

# Template 1: Budget Initiative template

There are five sections of this template agencies need to fill out:

- Overview and context
- Detail on the investment proposal
- Wellbeing impacts and analysis
- Cost understanding and options
- Collaboration

## Overview and context

Key Question/area	Comment/answer
<b>Agency to complete</b>	
Portfolio of lead Minister	Health
Portfolio(s) of other Ministers involved (if this is a joint initiative)	Hon Dr David Clark, Minister of Health
Votes impacted	Vote Health
Initiative title	National Bowel Screening Programme Implementation Year 3
Initiative description	<p>This funding for the National Bowel Screening Programme (NBSP) will enable a further [REDACTED] DHBs to implement the NBSP and fund the associated costs relating to the [REDACTED] DHBs in the National Coordination Centre, laboratory testing, diagnostic and surveillance colonoscopies and bowel screening regional centres.</p> <p>Bowel screening will reduce bowel cancer mortality, increase the proportion of bowel cancers detected at an early stage, reduce treatment costs, and increase five year relative survival rates for bowel cancer.</p>
Type of initiative	Non-discretionary cost pressure
If this initiative relates to a priority, please outline the specific priority/ies it contributes to	<p>Please specify the priorities this initiative aligns with. You can name more than one if relevant.</p> <ul style="list-style-type: none"> <li>• Supporting a thriving nation in the digital age through innovation, social and economic opportunities</li> <li>• Lifting Māori and Pacific incomes, skills and opportunities</li> <li>• Reducing child poverty and improving child wellbeing, including addressing family violence</li> </ul>
Does this initiative relate to a commitment in the Coalition Agreement, Confidence and Supply Agreement, or the Speech from the Throne?	<p>Y</p> <p>Speech from The Throne 8 November 2017 'This government is committed to major investments in ... health.... It will invest in the health system to provide the highest levels of care, support and treatment, wherever people live. [Māori] Fairness and equality of opportunity are not just aspirations but facts.</p>
Agency contact	Stephanie Chapman, Programme Director, Ministry of Health [REDACTED]
Responsible Vote Analyst	s 9(2)(f)(iv) [REDACTED]

## BUDGET SENSITIVE

### Funding

Funding Sought (\$m)	2019/20	2020/21	2021/22	2022/23 & outyears <sup>1</sup>	TOTAL
Operating	s 9(2)(f)(iv)				

Funding Sought (\$m)	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	TOTAL
Capital <sup>2</sup>	0	0	0	0	0	0	0	0	0	0

## 1. Executive Summary

### 1.1 EXECUTIVE SUMMARY

#### A. Short summary of the proposed initiative and expected outcomes.

The National Bowel Screening Programme (NBSP) will detect the early symptoms of bowel cancer in people aged between 60 and 74 years of age. Budget 2019 will: implement the NBSP in a further [redacted] District Health Boards (DHB), purchase Faecal Immunochemical Test (FIT) kits, laboratory testing, and diagnostic and surveillance colonoscopies. The national and regional coordination services will receive funding to support the expanded NBSP.

Funding from Budget 2016 enabled (1) the NBSP to develop an implementation programme; (2) capital funding for the information technology platform, the National Screening Solution (NSS).

Budget 2017 provided funding for the first five DHBs to offer the NBSP to eligible participants.

Budget 2018 enabled another five DHBs to join the NBSP and NSS operational funding.

Budget 2019 will fund [redacted] DHBs to offer the NBSP, supported by the NSS.

By 2020/21, 350,000 people will be invited, 210,000 test kits will be returned, 9,300 colonoscopies will be carried out and 700 bowel cancers will be detected.

New Zealand is one of the last countries in the Organisation for Economic Cooperation and Development (OECD) area to implement a National Bowel Screening Programme. As a result, New Zealand has the third highest mortality rate for bowel cancer.

As a new programme, DHBs do not include funding for the NBSP in their baseline budgets or budget bids and therefore, do not have the financial provision to provide bowel screening. For DHBs to offer bowel screening without specific funding, they would have to divert funds from other areas, and enter into contracts with the necessary suppliers (FIT kit supplier, testing laboratory, National Coordination Centre, or regional coordination centres) to support a safe and equitable bowel screening programme. Treatment costs resulting from bowel screening are part of DHB baseline funding.

Cabinet is aware the implementation cycle will take four financial years concluding at the end of the 2020/21 financial year [CBC-17-SUB-0081 refers].

The impact of scaling the NBSP funding on the population to be screened (those aged between 60 and 74 years) is diagnosis of bowel cancer at a later stage, with higher cost of treatment and a reduced chance of prolonging life.

On 27 November 2018, the Ministry of Health issued a news item about the revised NBSP implementation dates (<https://www.health.govt.nz/news-media/news-items/national-bowel-screening-programme-advises-dhbs-revised-roll-out-dates>)

<sup>1</sup> If funding is time-limited and does not carry on into out-years please delete the reference to "& outyears"

<sup>2</sup> The first 10 years of capital investment is counted against the multi-year capital allowance. Please reflect the full 10 year profile in the table.

## 2. The Investment Proposal

*This section asks you to outline your overall investment proposal and intervention logic. It should be supplemented with a one page intervention logic map showing the progression from outputs, outcomes and impacts of the initiative. See template 5 for an example of an intervention logic map that you can use as a template or guide.*

### 2.1 Description of the initiative and problem definition

#### What is this initiative seeking funding for?

Funding from Budget 2019 will enable the Ministry to purchase and commission services from [redacted] to commence [redacted] bowel screening in the 2019/2020 financial year including funding for an estimated 20 percent (f) additional colonoscopies as a result of bowel screening. It will enable the Ministry extend contracts with the National Coordination Centre (to invite eligible participants in the [redacted], and if they are in the priority population (Māori, Pacific, and socially deprived (Quintile 5)) undertake active follow up. Funding will also purchase the screening test (FIT) kits for the expanded numbers and subsequent laboratory testing and analysis. Funding will also support the increased clinical quality workload in the regional centres.

The NBSP is a cost pressure initiative, as without funding from Budget rounds, for the DHBs due to implement the NBSP each financial year, it cannot be delivered in more DHB regions.

The NBSP supports 'supporting a thriving nation in the digital age through innovation, social and economic opportunities', and will 'lift Māori and Pacific incomes, skills and opportunities'.

Once operational, the National Screening Solution (NSS) will provide a fully digitised processing platform for the NBSP. This will reduce data entry errors, and increase accuracy of record keeping. It will generate reminders and updates, enabling staff in the National Coordination Centre (NCC) to more easily identify priority populations and follow up with them. The NSS has the capacity to expand to support other screening programmes in the National Screening Unit.

The NBSP also supports Māori and Pacific opportunities as one of the key performance measures is ensuring equity of participation for Māori, Pacific and those in socially deprived (Quintile 5) (priority groups). The NBSP has additional support in place to encourage participation by the priority groups. Currently, although fewer Māori are diagnosed with bowel cancer, the morbidity rate for Māori is higher than non-Māori.

#### Why is it required?

##### The Problem

New Zealand has one of the highest rates of bowel cancer in the developed world. Bowel cancer is the second most common cause of cancer death in New Zealand, after lung cancer, with approximately 3,075 new cases registered and 1,252 deaths in 2013. New Zealand has the third highest mortality rate for bowel cancer in the Organisation for Economic Co-operation and Development (OECD) for women and the sixth highest for men.

There are population variations in bowel cancer incidence, with higher rates for older people (94 percent occurring in those aged 50 or over), males, non-Māori/non-Pacific, and the most socially deprived (Quintile 5).

##### The Opportunity

Bowel cancer is highly treatable when identified in the early stages. The high cancer mortality rates in New Zealand are amenable to change. Screening for bowel cancer presents an opportunity to reduce mortality rates, from a cancer that, if diagnosed and treated at an early stage can increase the chance of a five year survival. Those with localised disease (early stage) at diagnosis have a 95 percent chance of five year survival in comparison to those with distant spread (later stage) have only a 10 percent chance of five year survival.

##### The counterfactual

If funding for delivery of the NBSP in [redacted] DHBs is not committed in Budget 2019, there is a high degree of risk to the Ministry completing national implementation by June 2021.

If the NBSP is reduced (fewer than [redacted] join in 2019/20) delayed or discontinued, cost pressure could build within the cancer treatment services. This is because:

## BUDGET SENSITIVE

- Bowel cancer will continue to be diagnosed at a later stage (either stage 3 or stage 4) with higher treatment costs
- There will be no reduction in the numbers of bowel cancers first diagnosed through Emergency Department admissions
- Colonoscopies for symptomatic patients will continue to increase. (Since 2016, demand in referrals for colonoscopies has risen nationally by 28 percent). Funding for symptomatic colonoscopies comes from within DHB baselines. Over the 12 month period to September 2018, DHB performance against the colonoscopy wait time indicators has decreased, with most DHBs missing all targets:
  - Urgent colonoscopies taking place within 14 days or less (90 percent)
  - Non-urgent colonoscopies taking place within 42 days or less (70 percent)
  - Surveillance colonoscopies taking place within 84 days or less (70 percent).
- Bowel cancer mortality will remain high, with greater palliative care requirements
- Five-year relative survival rates will not improve.

In the Bowel Screening Pilot (the Pilot), 39 percent of patients were diagnosed at Stage 1 (localised cancer) compared with 13 percent in the PIPER<sup>3</sup> study (of the non-screened population). Diagnosis at Stage 2 and 3 was broadly similar for screened and non-screened populations, but diagnosis at Stage 4 (where cancer has spread to other organs) was significantly lower in the Pilot, only eight percent diagnosed at that stage compared to 24 percent of the unscreened population.

The impact on New Zealand as a whole (counterfactually), is the high rate of bowel cancer would not reduce when compared with other OECD countries. The cost of treatment for bowel cancer would continue to be high (and may rise) due to bowel cancer being detected at the later stages, and mortality from bowel cancer will remain high ie life expectancy is reduced (as is the patients' quality of life, their families and their whānau affected by such impacts, including loss of income if the patient is still in the workforce).

Reducing, delaying or discontinuing the NBSP is likely to have a disproportionate and negative impact on Māori because of the higher mortality rate. The Ministry of Health would fail in meeting its obligations under Te Tiriti O Waitangi, and will not lift Māori (and Pacific) opportunities.

### 2.2 Options analysis and fit with existing activity

What other options were considered in addressing the problem or opportunity?

Alternative options set out below update 2016 Cabinet decisions [SOC-16-MIN-0108 refers].

#### Option 1 – Do nothing

s 9(2)(f)(iv)

These budget bids would have to include directly contracting with the provider of FIT kits and laboratory testing. As a result, economies of scale may be lost, increasing overall screening cost.

For the NSS, work would continue on the build, and once ready all ten DHBs could migrate to it. However, the NSS would run at 'under-capacity', with a negative impact on operational costs.

By not on boarding any DHBs in 2019/2020 s 9(2)(f)(iv)

The delay would increase inequitable access to cancer screening programmes, in some of the most socially deprived areas of the country, with an additional inequitable health outcome for Māori.

#### Option 2 – implement a 'basic' bowel screening programme

In this option, up to DHBs would join the NBSP in 2019/20, but these participants would not be supported by their general practice (GP), or be funded for surveillance colonoscopies, if required. It would also create an inequitable bowel screening programme and disadvantage the populations in up to five DHBs areas.

In the basic bowel screening option, only FIT kits would be purchased and analysed by the laboratory. Those participants with a positive FIT result would be sent for a colonoscopy, but would

<sup>3</sup> The PIPER Project Final report 7 August 2015, Health Research Council reference: 11/764



## BUDGET SENSITIVE

	<p>not be placed on a surveillance colonoscopy cycle of every five years. Under this option, general practice (GP) would not be funded to receive the FIT result. Such a reduction is likely to increase health inequities, and support of the priority populations.</p> <p>s 9(2)(f)(iv)</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>
What other similar initiatives or services are currently being delivered?	<p>The NBSP is currently delivered in seven DHBs (five on the North Island and two on the South Island). Approximately one-third of eligible 60 to 74 years olds in New Zealand have an opportunity to participate. In the 12 month period to September 2018, 112,560 people were invited and 69,220 people (61.5 percent) participated. In the 12 month period to the end of May 2018 57 cancers were detected (two percent overall). By ethnicity 2.4 percent of bowel cancers were detected in Māori, 2.1 in Asian, 2.1 in other and zero percent in Pacific.</p>
What other, non-spending arrangements in pursuit of the same objective are also in place, or have been proposed?	N/A
Strategic alignment and Government's priorities/direction	<p><b>Ministry of Health's strategic intentions</b></p> <p>The NBSP supports the New Zealand Health Strategy: Future direction (published 2016) by:</p> <ul style="list-style-type: none"> <li>• promoting people-powered health (strategic theme one)</li> <li>• closer to home [services] (strategic theme two)</li> <li>• [using] smart systems (strategic theme five) linking to:             <ul style="list-style-type: none"> <li>○ Digital Health 2020 (to develop a preventative health IT capability... to support and improve the targeting of screening....).</li> </ul> </li> </ul> <p>The NBSP supports the Faster Cancer Treatment Programme (FCTP) by enabling earlier identification of abnormalities, and reduced demand for some cancer services (such as chemotherapy and radiotherapy). Screened participants found to have cancer will move to the FCTP, and be removed from the NBSP.</p> <p>The NBSP aligns with the New Zealand Cancer Plan 2015-18 meeting the expectation of screening, faster and using more standardised (and effective) diagnostic and treatment processes.</p> <p>The investment aligns with the New Zealand Cancer Information Strategy by improving data capture and quality to enable a more complete picture of cancer treatments and outcomes.</p> <p>The investment aligns with the Statement of Intent 2015-2019 as the NBSP improves the quality of screening services and supports Cancer Health Information Strategy, phase one implementation.</p> <p><b>Government general commitment</b></p> <p>The NBSP supports the Government's commitment to improve cancer care for Kiwis by developing a national patient pathway with key stages (such as number of days to be referred for diagnostic testing) set out in contracts and Key Performance Indicators.</p>

## BUDGET SENSITIVE

2.3 Outcomes	
<b>Overall outcomes expected from this initiative</b>	<p>The NBSP assumptions are:</p> <p>In the first year of full operation (all 20 DHBs)</p> <ul style="list-style-type: none"> <li>• 350,000 people will be invited</li> <li>• 210,000 test kits will be returned by mail</li> <li>• 9,300 colonoscopies will be carried out</li> <li>• 700 people will have bowel cancer detected.</li> </ul> <p>Without the NBSP, less bowel cancers will be detected at Stage 1 or 2, and more bowel cancers will be detected at Stage 3 and 4, when they are harder to treat, more expensive and more likely to reduce life expectancy. Cost savings from early detection would not be realised, and many Stage 3 and 4 bowel cancers will be detected on presentation to an Emergency Department.</p>
2.4 Implementation, Monitoring and Evaluation <sup>4</sup>	
<b>How will the initiative be delivered?</b>	<p>The Ministry's Population Health and Prevention Directorate is leading the implementation of the NBSP. The delivery of the NBSP is by the National Coordination Centre, FIT testing laboratory and DHBs under contract to the Ministry. The contracts identify what capability is needed to implement the NBSP, and is supported by funding to deliver the required services.</p> <p>There may be capital requirements for DHBs in terms of clinical facilities like endoscopy suites. The Ministry has a preference for DHBs to manage their screening based increased demand within existing capability, or outsourcing to private, rather than new capital builds.</p> <p>2019/20 is the third year of implementation, with the completion date set at the end of the fourth year (2020/21).</p> <p>The NSS is being delivered by an external contractor as a result of an open tender process.</p> <p>Before bowel screening goes live in a DHB region, the Ministry undertakes a readiness assessment. DHBs commence implementation planning, including readiness assessment preparation at least nine months prior to screening commencement. The NBSP also participates in Gateway reviews and other Central Agency reviews.</p>
<b>How will the implementation of the initiative be monitored?</b>	<p>The NBSP has quality standards for the bowel screening pathway. Ongoing monitoring is undertaken at national, regional and local levels. Key performance indicators are monitored at the national level by the Ministry. Regular six monthly monitoring reports are published. Regional bowel screening centres manage quality across the region to ensure service providers are meeting national quality standards. Providers have continuing quality assurance processes in place.</p> <p>Monitoring indicators include participation, positivity, time to colonoscopy, colonoscopy completion rate and cancer detection rates. All indicators are stratified by ethnic group, age, sex, and deprivation quintile. Investigations are taking place to ascertain whether indicators can also be reliably stratified by urban/rural profile and by mental health service access</p>
<b>Describe how the initiative will be evaluated</b>	<p>The success of the NBSP will be evaluated through the Benefits Realisation Plan (<a href="https://www.health.govt.nz/our-work/preventative-health-wellness/screening/national-bowel-screening-programme/key-documents-national-bowel-screening-programme">https://www.health.govt.nz/our-work/preventative-health-wellness/screening/national-bowel-screening-programme/key-documents-national-bowel-screening-programme</a>) with stated objectives measured through Programme monitoring and health outcome data (at least 10-years post screening implementation).</p> <p>A post implementation evaluation will be undertaken once the roll out to DHBs is complete.</p>

<sup>4</sup> This doesn't necessarily have to include a full implementation and evaluation plan, however the information provided must provide confidence that the proposal will be successfully delivered and there is a plan to ensure that the outcomes described are actually achieved.

### 3. Wellbeing Impacts and Analysis

This section builds on the information provided in section 2 above and goes into further detail on the impacts, evidence and assumptions underpinning the intervention logic. It also asks that you demonstrate how your initiative will impact on wellbeing domains, the four capitals and risk and resilience.

The focus is on showing a strong narrative underpinned by evidence rather than monetisation of benefits and showing a positive return on investment. However, the use of the CBAX tool and monetisation is encouraged for key impacts with good evidence where it will strengthen the case for intervention.

Completion of this section is strictly limited to a maximum of three pages. This section helps the Treasury to assess and advise how the proposed initiative will impact the wellbeing of New Zealanders relative to the counterfactual. It may be provided to Ministers to support Budget prioritisation.

Impact summaries need to be framed against the three components of the Living Standards Framework, with supporting evidence where available:

- **Wellbeing domains** – identify the value to New Zealand, magnitude and timeframe (up to 50 years) for impacts on the primary and (up to three) secondary domains targeted.
- **Four capitals** – identify the draw-downs, build-ups and/or transfers across the four capitals (physical, social, natural, human) resulting from funding the initiative.
- **Risk and resilience** – linking to the counterfactual and intervention logic, explain how the initiative adapts to or absorbs risk and/or how it maintains or builds resilience













Please be aware that impacts or evidence are not mutually exclusive between wellbeing domains, capitals, and risk and resilience. They are interrelated cuts of the same information, we would expect that some answers may be duplicated.

#### 3.1 Wellbeing domains – People's experience of wellbeing over time

##### Identify and quantify how the initiative impacts on wellbeing domains

Please fill in Table 3.1 below. Impacts need to be grouped under the relevant domains, as provided in the key below. Use the relevant domains, ordering them from top to bottom according to which domain your initiative achieves the greatest impact in. This analysis must also capture any negative impacts.











The wellbeing domains are outlined here for you to use in your table:

Civic engagement and governance 	Jobs and earnings 
Cultural identity 	Knowledge and skills 
Environment 	Safety 
Health 	Social connections 
Housing 	Subjective wellbeing 
Income and consumption 	Time-use 
	Other



## BUDGET SENSITIVE


### 3.1 Wellbeing domains – People's experience of wellbeing over time

Domains	Impact(s) description	Who are affected?	Magnitude of impact	How big?	Realised in	Evidence base	Evidence quality
List domains, using the key above, where there is an impact. Order domains by magnitude of impact, i.e. largest impact domain first <sup>5</sup> .	Identify the impacts, with a separate line for each impact relating to a specific domain <i>Note you can identify multiple impacts for a particular domain. Delete/add rows as needed.</i>	Individuals/families/government/etc? Be as specific as possible. Are there distributional differences?	Relative to the counterfactual key assumptions, quantified to extent possible, and where possible monetised	High/ Moderate/ Low, or where possible present value	<5 / 5-10 / 10+ years	Nature of evidence and key references	High/ Medium/ Low
Health  Primary	QALY gains	60 -74 year olds All ethnicities will benefit from the NBSP. Because the incidence of bowel cancer is lower in Māori than non-Māori, non-Māori will benefit more.	Assume 0.0607 QALY (22 days) per person invited. Screening is an established and effective method of identifying disease before physical symptoms appear – high evidence base of effectiveness from overseas application		<21 years ongoing	International experience of bowel screening and the evidence from the bowel screening pilot between 2012 and 2017	High
	Fewer hospital visits	Government – District Health Boards	Fewer Emergency Department (ED) admissions required as patients are diagnosed earlier through screening. Also reduced treatment costs (less chemotherapy and radiotherapy needed to treat bowel cancer). Assume 62 percent detection rate based on current age-range and positivity threshold.		<5 years ongoing		Low
Jobs and earnings  Secondary	Avoid lost work and productivity	60 -74 year olds Whānau of 60-74 year olds, especially as adult relatives may need to support those directly affected	This may have a greater impact in rural or remote areas, where public transport is either inadequate or non-existent.	Med	<5 years ongoing		Low
Jobs and earnings  Secondary	Retained workforce	60 to retirement age are more likely to be retained in the workforce if diagnosed with bowel cancer early.	These people will have additional benefits for society as carers (eg grandparents caring for children whilst parents work). There will also be fewer carers required for those who were diagnosed earlier than they would have been without screening.				
Knowledge and skills  Secondary	Remain in work, or be able to provide child/elder care for family	Government – childcare/reduced benefits	Healthy older people can provide childcare for mokopuna and tamariki, which may reduce the call on government subsidies for childcare and enable younger adults to gain employment or extend employment hours (eg move from part time to full time)	Low	<5 years ongoing		Low
Cultural identity  Social connections 	Intergenerational interaction	Individuals, families and communities.	On average Māori and Pacifica communities have a higher mortality rate than Pākehā. A screening programme that identifies bowel cancer at an earlier stage increase 10 year survival rates. This will support intergenerational connections.		5 – 10 years		
Civic engagement and governance 	Cost of initiative for bowel screening	Government – primary health sector	Screen 60% of 350,000 (210,000) 60-74 year olds, undertake 9,300 colonoscopies and detect 700 bowel cancers	 At 6 percent	<5 years ongoing	Costed by xxx. Increases if uptake above 80%	High

<sup>5</sup> Please note that in CFISnet, you will need to include the primary domain impacted, and up to two secondary domains impacted by the initiative. You can include as many domains as relevant in this table.



BUDGET SENSITIVE


Civic engagement and governance 	Increased life expectancy	Government – superannuation	More people survive longer in the pensionable age-band, increasing pressure on government funding. However, this is offset by some retirees performing child minding activities making it easier for their parents to work benefitting society and the Crown.				
---	---------------------------	-----------------------------	---	--	--	--	--

## BUDGET SENSITIVE

### 3.2 Wellbeing capitals – Sustainability for future wellbeing

#### Wellbeing capitals

Please fill out the table below to demonstrate how your initiative may contribute positively, negatively or neutrally to the four capitals.

 Capitals	Describe the impact and its magnitude	Realised in <5 / 5-10 / 10+ years
Financial/Physical	<b>Decrease</b> This initiative draws down financial capital to maintain the bowel screening programme to ensure the best outcomes are achieved for New Zealanders	<5 years
Human	<b>Increase</b> This initiative maintains and improves population wellbeing by ensuring continued access and ensuring that any early intervention is achieved for the best outcomes for patients.	<5 years
Natural	<b>Maintain.</b> This initiative has no impact on natural capital.	N/A
Social	<b>Maintain.</b> The initiative supports trust in primary health care services and enhances community wellbeing and social connections.	<5 years

### 3.3 Risk and resilience narrative

#### Does the initiative respond to or build resilience?

#### Resilience

The staged implementation of the NBSP has built resilience in the programme. The Ministry readiness assessments undertaken before a DHB commences bowel screening, considers the DHB's capacity and capability to ensure participants are able to join a robust programme.

The patient pathway has inbuilt resilience for equitable access once the participant has completed the initial FIT test. (The bowel screening pilot evidence was once a person participated in bowel screening once, they were more likely to return their completed kits in subsequent rounds.) The challenge is ensuring that priority populations engage in the first instance.

#### Risks

There is a risk that if Budget 2019 does not fund [REDACTED] DHBs to join the NBSP, there will be a loss of momentum, and the under-utilisation of the NSS.

If Budget 2019 funds fewer [REDACTED] DHBs to join the NBSP the national implementation of bowel screening by June 2021 is at risk.

For each year the NBSP is delayed, it will result in:

- A whole cohort of people aged 74 years (over 36,000 people) not being offered bowel screening in their lifetime
- Approximately 130 cancers will not be detected in the next DHBs to commence screening A delay in detecting an estimated 700 cancers across the whole country by the time full roll out is achieved.

Opportunities to meet the New Zealand Health Strategy: Future direction (published 2016) will be lost as the NBSP would not support:

- promoting people-powered health (strategic theme one)
- closer to home [services] (strategic theme two)
- [using] smart systems (strategic theme five).

## BUDGET SENSITIVE



## 4. Costing understanding and options

*This section will provide further information on the costs of delivering the initiative and options for scaling and phasing to support assessment, prioritisation and decision-making.*

### 4.1 Detailed funding breakdown

**Please provide a breakdown of the costs of this initiative**

To roll out the NBSP, the Ministry must purchase and commission services from a range of providers including District Health Boards (DHBs) (to carry out colonoscopies), laboratory services (to analyse screening samples), a national coordination centre (administration of the NBSP and participant contact), training providers, endoscopy quality improvement providers and Information Technology (IT) providers.

#### **Funding from the Budget 2019 will purchase:**

##### National Coordination Centre costs

Approximate total **£9(2)(f)(iv)**, comprising:

- Annual postage costs for FIT kits (first distribution)
- Annual postage costs for FIT kits (subsequent distribution eg spoilt or reminder kits)
- Annual postage costs for returned FIT kits (from the participant to the laboratory)
- Communication costs
- Staffing costs and overheads
- Active follow up of priority populations who don't return their test kits
- 0800 number phone system

##### National FIT Laboratory

Approximate total **£**, comprising:

- Staffing costs
- FIT kit purchase

##### Training, Quality and Communication

Approximate total **£**, comprising of Nurse Endoscopy training, national endoscopy quality improvement.

##### DHBs

Approximate total **£**, comprising:

- DHB one off set-up costs
- Supporting colonoscopy provision (eg clinical leadership, training GP's)
- Colonoscopy service provision following a positive FIT, including histology of polyps and adenomas found during colonoscopy and computed tomography colonography (CTC) following positive FIT
- Surveillance colonoscopy for those deemed at higher risk after a positive FIT colonoscopy
- Payment of GP's for positive FIT result management
- Funding to Primary Health Organisations (PHOs)
- Participant recruitment and health promotion
- Advertising

### 4.2 Options for scaling and phasing

**Scaling, phasing or deferring - including 75% and 50% scenarios**

The implementation of the NBSP is already phased. It does not have a scaling option unless the service delivery model options explored in the approved 2016 Programme Business Case and updated in section 2.2 were revisited. This would have considerable reputational consequences in addition to incurring costs to both analyse the consequences of changing the service delivery and change management that have not been quantified.

The deferral options are:

## BUDGET SENSITIVE

### Funding at 75 percent

If the NBSP receives 75 percent of the funding requested, based on the funding required per DHB, either Auckland or Capital and Coast with a smaller DHB (Tairāwhiti or South Canterbury) would have their implementation date deferred to the 2020/21 year.

### Funding at 50 percent

If the NBSP receives 50 percent of the funding requested, based on the funding required per DHB, it is likely that either Canterbury and a smaller DHB or Auckland, Capital and Coast and a smaller DHB would have their implementation date deferred to the 2020/21 year.

### Funding at 25 percent

If the NBSP receives 25 percent of the funding requested, based on the funding required per DHB, Auckland, Canterbury and South Canterbury would have their implementation date deferred to the 2020/21 year.

### Funding at zero percent

The implementation of bowel screening would stop after implementation in the Mid Central DHB region in November 2019, resulting in bowel screening being available in 10 DHB regions covering 49% of the eligible population.

For levels of funding less than 100 percent and greater than zero percent the Ministry would use the implementation formula across the deferral options to determine which would be least impacted by a deferred date. The implementation formula determines priority based on the size of the eligible population, the percentage of the eligible population that is a priority, bowel cancer rates, and DHB capability and capacity.

Implementation of bowel screening in the deferred DHB regions would be subject to a successful Budget 20 bid for both those deferred and those originally planned to implement in 2020/21.

Deferral represents a reputational risk to the Programme, the Ministry and the Government. DHBs and the public may question whether they can have trust and confidence in a programme which is continually changing implementation dates. Pressure to continue implementation can be expected given the significant health benefits of bowel cancer screening, as well as questions raised about why a commitment made in 2016 is not being honoured and why implementation is being so readily deferred for other priorities. Inequity across the New Zealand population is being prolonged with those who can access bowel screening benefitting from early detection.

The deferred implementation would impact on:

- DHB costs and motivation. Clinical staff will become change fatigued and less willing to carry the load required to implement a new initiative. In addition they will become increasingly frustrated at not being able to deliver the health gains to their population that the screening DHBs can. DHBs would require additional set-up funding to ensure their implementation plan is still appropriate, as well as implementation liabilities already incurred prior to the Budget (and deferred implementation date) announcement. These have not been quantified but will be greatest for those DHBs going live earliest in the 2019/20 financial year.
- Purchasing services from the external providers (the National Coordination Centre, the purchase of FIT kits and laboratory testing would all reduce). It is likely a re-negotiation of their contracts would be required as their medium term business plans would be adversely impacted. The Ministry has entered into contracts with the laboratory and FIT kit provider which end on 30 June 2020, with one right to renew for a further year up to 30 June 2021. The NCC contract expires on 30 November 2022, with one right to renew for five years up to 30 November 2027. In all contracts, it is anticipated that a further five DHBs would be added each year.
- the Ministry's ability to meet its June 2021 implementation deadline The Ministry will need to reconsider the implementation schedule and determine if feasible to complete national implementation as previously agreed with Cabinet (HR20171753 refers) by June 2021, or seek Cabinet's approval to extend the implementation completion date. The Ministry Bowel Screening team contains a range of skills to achieve go live with a DHB that would have a reduced workload during 2019/20. However the costs are unlikely to be able to be prorated because retaining partial FTEs across the skill sets would be difficult. In addition both an increase in the number of DHBs implementing the NBSP in 2020/21, and extending the

## BUDGET SENSITIVE

implementation beyond June 2021 will require additional funding for Ministry resources, as it is unlikely the Ministry would be able to redirect funding from other programmes to implement the NBSP.

- the risks articulated in section 3.3 being realised.
- the benefits outlined in the NBSP Benefits Realisation Plan and the approved 2016 Programme Business Case would be deferred. The realisation of the cost effectiveness<sup>6</sup> of bowel screening would be deferred proportional to the extended timeframe for the national screening service to be fully implemented.

In summary there are significant tangible and intangible risks associated with deferring implementation of the programme and changing the roll-out order yet again for DHBs.

---

<sup>6</sup> The cost effectiveness of bowel cancer screening in New Zealand: a cost-utility analysis based on pilot results. Sapere Research Group, July 2016 (<https://www.health.govt.nz/system/files/documents/publications/appendix4-cost-utility-analysis-based-on-findings-of-the-pilot-results.pdf>) stated "we found bowel screening to be highly cost effective, and in some scenarios actually to be cost saving from a health system perspective".



## 5. Collaboration

*This section provides information on how agencies have engaged both within and outside of their own departments in the development of this initiative. Cross-agency and cross-portfolio collaboration are both important in this context. Please ensure this section is clear and succinct, and no longer than one page.*

### 5.1 Collaboration and evidence

<b>What type of cross-agency and/or cross-portfolio initiative is this?</b>	<p>This initiative is not a cross-agency and/or cross-portfolio bid where there is collective responsibility, but there are <b>cross-agency relationships and implications</b>.</p> <p>The Ministry works closely with the Central Agencies (Treasury, Government Chief Digital Officer (GCDO), and the Ministry of Business, Innovation and Employment (MBIE). This is because the NBSP information technology project – the National Screening Solution went through an open procurement process (MBIE), is seeking to use cloud based technology and social licence (GCDO), and the NBSP is a high investment/high risk project (Treasury through the Better Business Case clinics, Gateway reviews.</p> <p>The Ministry is also working with the Corrections Department and the Ministry of Defence to deliver equitable bowel screening services across their populations.</p>
<b>Agencies and Ministers that have been engaged in initiative development</b>	<p>In 2016, Cabinet [SOC-16-MIN-0108 refers] agreed that the Minister of Finance and Minister of Health should jointly approve all NBSP business cases for the implementation of the programme. In support of the business cases submitted to Ministers by the Ministry, the Ministry receives detailed information and implementation plans from each DHB as it prepares to implement the NBSP. This year, the Ministry will receive implementation plans from Auckland, Canterbury, Capital Coast, South Canterbury and Tairāwhiti DHBs.</p>
<b>Impact of cross-agency collaboration</b>	<p>The timing of the roll out of the NBSP implementation has been influenced by MBIE through ensuring that the Ministry's procurement process is robust and meets best practice, and is also comparable to other large scale IT commissioning projects. The IT design and commissioning has also been supported by expert advice from the GCDO. The support from Treasury has enabled the Ministry to produce acceptable business cases that have been approved by the Ministers.</p>
<b>Risks and challenges</b>	<p>In the 2017/18 financial year, the biggest challenge for the NBSP came from the Independent Assurance Review for the NBSP. Until the final report was published, there was a risk that the independent reviewers would conclude that the NBSP was not and would not achieve its objective of reducing bowel cancer mortality rates. The ongoing risks identified by the review are from information technology, particularly the interim system supporting the first eight DHBs providing the NBSP, and the ongoing risks of workforce capacity in colonoscopy.</p> <p>The Ministry will report in February 2019 and August 2019 on its progress against the review's recommendations. As well as these challenges, the Ministry is also cognisant of the recommendations made by Gateway, which it is also addressing.</p> <p>The implementation of the NSS as a strategic information technology solution extendable for use by other population health programmes (subject to funding approval) is a challenge that is being carefully managed by the Ministry and monitored with support from Central Agencies. The delivery of the NSS is necessary for bowel screening to be delivered by the latest seven DHB regions (Whanganui, Mid Central, Auckland, Canterbury, Capital and Coast, South Canterbury and Tairāwhiti). The use of the interim IT system will not be extended beyond the first eight DHB regions to offer bowel screening. The NSS is due to be stood up in August 2019, ready to be used by the seven DHBs over a staged implementation period from October 2019 to June 2020.</p>