Memo [BUDGET SENSITIVE]

Date:	15 March 2019
To:	Hon Dr David Clark, Minister of Health
CC:	Dr Ashley Bloomfield, Director General, Ministry of Health
From:	Maree Roberts, Deputy Director General, System Strategy and Policy Fergus Welsh, Chief Financial Officer, Corporate Services
Subject:	Budget 2019 advice ahead of your meeting with the Minister of Finance on 19 March 2019
For your:	Noting

Purpose

1) You have a meeting with the Minister of Finance on 19 March 2019 regarding Budget 2019 initiatives. This memo provides you with advice for that meeting and responds to issues you discussed with officials on 13 March. It also contains an A3 detailing the individual Budget 2019 initiatives that have been proposed, an A3 summarising the whole Vote Health Budget 2019 package and an A3 detailing the mental health Budget 2019 bids.

Requested Advice

2) You requested the following advice on 13 March 2019:

   a) When did the Ministry of Health move from measuring elective surgeries to measuring planned care?
      i) During 2018/19, we amended the language of 'Electives' to 'Planned Care (Electives)'. This was done as an early signal of our intended future approach to focus the programme on a more comprehensive set of interventions, being more focused on what was delivered rather than where the intervention took place (ie, greater range of facilities and ability to treat people in less-intensive care settings).

         While the language has changed in 2018/19, at this point, the definition of what is counted as 'Planned Care (Electives)' is currently the same as what was 'Electives' in 2017/18, and it is this definition that has been used to contract DHB delivery in 2018/19.

         Advice is being provided to you in March on recommended changes to support Planned Care, which includes a proposed definition change. It is anticipated that, if supported by you, this would 'go live' from 1 July 2019. The Planned Care Budget 2019 bid for growth in delivery is based on the proposed new approach, reflecting the investment required to continue to grow service delivery in line with demographic changes

   b) What level of funding is required to keep VLCA primary care consultation co-payments at no more than $19? In addition how does the Vote Health funding component of primary care compare to the ACC component?

i) PHOs are allowed to increase their maximum co-payments if the Ministry of Health and DHBs do not fund the entirety of their cost pressures. s 9(2)(g)(i) over four years is required to keep 2019/20 maximum VLCA co-payments at no more $19. This is split between [redacted] in funding from the Ministry of Health and [redacted] in funding from DHBs. It is estimated a further [redacted] will need to be [redacted] to maintain co-payments at $19 for VLCA in 2020/21.

ii) ACC will ensure their regulations and pricing match the level of co-payment agreed by the Ministry of Health, DHBs and PHOs.

c) What will capital investment in alcohol and other drugs purchase?
   i) s 9(2)(f) over four years is requested to expand alcohol and other drugs services. Included in this is [redacted] in 2019/20 to improve supported accommodation facilities (a mixture of refurbishment and new builds) and [redacted] over four years to meet DHB cost pressures which includes some capital purchases (eg, cars to enable community outreach).

d) What are the options available in the roll-out of the primary mental health bid?
   i) Option 1: [redacted] over four years with a five-year roll-out

   This option phases national roll-out over five years, with five DHB regions added per year. This option has capacity to provide services to a total of [redacted] people nationally [redacted] of the total population, which is higher than the expected uptake based on current services of [redacted]. Option 1 costs s 9(2)(f)(iv) [redacted] four-years.

   Scaled service delivery ([redacted]) begins in Year 1 in settings or areas that are ready to implement (eg, Youth One Stop Shops). The first five regions selected for national roll-out will begin co-design in Year 1, with full service delivery starting in those regions in Year 2. This co-design approach allows for flexibility in the design of services. The range of responses and skill mix will be developed locally to meet the needs of the community, and to accommodate workforce constraints within the region.

   Even with this flexibility, roll-out over this time period will be very challenging, given significant workforce shortages and pressures across sectors. For every 5,000 people seen, up to an estimated 25-30 FTE will be required, depending on the mix of workforce required. Based on this assumption, national roll-out to [redacted] people will require up to an estimated [redacted] by the end of Year 5. This will include a mix of peer and support workforces, health coaches, counsellors, health improvement practitioners, social workers, occupational therapists, nurses, GP and psychologists.

   This level of workforce demand is mitigated to an extent by the proposed investment to upskill, expand and develop new workforces; however, Option 1 will likely need to rely heavily on peer and support workforces, rather than registered workforces, to account for the lag-time for workforce training. It may be possible to roll-out regionally to all sites and begin to deliver services to lower numbers of people, or with low levels of interventions, while building the workforce.

   ii) Option 2: [redacted] over four years with a [redacted] roll-out

   This option phases national roll-out over nine years, with 2.5 DHB regions added per year. This option has capacity to provide services to a total of [redacted] people nationally [redacted] of the total population, which is higher than the expected uptake based on current services of [redacted]. Option 2 [redacted] over four-years.

   Feasibility issues around workforce are reduced with a longer implementation period. For the total of [redacted] people seen, up to an estimated [redacted] FTE with a mix of skill levels will be required by the end of [redacted] This allows a much greater lead-in time for workforce

development and expansion, so would enable a more balanced mix of clinical and non-clinical workforces to be incorporated into responses.

e) If the implementation of the National Bowel Screening Programme is scaled back this year can the original roll-out times still be achieved?
   i) The full National Bowel Screening Programme bid requested [redacted] over four years to roll out to [redacted]. However, following conversations with Auckland DHB the Ministry has accepted their request to defer their implementation to the 2020/21 financial year. This revises the Budget 2019 bid down to [redacted] over four years. The Ministry advises that scaling the bid further would require delaying implementation in further DHBs and would put the full National Bowel Screening Programme implementation target of June 2021 at risk.

3) The Ministry of Health has also made the following changes you requested to the Budget package:
   a) rheumatic fever is mentioned in both the child wellbeing and equity sections with funding only being requested in the equity section
   b) an individual funding figure has been attached to [redacted] mental health services
   c) the workforce package has been renamed 'rural and regional workforce' to reflect the package's focus
   d) s 9(2)(f)(iv) [redacted]
   e) nursing workforce accord has replaced [redacted]
   f) s 9(2)(g)(i) [redacted]

END.