor liaison coordinator roles in renal service provider DHBs, the New Zealand Kidney Exchange and additional funding support for Organ Donation New Zealand. Work is underway to implement the provisions of the Compensation for Live Organ Donors Act 2016

## **Diabetes**

Diabetes Care Improvement Packages were introduced in July 2012 to enable a more tailored and individualised approach to diabetes care and management. Budget 2013 funding of \$12.4m was made available over four years to June 2017 to support the implementation of initiatives, including integrated models of care. There was 100 percent compliance, with all DHBs reporting quarterly, through written reports or teleconferences, on the delivery of those services.

## **Long-term Conditions**

Implementing NZHS was the focus of work during 2016/17. An outcomes framework and service expectation for long term conditions (LTC) were developed and published. Learnings of best practice were shared at the World Integrated Care Conference and the annual LTC workshop alongside the updated guidance presented on the Ministry's website.

The partnership of the Health Research Council and the National Science Challenge has resulted in five innovative cross condition research projects to investigate new models of care. Self-management remains a priority with capability building work being progressed for general practice communities.

## **Stroke Services Improvements**

The Ministry maintains support for DHBs with regular contact through the four regional teleconferences every quarter. The DHBs continue to progress their thrombolysis and stroke services, and have improved the average national percentages for the two stroke indicators.

## **Oral Health Promotion Initiatives**

To promote good oral health and improve oral health outcomes from childhood to adulthood for young children, the government has committed to spending \$10 million over four years on oral health initiatives. The initiatives have two components; the development of a social marketing campaign and the distribution of toothbrushes and toothpaste to families for their young children.

In November 2016, a social marketing campaign was launched which included a television commercial where the "Tooth Fairy" encourages parents to brush their children's teeth. The distribution of toothbrushes and toothpaste (the second component of the oral health initiative) is expected to commence in 2018

## **Electronic Oral Health Register Programme (EOHR)**

During 2016/17, the Ministry collaborated with district health boards and other stakeholders on the co-design of the electronic oral health record programme. The purpose of this programme is to ensure that a patient's electronic medical record includes his/her oral health data. Improved capture of a patient's oral health data will support clinical decision making and assist with service development and planning.

The next phase of the programme will include identifying an appropriate solution and then developing a plan to implement the programme.

## Summary of financial performance

Actual National personal health services 30/06/2016 \$000		Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
105,563	Total appropriation	82,027	98,694	82,638

# Primary Health Care Strategy

This appropriation is limited to services to implement and deliver the Primary Health Care Strategy. This appropriation is intended to ensure that accessible primary health care services are provided to New Zealand communities, enabling people to live healthier, more independent lives.

This appropriation is intended to achieve services and models of care that provide services closer to home; services for high-needs patients accessing primary health care services; free under sixes general practice services nationally for enrolled children; pharmacists being part of primary health care teams; advice and support for shifting services from secondary to primary health care settings; and developing Integrated Family Health Centres (IFHCs), new models of care and other integration initiatives.

Funding is provided for primary health care services to further develop the primary health care sector. The majority of the appropriation is managed by DHBs and reported in their annual reports.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Access to affordable primary health care services</b>			
774,000	The number of [high needs] patients in Very Low Cost Access (VLCA) practices	788,707	774,000
99% Day time 97% After hours	The percentage of New Zealand children who receive free access to Under 13 services during day time and after hours – see note 1	99% Day time 97% After hours	80%
140,000	The number of patients receiving a long-term conditions (LTC) service in pharmacies nationally	131,316	140,000
N/A	Rural retention and locum support	Achieved	Achieved

Note 1: Higher than expected uptake of the zero fees at the General Practices has resulted in higher levels of access.

## Comments

Access to primary care services is improving. The configuration of primary care needs to change in order to meet the future demands of an aging population and increasing numbers of people with long-term conditions. The Ministry and the sector are exploring options for the future structure and organisation of primary care including service model, workforce and funding.

Highlights for 2016/17 include:

- 94 percent of New Zealanders are enrolled with a PHO, receiving subsidised visits to general practice
- 99 percent of children under 13 receive free general practice services and prescriptions during the day  
an approximate 15 percent increase in the number of GP visits for Maori children  
an approximate 11.1 percent increase in the number of GP visits for Pacific children
- improved access for children has reduced demand on Emergency Departments with a sustained decreasing trend in ED presentations for Māori and Pacific children aged zero to 5 years old.

Pharmacists are playing a larger role in primary care ensuring more effective prescribing and appropriate self-management as the number of people receiving long-term conditions medicines adherence service grows. The Ministry is working with DHBs and PHOs to explore options to better target funding for high needs New Zealanders.

DHBs and PHOs, with Ministry support, are developing new models of general practice with a broader range of types of consultation (e.g. email and texts) using multi-disciplinary teams with a stronger nursing presence and a wider scope for pharmacists.

## Summary of financial performance

<b>Actual</b>	<b>Primary health care strategy</b>	<b>Actual</b>	<b>Main estimates</b>	<b>Voted</b>
<b>30/06/2016</b>		<b>30/06/2017</b>	<b>30/06/2017</b>	<b>appropriation</b>
<b>\$000</b>		<b>\$000</b>	<b>\$000</b>	<b>30/06/2017</b>
179,615	Total appropriation	185,360	186,019	185,794

# Problem gambling services

The Problem Gambling Services appropriation delivers to the strategy; Prevent and Minimise Gambling Harm 2016/17 to 2018/19 (*Gambling Strategy*), in accordance with the Gambling Act 2003.

The outcomes and objectives of the *Gambling Strategy* and associated research is to prevent and minimise harm from gambling, reduce inequities associated with gambling, and to provide support services to those, including whanau, who are experiencing gambling harm. that minimise the harm from gambling, in accordance with the Gambling Act 2003.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>Implementation of the Preventing and Minimising Gambling Harm (PMGH) Strategy</b>			
N/A	The number of innovative service delivery pilots procured	3	2
6,578	The number of people seeking support from problem gambling services – see note 1	6,216	6,750
N/A	The number of brief only interventions delivered	7,620	6,000
67%	Percentage of treatment service users experience an improvement in their condition – see note 2	N/A	90%
N/A	Independent scientific research identifies incidence of moderate risk and problem gambling annually – see note 3	N/A	TBC

Note 1: Preliminary data shows that at least 6,216 people sought support from gambling harm services during the 2016/17 financial year. Support includes people seeking help through treatment services due to their own or someone else's gambling.

Note 2: This was measured as part of an evaluation and clinical audit project and is not available for 2016/17.

Note 3: The Ministry measures the incidence and prevalence of problem and moderate risk gambling as part of national surveys such as the Health and Lifestyles Survey and the National Gambling Study. Results from both studies in are yet to be finalised for publication.

## Comments

Services procured under the Gambling Act 2003 included:

- Primary prevention services to protect people from health threats and promote better health for all New Zealanders (primary prevention services are population-focused and include targeted programmes for specific groups of people disproportionately affected by gambling harm)
- Intervention services for those, including families/whanau, who are experiencing gambling harm, including screening, intervention, counselling and help with accessing appropriate allied health and social services
- A research programme to inform further policy and service development to prevent and minimise gambling-related harm.

Most of the people who seek support are in crisis. Face-to-face services assisted over 14,700 people in total during this period (including brief interventions).



The Gambling Helpline received between 500–600 in-bound calls per month during the 2016/17 financial year.

## Summary of financial performance

Actual Problem gambling services 30/06/2016 \$000		Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
18,205	Total appropriation	14,900	17,440	19,865

# Public health service purchasing

This appropriation is intended to ensure communities are supported with identifying, managing and treating public health issues. This includes health promotion, screening for cancer and other conditions, investigating environmental or border health issues and identifying and managing communicable diseases.

The services include the following core public health functions: health assessment and surveillance; public health capacity development; health promotion; health protection and preventive interventions. These health functions include the following services:

- national screening services
- nutrition and physical activity
- tobacco control
- communicable diseases and immunisation
- physical and social environments
- emergency preparedness
- suicide prevention and mental health literacy
- services for children
- prevention of alcohol and other drug-related harm
- sexual and reproductive health
- rheumatic fever prevention.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>National Cervical Screening Programme (NCSP) eligible women to be screened every three years</b>			
77%	The number of women screened within the last three years, as a proportion of the eligible population (women aged 25–69 years, hysterectomy adjusted)	75%	80%
66%	The number of Māori women screened within the last three years, as a proportion of the eligible population (Māori women aged 25–69 years, hysterectomy adjusted) – see note 1	65%	80%
77%	The number of Pacific women screened within the last three years as a proportion of the eligible population (Pacific women aged 25–69 years, hysterectomy adjusted) – see note 1	76%	80%
66%	The number of Asian women screened within the last three years, as a proportion of the eligible population (Asian women aged 25–69 years, hysterectomy adjusted) – see note 1	63%	80%
<b>Breast Screen Aotearoa (BSA) eligible women to be screened every two years</b>			
72%	Women screened within the last two years, as a proportion of the eligible population (women aged 45–69 years)	72%	70%
65%	Māori women screened within the last two years, as a proportion of the eligible population (Māori women aged 45–69 years) – see note 2	64%	70%
72%	Pacific women screened within the last two years, as a proportion of the eligible population (Pacific women aged 45–69 years)	71%	70%
<b>Bowel Cancer Screening</b>			
N/A	Implement bowel cancer screening programme	100%	100%
<b>Tobacco-Control Programme</b>			
	‘Better help for smokers to quit’ health target		
95%	Hospital indicator	95%	95%
85%	Primary Care Indicator	87%	90%
90%	Pregnancy indicator	90%	90%
<b>Smokefree New Zealand 2025 Innovation Fund</b>			
21	The number of projects funded across New Zealand will be	24	24
100%	The percentage of project reports due that are received for assessment will be no less than	95%	90%
100%	The percentage of project reports received that have been reviewed and assessed will be no less than	100%	100%
<b>Tobacco</b>			
	The Quit Group will achieve up to 65,000 quit attempts		
59%	Percentage of attempts – see note 3	55%	70%
38,154	Number of attempts – see note 3	19,332	35,000
N/A	The Quit Group will maintain an annual average abandonment rate of no more than – see note 3	10%	10%

<b>Environmental and Border Health</b>		
100%	Providers of environmental and border protection scientific, surveillance, analysis and/or advisory services, with contracts over \$500,000 per annum, deliver milestones in accordance with contract requirements	100% 95%
18	The number of training courses, workshops and forums provided to public health statutory officers from DHB public health units during the year	15 15
<b>Services for Children</b>		
	The proportion of infants exclusively and fully breastfeeding at	
66%	Six weeks	73% 75%
57%	Three months	59% 57%
<b>Other Child and Youth – Violence Intervention Programme (VIP)</b>		
95%	DHBs achieve Violence Intervention Programme benchmark audits scores of 80/100	93% 90%
91%	DHBs have improved programme responsiveness to Māori as required by the evaluation measurement	93% 90%
<b>Rheumatic fever</b>		
95%	Providers of rheumatic fever prevention services with contracts over \$500,000 per annum deliver milestones in accordance with contract deliverables – see note 4	71% 95%
<b>Communicable Diseases</b>		
95%	Written responses are provided within ten working days of receipt of monthly contract reports from providers of scientific advice, outbreak response and surveillance with contracts over \$500,000 per annum	100% 95%
<b>Immunisation</b>		
	Annual influenza immunisation programme	
	Annual Influenza Immunisation Programme: Over 1 million people are vaccinated annually and 75% of over 65-year-olds are immunised	
1.2 million	Number of people are vaccinated annually – see note 5	1.2 million Over 1 million
67%	Percentage of over 65 year olds are immunised – see note 6	65% 75%
<b>Sexual and reproductive health</b>		
	New Zealand AIDS Foundation	
100%	The percentage of all clients tested for HIV/AIDS are provided with a pre- and post-counselling session	100% 100%
Achieved	Convene and facilitate National HIV/AIDS Forum	Achieved Achieved
	New Zealand Family Planning Association	
156,362	The number of general consultations across the 17 DHB regions contracted to deliver services	158,775 159,309
8,460	The number of school linked and outreach consultations across the 17 DHB regions contracted to deliver services – see note 7	8,057 12,600
8,318	The number of pregnancy/maternity single-episode consultations across the 17 DHB regions contracted to deliver services – see note 8	8,114 12,250

<b>Emergency preparedness</b>			
Achieved	Maintain National Reserve Pandemic stocks	Achieved	Achieved
Achieved	Maintain emergency management capability and capacity in DHBs	Achieved	Achieved
Achieved	Maintain emergency management capability and capacity in road ambulance services	Achieved	Achieved
<b>Suicide Prevention</b>			
	Community Postvention Response		
75	The forecast number of completed assessments to identify possible emerging clusters per annum	56	50
8	The forecast number of communities that are experiencing level three cluster suicides, provided support per annum – see note 9	6	3
	Bereavement Support Service <sup>9</sup>		
2,272	The number of family/Whānau members bereaved by suicide provided with support – see note 10	2,489	4,000
	MH101 – Mental health literacy		
40	The forecast number of family/whānau members bereaved by suicide provided with support – see note 11	40	40
	Applied suicide intervention skills training		
231	The number of partially subsidised places at ASIST trainings delivered – see note 12	77	250
20	Travellers school-based education programme for at-risk youth. The number of new schools recruited to the Travellers programme	10	10

Note 1: There are inequities in coverage for Māori, Pacific and Asian women and the NCSP is addressing this through multiple strategies. Cervical screening coverage is a target in the Māori Health Plans and a contributory measure in the System Level Measures. Provision of free smears is available for priority women (Māori, Pacific, Asian, unscreened and under-screened) and there is data matching to target under-screened women including through social marketing strategies.

Note 2: Breast Screen Aotearoa is addressing inequities in coverage for Māori women through multiple strategies including data matching with primary care to identify under-screened women, regional collaboration, Māori Health Plan activity and social marketing initiatives. In addition, Support to Screening Services have been redesigned to improve service access for Māori and Pacific women and strengthen an outcomes focus.

Note 3: Quitline Services was merged with the National Telehealth Service during 2016/17. The number of attempts is taken from the number of enrolments as a representation of the number of people who have enrolled in the service to support them to quit. The budget standard for these performance measures was set prior to the merge of these services and are no longer comparable with the results from the merged service due to refresh of the operating model. Replacement performance measures aligned to the refreshed services will be included in 2017/18.

Note 4: The Ministry is working closely with DHBs which have not met their milestones to develop and implement a resolution plan which takes into consideration learnings from other DHBs who have had successes reducing their numbers.

Note 5: This result is based on provisional data available as at 31 August 2017.

Note 6: The number of those aged 65 continues to increase each year due to the aging profile of the New Zealand population. The Ministry is expanding its vaccination programme in 2017 to enable pharmacists to vaccinate those aged 65 and over to help increase the vaccination rate.

<sup>9</sup> The results for this measure is based on indicative data about the number of unique clients provided with support over the year.

- Note 7: Volumes of school-aged populations using these services continue to decline with demand. It is expected the increased access to telephone and internet-based Family Planning services has impacted this reduction in demand.
- Note 8: Demographic changes to some DHB regions, reduced birth rates and uptake of long acting reversible contraceptives (LARCS) have reduced volumes requiring this service.
- Note 9: The number of cluster /contagion situations will differ from year to year and services are provided as required.
- Note 10: The number of unique bereaved families/whānau members needing support varies depending on the situation and the number of people impacted as well as personal preferences for support services. The budget standard was set based on the pilot programme and a more appropriate budget standard based on national demand is approximately 2,200 – 2,800.
- Note 11: The wording for this performance measure was incorrectly transposed from the measure directly above. The correct performance measure is “number of mental health and addiction literacy workshops provided”. These workshops are provided to help people who want to be better prepared to identify and help those experiencing mental illness or distress and often engage with these people as part of their everyday life (eg. social services workers). The Ministry funds the infrastructure for this programme and 40 free workshops (each workshop reaching 20 – 25 people). Due to the success of this programme which scored at the highest level for all aspects in the New Zealand Qualification Authority external evaluation and review, further workshops have been sought and funded by other organisations.
- Note 12: The budget standard was incorrectly based on total participants rather than subsidised placements in training courses. The number of planned partially subsidised placements was 77 for 2016/17 and all were filled during the contract period ending 31 March 2017. The prior year comparative for subsidised placements is 120.

## Comments

### National Screening Unit

The National Screening Unit (NSU) is responsible for delivering safe, effective and equitable screening programmes nationwide. In 2016/17, four screening programmes and one quality improvement initiative were delivered:

- National Cervical Screening Programme
- BreastScreen Aotearoa
- Newborn Metabolic Screening Programme
- Universal Newborn Hearing Screening and Early Intervention Programme
- quality improvement measures for antenatal screening for Down syndrome and other conditions.

In November 2016 the National Bowel Screening Programme (NBSP) moved to the NSU, in preparation of the national roll-out of the programme in 2017/18.

### National Cervical Screening Programme (NCSP)

Cervical cancer is one of the most preventable cancers. Cervical screening reduces the risk of women developing cervical cancer. The aim is to increase cervical screening coverage to 80 percent for all ethnic groups.

As at 30 June 2017, overall coverage (three-year) for the NCSP was 75.0 percent for women aged 25–69. Five-year coverage is measured to capture women who may access screening slightly later than the recommended three-yearly interval but are still being screened. The coverage for the five-year period is 88.6 percent.

The additional women needing to be screened to reach the 80 percent coverage target are primarily in the NCSP priority groups, which are Māori, Pacific, Asian, unscreened and under-screened women. The NCSP is addressing inequities in coverage through multiple strategies, for example, monitoring provider initiatives through contracts, cervical screening coverage included as a target in the DHB Māori Health Plans and as a contributory measure in the System Level Measures, provision of some free smears for priority women, data matching to target under-

screened women and social marketing strategies. NCSP and BreastScreen Aotearoa have also redesigned their support to screening services contracts to improve service access for priority women<sup>10</sup> and strengthen an outcomes focus.

### **Breast Screen Aotearoa (BSA)**

Eligible women are invited to be screened every two years under the BSA programme. Overall, 71.7 percent of women aged 45-69 were screened in the 24 months ending 30 June 2017. Coverage for Pacific women aged 45-69 was also above the 70 percent standard.

BSA is addressing inequities in coverage for Māori women through multiple strategies, including monitoring provider initiatives through contracts, data matching with primary health care to identify under-screened women, regional collaboration, DHB Māori Health Plan activity, redesigned support to screening services contracts and social marketing initiatives.

### **National Bowel Screening Programme (NBSP)**

Budget 2017 provides \$38.5 million over four years to operate the NBSP in the first five DHBs, (Hutt Valley, Wairarapa, Waitemata, Southern and Counties Manukau) as well as the National Coordination Centre and four regional centres. This is in addition to the \$39.3 million allocated to the NBSP in Budget 2016 for the design, planning and set-up phases across the 20 DHBs.

The NBSP will screen eligible men and women aged 60 to 74, and provide colonoscopies to participants whose screening test is positive. The priority groups are Māori, Pacific, and those in the lowest socio-economic group. It is estimated that when the programme is fully implemented 62 percent of the eligible population will be screened, and between 500 and 700 cancers will be detected and treated each year.

### **Smokefree New Zealand 2025 Innovation Fund**

The Pathway to Smokefree New Zealand 2025 Innovation Fund was established to advance progress towards the Government's aspirational goal of Smokefree Aotearoa 2025. Its purpose is to support innovative approaches to reduce the smoking prevalence among Māori, Pacific people, pregnant women and young people across New Zealand.

### **Tobacco Control programme**

Tobacco use is a leading modifiable health risk factor in New Zealand, accounting for around 4500–5000 deaths per year. New Zealand has a comprehensive tobacco control programme that incorporates internationally recommended strategies of legislation, taxation, health promotion and smoking cessation services to minimise harm.

The smoking rate is steadily decreasing but remains high in some groups, particularly Māori. The rate of daily smoking has decreased from 18.3 percent in 2006/07 to 14.2 percent in 2015/16. For Māori the daily smoking rate in 2015/16 was 35.5 percent and for Pacific peoples 22.8 percent.

The total amount of tobacco consumed per capita (age group 15+) has fallen by nearly 23 percent from 2010 to 2014, and importantly, the rate of daily smoking by Year 10 students (14 and 15 years of age) has decreased from over 15 percent in 2000 to under 2.53 percent in 2015<sup>44</sup>. The Government has set an aspirational goal of reducing smoking prevalence and tobacco availability to minimal levels to make New Zealand essentially a smokefree nation by 2025.

To achieve this goal, we are:

<sup>10</sup> 'Priority women' in BSA and the NCSP are Māori and Pacific women, women who have never been screened and women who are under-screened. In addition, Asian women are a priority group in the NCSP.

- investigating changes to acts and regulations
- ensuring stop smoking services, advocacy, compliance and enforcement services are operating efficiently and effectively
- monitoring and evaluating research and stop-smoking initiatives to assess their relevance to New Zealand
- supporting the wider health sector to implement smokefree policies
- monitoring New Zealand's progress towards a Smokefree New Zealand 2025

## **Environmental and Border Health**

Environmental and border health protects the public from environmental health risks, working with other sectors to promote or maintain safe and healthy environments, and reducing the impacts of environmental hazards on at-risk communities. This service reduces the incidence and impact of public health risks at New Zealand points of entry, including managing biological, chemical and radiological risks of international concern and undertaking surveillance, exclusion, eradication and effective management of pests of public health significance.

This service includes guidance and information on border health protection and quarantine procedures in New Zealand. Environmental and border health includes the requirements for ships and aircraft arriving from overseas and the provision of public health responses to public health events of international concern at points of entry to avoid unnecessary interference with international traffic and trade.

The 12 DHB-owned public health units employ public health statutory officers, including medical officers of health, health protection officers, and drinking-water assessors who are designated or appointed by the Director-General of Health to exercise statutory powers and to contribute to the enforcement of legislation. During the year, training courses, workshops and forums were provided to public health statutory officers from DHB public health units.

Acts administered by the Ministry (where the Ministry has policy and primary implementation responsibility) are:

- Health Act 1956
- Smoke-free Environments Act 1990
- Misuse of Drugs Act 1975
- Burial and Cremation Act 1964
- Radiation Protection Act 1965
- Epidemic Preparedness Act 2006.

The Ministry and public health statutory officers have certain implementation and/or enforcement responsibilities under other acts that are administered by other ministries.

## **Services for children –breastfeeding**

Breast-feeding has a positive influence on the health status and social well-being of the baby, mother, family and community. Breast-feeding rates have multiple drivers including drivers outside the health sector's influence. IN 2016/17 work continued to improve rates through the Well Child/Tamariki Ora quality improvement programme and through breast-feeding-related initiatives, such as improved resources for clinicians (Mama Aroha talk cards) and the Baby Friendly Hospital Initiative (BFHI).

## **Other child and youth – Violence Intervention Programme**

Implementation of the national child protection alert system (NCPAS) by all 20 DHBs is an indicator of the Better Public Services target to reduce the number of assaults on children. All DHBs are approved to lodge alerts on the NCPAS. Quarterly monitoring and biennial reviews of the NCPAS ensure consistency and availability of the system across all DHBs.



Work continues towards reducing assaults on children by embedding the Violence Implementation Programme (VIP) in designated services, including routine partner abuse screening and child abuse and neglect risk assessment in maternity and child health, mental health, alcohol and drug, sexual health and emergency department services.

The VIP is also implemented in all 20 DHBs. It seeks to reduce and prevent intimate partner violence and child abuse and neglect through identification, assessment and referral of victims presenting to health services. Under the VIP, all DHBs have comprehensive systems in place, including policies, initial and ongoing training, and quality improvement activities.

### **Rheumatic Fever**

The Ministry is responsible for delivering the Rheumatic Fever Prevention Programme, which had seven contracts over \$500,000 in the 2016/17 financial year.

Two DHBs with a contract over \$500,000 have not met their target and have therefore not delivered milestones in accordance with their contract deliverables. The Ministry has worked closely with these two DHBs to develop and implement a resolution plan that takes into account learnings from other DHBs who have had success reducing their numbers.

The Rheumatic Fever Prevention Programme ended on 30 June 2017. However, rheumatic fever prevention will continue to be a focus for the 11 DHBs with a high incidence of rheumatic fever. The government has allocated \$5 million per year over the next 5 years to these DHBs so they can continue to deliver a balanced mix of rheumatic fever prevention activities to address rheumatic fever and reduce rheumatic fever rates and the Ministry will continue working closely with these DHBs.

### **Communicable diseases**

The role of the Communicable diseases team is to protect the public against notifiable diseases and other threats such as new and emerging communicable diseases (including antimicrobial resistant pathogens), improve New Zealand's readiness for a pandemic and improve the health of populations through effective prevention and control of communicable diseases.

The Institute of Environmental Science and Research Limited is contracted to assist and support the Ministry to prevent and control communicable diseases by providing reference and specialist testing services, scientific support services and agreed special communicable disease projects. A number of projects in the contract have been delayed as a result of re-prioritisation of resources to support large scale outbreak responses and work involved in the implementation of the Health Protection Amendment Bill. Mitigations are in place to manage this issue, including fortnightly meetings with ESR management and an ESR staff presence in the Ministry to ensure communication and cooperation. ESR have given assurance that delayed projects will be completed by the end of the first quarter of 2017/18.

### **Immunisation**

The Ministry monitors the volume of influenza vaccine doses distributed annually. The annual influenza immunisation programme will end on 31 December 2017 with the majority of vaccinations given before the peak of influenza season. Overall, 1.2 million doses of influenza vaccine are distributed.

The Ministry and DHBs are working together to improve the reporting of influenza vaccinations recorded on the National Immunisation Register (NIR).

### **Sexual and reproductive health**

The New Zealand AIDS Foundation are required to provide pre- and post-counselling services to all people who sought an HIV/AIDS test through their organisation during the 2016/17 financial

year. Increased demand for counselling services has resulted in some funding pressures being experienced.

Changes have been made to the Family Planning contract since the 16/17 measures were established. Family Planning will no longer be reporting on school-linked and outreach consultations as these will now be counted under General Consultations. Family Planning will continue to have the ability to provide specific information in regards to the age and ethnicity of service users and where they are accessing services should this be required. The Ministry will continue to track maternity consults as a distinct category even though these continue to decline with the declining birth rate and the increase use of LARC's.

### **Emergency preparedness**

The Ministry leads the all-of-government response for human health emergencies and supports the response to a wide range of hazards and threats across the national security system. This includes responsibilities to link to and coordinate planning with other agencies, in particular civil defence and emergency management.

During 2016/17 the health sector responded effectively to a range of significant challenges including numerous local events and a number of regional and national events. The Ministry led and coordinated numerous health sector responses from the National Health Coordination Centre. These included the Havelock North Gastroenteritis outbreak, Kaikoura-Hurunui Earthquake Sequence and Whakatane flooding where Health worked effectively with a range of agencies.

The Ministry's emergency management team continues to work with the sector, other government agencies and providers on a range of projects to enhance the reduction, readiness, response and recovery capacity and capability of the sector, in line with the national Civil Defence Emergency Management (CDEM) Strategy. This included ongoing maintenance of the national pandemic reserve supplies, funding St John and Wellington Free Ambulance to maintain and develop major emergency capabilities (including delivering mass casualty simulation exercises in hospitals) and the ongoing development of the New Zealand Medical Assistance Team (NZMAT) capability.

### **Suicide prevention and mental health literacy**

With the previous Suicide Prevention Strategy (2006–2016) ending in 2016 the Ministry had led work on the next step. 'A Strategy to Prevent Suicide in New Zealand: Draft for public consultation' was publicly consulted on from 12 April to 26 June 2017.

Selected programmes, delivered by multiple organisations, include:

- Waka Hourua, a national suicide prevention programme for Māori and Pacific communities, aimed at supporting and coordinating communities to prevent suicide
- The family/whānau suicide prevention information service that has launched a website for the suicide bereaved and provided resources for people concerned about someone and also for those at risk
- The media response service providing advice to the media on safe reporting practice and inclusion of recovery stories
- A service supporting the bereaved in the immediate aftermath of a suicide, and the community postvention response service aims to reduce community distress and anxiety, especially further suicide attempts by coordinating community efforts to identify potentially vulnerable individuals and ensure that they are linked with appropriate supports and services
- The MH101 health and addictions literacy programme.
- The development of the Lifekeepers National Suicide Prevention Training Programme.

## Summary of financial performance

Actual 30/06/2016 \$000	Public health services purchasing	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
169,016	DHBs	185,323	163,364	164,439
15,201	The Institute of Environmental Science and Research	15,449	15,540	15,540
9,609	Health Promotion Agency (HPA)	7,195	7,290	7,290
5,375	The University of Auckland	5,412	6,332	6,332
1,550	Massey University	1,022	1,414	1,414
974	University of Otago	691	381	381
54	Crown Law Office	43	181	181
170,333	Non-government organisations	170,953	206,141	197,334
372,112	Total appropriation	386,087	400,644	392,911

# Non-departmental other expenses

## Provider development

The scope of this appropriation is funding to provide assistance for the development of the third-party health service workforce, in particular, Māori and Pacific people's providers. This appropriation is intended to ensure that such services are supported to become more effective, efficient and sustainable.

The Māori provider development within this appropriation aligns with He Korowai Oranga: Māori Health Strategy and is implemented across three programmes:

- the Māori Provider Development Scheme (MPDS) is a fund to improve the capacity and capability of Māori health and disability providers. The scheme also awards Hauora Māori Scholarships to Māori students undertaking a course in health and disability studies that has been accredited by the New Zealand Qualifications Authority (NZQA)
- the Māori health workforce programmes are aimed at increasing the number of Māori students taking up health careers. Building a competent, skilled and experienced Māori health and disability workforce is crucial to improving health outcomes for Māori, as well as providing appropriate care for Māori individuals and their whānau
- Te Ao Auahatanga Hauora Māori: the Māori Health Innovation Fund seeks to improve Māori health outcomes and advance Whānau Ora by supporting new Māori health innovation programme pilots over a four-year funding cycle.

The Pacific Provider and Workforce Development Fund (PPWDF) within this appropriation aligns with 'Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014–2018 ('Ala Mo'ui). The aims of the PPWDF funds are to:

- increase the Pacific health workforce through a pipeline approach
- fund Pacific health provider collectives, with the aim of strengthening Pacific health providers to be sustainable and deliver quality health services that best meet the needs of the Pacific communities
- fund the Pacific health providers network to strengthen the synergies of activities by Pacific providers as collectives within a region.

## Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
<b>To support the sustainability of viable Māori providers for improving access to, and the quality of services</b>			
115	The number of Māori providers receiving funding	111	115
<b>To recruit to and retain Māori health professionals on a health career pathway</b>			
518	The number of students funded by Hauora Māori Scholarships	520	520
<b>Te Ao Auahatanga Hauora Māori: the Māori Health Innovation Fund</b>			
92%	Percentage of programmes monitored and identified with successful models of innovation – see note 1	95%	100%
96%	Percentage of six-monthly reports reviewed against contracted deliverables	100%	100%
<b>Pacific Provider Development</b>			
<b>Pacific providers are supported to improve access and service delivery to the Pacific communities they serve:</b>			
100%	All Pacific Collectives have networks of providers who input into models of care appropriate for Pacific people	100%	100%
<b>To recruit to and retain Pacific health professionals on a health career pathway:</b>			
N/A	The number of Pacific students funded through the Aniva Scholarships is at least – see note 2	190	140
N/A	The percentage course completion for the Master of Nursing Health Programme - see note 3	N/A	80%
70%	The percentage of Pacific Foundation Programme students applying for and accepted into first year health science at the University of Otago – see note 4	57%	80%

Note 1: The programmes in progress have all been monitored and had feedback given to providers and evaluators. However, it is too early to determine the success of these programmes, however many are in the second stage of innovation funding and indications so far expects these to be successful.

Note 2: This year was the most successful year for the Pacific Health Scholarships. We received over 330 applications and were able to fund 190 students which reflects the Ministry's development of stronger relationships with Tertiary Institution Pasifika leaders to get messages out to their Pasifika students. In 2015/16, the number of scholarships provided was finalised as 168.

Note 3: The percentage of students completing the Master of Nursing programme will not be available until the end of three year programme in 2018.

Note 4: This programme remains in progress. Currently, of the total students supported under the Pacific Foundation Programme, 57% of students will be transitioning into first year health sciences and 28% of students will be studying towards a Bachelor of Science degree (with health related majors). Due to changes in the student's situation, 15% of students will exploring study a non-health related career pathway.

## Comments

### Māori Providers Development Scheme (MPDS) 2016/17: Provider development

The MPDS provided funding to 111 Māori providers across New Zealand to strengthen their organisations in areas of infrastructure, workforce, governance and management development.

## MPDS: Hauora Māori Scholarships

Hauora Māori Scholarships faced an increasing demand from students with over 1,200 applications this year. 522 scholarships were awarded across the 11 categories shown in the table below. There has been a notable increase in medical, nursing and dental applications.

Scholarship category	Number
Community Health	26
Dentistry	11
Dietician	1
Health Management	2
Medicine	133
Midwifery	26
Nursing	166
Pharmacy	11
Physiotherapy	24
Postgraduate	52
Undergraduate	70
<b>Total</b>	<b>522</b>

## Te Ao Auahatanga: The Māori Innovation Fund

Te Ao Auahatanga: Māori Innovation Fund provided support to 21 Māori providers for Te Kakano (seeding) innovations. A brief description of four of these programmes that will progress to the next phase of Te Ruinga (spreading) are listed below.

- Ka Rewa in the Central Region is a school-based programme that supports 11-12 year old tamariki (and their 50hanau) who may be experiencing issues such as; violence, depression, bullying, drugs and alcohol abuse. Initial reports show that enrolled tamariki have shown improvement in areas including academic performance, better engagement with teachers and in the classroom, and a reduction in truancy and strengthened cultural linkages
- iMOKO is a unique virtual consulting, diagnosis and treatment programme that uses a specially developed Application installed in iPads and digital clinical equipment provided to schools. It is run by trained volunteers supported by mobile nurses and medical resources. By mid-2016 there were 33 schools, 12 kohanga and four Early Learning Centres (rural and/or isolated) that target 2,000 children enrolled in the programme
- Nga Kaupapa Matauranga o Nga Mahi o te Ra is an online training programme for Māori who have an intellectual disability. It is run nationally by Te Roopu Taurima who have uniquely developed multi-lingual (English, Māori, sign language) kaupapa Māori learning and education resources. The modules are the only trilingual training resources internationally for people with an intellectual disability
- Mana Atua – Mana Tamariki – Mana Mokopuna is a motivational community based and whānau focused healthy lifestyle programme in the Hawkes Bay. The innovation integrates exercise, sports, games, healthy food choices and referrals to health and social services for vulnerable individuals and their whānau in a non-threatening community and family oriented environment. Evidence shows that the healthy lifestyle programme has benefitted whānau, especially in low decile areas of Camberley and Flaxmere (West Hastings) with high Māori populations.

## Māori Workforce Development

The Māori Workforce Development funded nine programmes in 2016/17 based on the workforce 'pipeline' model aimed at increasing the number of Māori students taking up health careers. Two of these, located in the Universities of Otago and Auckland, have seen significant increases in Māori entering and completing health qualifications.

The success of the pipeline approach to the workforce programmes is demonstrated in part by the growing number of Māori secondary students registered with the Kia Ora Hauora programme, which encourages science studies at school and promotes health as a career. The students are linked into university programmes, either the Otago Project in Dunedin, or Whakapiki Ake in Auckland. Both programmes provide pre-entry to tertiary health science programmes and ongoing academic support until graduation. The pipeline approach has enabled the Otago project, for example to increase the number of Māori students in health professional programmes from 138 in 2010 to 315 in 2017. In December 2016, 45 Māori doctors graduated from the University of Otago and 25 graduated from the University of Auckland.

### Pacific providers – Increase the Pacific health workforce

#### *Attract and train:*

Three Health Science Academies in low decile high schools for Pacific students taking science subjects in years 11, 12 and 13 are funded in Auckland, providing additional academic and pastoral support to 75 Pacific students. There are up to 50 students at Auckland tertiary institutions that are mentored and 400 Pacific students at the University of Otago who are mentored and supported while 10 Pacific students are funded to go through the foundations programme to gain entry into first-year health science subjects at the University of Otago.

#### *Strengthen, up-skill and retain:*

It is expected that a total of 25 Pacific nurses will go through the Masters of Nursing in Pacific health programme by 2018.

### Strengthen Pacific providers to deliver quality health services

Overall, there has been a growth in the membership of the North Island collectives, largely due to greater collaboration across the sector with Pacific Providers who offer other essential services to Pasifika families requesting to join, as they see the benefit of shared support and engagement.

In the 2017 round of Pacific Health Scholarships, 325 applications were received and 190 scholarships awarded. Scholarships awarded in priority areas of identified gaps in the Pacific health workforce include midwifery, oral health, nursing and medicine.

The Pacific Foundation Programme (PFP) target was not met. Four students will be transitioning into first year health sciences, two students will be studying towards a Bachelor of Science degree (with health related majors), and one student is exploring studying a non-health related career pathway.

## Summary of financial performance

Actual 30/06/2016 \$000	Provider development	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
22,709	Total appropriation	23,831	25,414	24,434

# Non-departmental capital expenditure

## Deficit support for DHBs

This appropriation is limited to equity injections to District Health Boards to address deficits and to ensure DHBs are supported to maintain their working capital.

### Summary of financial performance

Actual 30/06/2016 \$000	Deficit support for DHB	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
14,000	Total appropriation	37,700	50,000	74,624

## Equity for capital projects for DHBs and health sector Crown agencies

This appropriation is limited to providing capital contributions to health sector Crown entities or agencies for new investments and reconfiguration of their balance sheets.

Equity funding is provided to DHBs to fund the cost of capital projects, where the DHB is unable to fund projects within their cash flows. DHBs will report on any equity funding received in their annual reports.

### Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
100%	DHBs seeking equity funding for approved business cases receive that funding	100%	100%

### Summary of financial performance

Actual 30/06/2016 \$000	Equity for capital projects for DHB and the NZ Blood Service	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
41,030	Total appropriation	2,539,467	185,299	2,722,345

The variance against the Main Estimates is mainly due to the additional costs associated with DHB debt funding being converted to equity during 2016/17, and the timing of funding required for DHB capital projects.



## Health sector projects

This appropriation is limited to the provision or purchase of health sector assets. And is intended to ensure Ministry-managed capital projects are delivered on behalf of the Crown and support health sector organisations to deliver health services for New Zealanders.

### Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
80%	Grey Base Hospital redevelopment project meets project milestones	100%	100%

### Summary of financial performance

Actual 30/06/2016 \$000	Health sector projects	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
162,418	Total appropriation	156,258	402,397	241,059

The hospital redevelopment projects at ASB (Acute Services Building) Christchurch and Greymouth are expected to be completed in late 2018.

## Loans for capital projects

The scope of this appropriation is provision of new loans to DHBs for the purpose of facilities redevelopment and other purposes agreed by the Crown, including balance sheet reconfiguration.

### Summary of output performance

Actual 30/06/2016	Measure Description	Actual 30/06/2017	Budget Standard 30/06/2017
N/A	DHB seeking debt funding for approved business cases receive that funding	100%	100%

### Summary of financial performance

Actual 30/06/2016 \$000	Loans for capital projects	Actual 30/06/2017 \$000	Main estimates 30/06/2017 \$000	Voted appropriation 30/06/2017 \$000
-	Total appropriation	85,000	90,000	85,000

## Refinance of Crown loans

The scope of this appropriation is limited to refinancing existing Crown loans made to DHBs for the purpose of facilities redevelopment and other purposes agreed by the Crown, including balance sheet reconfiguration.

This appropriation is required so that DHBs can refinance capital expenditure loans with the Crown. This expenditure is a technical financial matter and is not reflected by any actual change in the DHBs' or Crown's assets or liabilities.

## Summary of output performance

<b>Actual 30/06/2016</b>	<b>Measure Description</b>	<b>Actual 30/06/2017</b>	<b>Budget Standard 30/06/2017</b>
100%	Crown loans are refinanced on or before their expiry date	100%	100%

## Summary of financial performance

<b>Actual 30/06/2016 \$000</b>	<b>Refinance of Crown loans</b>	<b>Actual 30/06/2017 \$000</b>	<b>Main estimates 30/06/2017 \$000</b>	<b>Voted appropriation 30/06/2017 \$000</b>
207,520	Total appropriation	204,214	60,500	204,214

## Residential care loans – payments

The scope of this appropriation funding is to provide interest-free loans to people entering aged residential care facilities.

## Summary of output performance

<b>Actual 30/06/2016</b>	<b>Measure Description</b>	<b>Actual 30/06/2017</b>	<b>Budget Standard 30/06/2017</b>
Increases in levels of loans funded as required	Funding for increases in levels of residential care loans	Increases in levels of loans funded as required	Increases in levels of loans funded as required

## Summary of financial performance

<b>Actual 30/06/2016 \$000</b>	<b>Residential Care Loans - Payments</b>	<b>Actual 30/06/2017 \$000</b>	<b>Main estimates 30/06/2017 \$000</b>	<b>Voted appropriation 30/06/2017 \$000</b>
10,653	Total appropriation	10,400	15,000	15,000

This appropriation is driven by the number of people who qualify for the loans. The under-spend of \$4.6 million against the main estimates (30.6% of the appropriation) is a result of demand being lower than expected.