Briefing for decision

Budget requirements relating to World Health Organisation

Date due to MO:	10 October 2024	**Action required by:**	
Security level:	IN CONFIDENCE	**Reference:**	H2024051792
To:	Hon Dr Shane Reti, Minister of Health		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
Fergus Welsh	Chief Financial Officer, Corporate Services	s 9(2)(a)
Salli Davidson	Group Manager, Global Health, Public Health Agency	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Overtaken by events
☐ Needs change	☐ Seen	
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Briefing for decision

Budget requirements relating to World Health Organisation

Security level:	IN CONFIDENCE	**Date:**	10 October 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This briefing provides background information on New Zealand's increasing financial contribution to the World Health Organization (WHO), which is based on a set formula. We outline options for managing the future financial impacts of New Zealand's annual assessed contribution to the WHO.

Summary

2. In 2022 Member States, including New Zealand, agreed to improve the WHO's financial sustainability by increasing Assessed Contributions (AC) to reach a level of 50% of the WHO's 2022-2023 core baseline budget by 2030-2031.

3. The first increase for the 2024 – 2025 period is in excess of the current Vote Health appropriation by between $0.696 million and $0.915 million (depending on foreign exchange fluctuations). You have agreed through the 2024 October Baseline Update (H2024049243 refers) to support for a small reprioritisation of funding to occur to address the immediate risk of unappropriated expenditure up to April 2025 to provide time for a longer-term solution to be developed to address the cost pressure for the remainder of this financial year and beyond.

4. A decision is required to enable the Ministry of Health (the Ministry) to cover projected increases in AC levels for outyears, which are also over the current Vote Health appropriation. The incremental steps and timeframe for the AC increases will be considered by Member States as part of WHO's biennial programme and budget deliberations at the World Health Assembly in May 2025.

5. Advice from the Ministry of Foreign Affairs and Trade (MFAT) stresses the obligation to meet multilateral membership subscriptions and the reputational risk to New Zealand of not doing so.

6. s 9(2)(g)(i) [redacted]

Recommendations

We recommend you:

a) **Note** that in 2022 Member States agreed to increase the WHO's sustainability by incrementally increasing ACs to reach a level of 50% of the WHO's 2022-2023 core baseline budget, by the biennium 2030-2031 (with the aim of achieving this by the biennium 2028-2029).

b) **Note** that the first AC increase took effect from January 2024 and further increases will be considered within the WHO's Programme Budget for 2026/2027 at the World Health Assembly (WHA) in May 2025.

c) **Note** that AC are funded from the International Health Organisations non-departmental other expense appropriation in Vote Health and there is insufficient funding in this appropriation to meet the forecast increases in the AC contributions.

d) s 9(2)(f)(iv) [redacted]

e) **Note** further funding is required to meet the financial commitment in 2024/25 of approximately $0.300 to $0.400 million.

f) **Approve** the preferred approach to address the remaining funding risks in 2024/25:

I.	Identify further savings within the Ministry's work programme, **OR**	**Yes/No**
II.	Engage the Minister of Finance on the opportunity to progress through Budget 2025.	**Yes/No**

g) **Approve** the preferred approach to address the cost pressures in outyears from 2025/26 to 2027/28:

I.	Request Ministry officials to provide a further briefing on the next WHO biennium programme and budget proposals (including AC levels), along with other likeminded country positions in February 2025, **OR**	**Yes/No**
II.	Engage the Minister of Finance on the opportunity to progress through Budget 2025, **OR**	**Yes/No**
III.	Further investigate the option of paying up to the current appropriation limit or new 2024/25 AC baseline (and falling into arrears if further increases are agreed at the WHA in May 2025), noting the significant membership and reputational risk to New Zealand associated with this option, **OR**	**Yes/No**
IV.	Consider other options to meet these costs within Vote Health baselines and understand the trade-offs and impacts.	**Yes/No**

Dr Diana Sarfati
Director-General of Health
Te Tumu Whakarae mō te Hauora
Date: 10 October 2024

Hon Dr Shane Reti
Minister of Health
Date:

Budget requirements relating to World Health Organisation

Background

New Zealand's membership of the World Health Organization

1. In a globally connected world, countries benefit from international health organisations, particularly the World Health Organization (WHO), that promote health, and provide information and cooperation that keeps us safe from preventable diseases and illness.

2. The WHO has 196 Members and Associate Members. New Zealand has been a founding member of the WHO since its establishment in 1948. Membership includes:

   a. governance of the organisation (such as serving on the Executive Board from 2015 to 2018 and contributing to programme and budget decisions taken at the annual World Health Assembly and Western Pacific Regional Committee meetings), and

   b. funding the organisation through Assessed Contributions (AC). ACs are a key source of predictable financing for the WHO. New Zealand also makes Voluntary Contributions (VC) directed to specific WHO projects (see Appendix A, Table 1).

3. As a member of the WHO, New Zealand can learn about and influence health issues that advance our interests, as well as those that go beyond individual countries - requiring a common global understanding and approach and, often, common global rules.

4. s 9(2)(g)(i) [redacted]

5. We also utilise our membership to support the health priorities of Pacific Island Countries (PICs). WHO has a strong presence in the Pacific, with a Division of Pacific Technical Support based in Suva, as well as offices in six PICs. Pacific Health Ministers and senior officials are active in WHO governance, including on the Executive Board and leading resolutions at the World Health Assembly (such as climate change and health). The former Tongan Minister of Health is the recently appointed WHO Western Pacific Regional Director based in Manila.

Achieving a sustainable financing model for WHO

6. Sustainable financing has been an integral component of the WHO's organisational reform.

7. The main income sources are:

   a. AC - the amount that each of the 196 Members and Associate Members must pay to WHO on an annual basis. The assessment scale is calculated by the United Nations based mainly on the country's Gross Domestic Product. These have declined as an overall percentage of the WHO budget and have, for several years, accounted for less than 20% of the organisation's financing. New Zealand's AC are funded through Vote Health (in line with a long-standing principle that international subscriptions sit with the agency that holds both New Zealand's main interest in

membership of the organisation and the associated balance of responsibilities (including policy and technical leads for the engagement).

b. VC – additional contributions made at the discretion of donors, including Member States and philanthropic organisations. These can be tagged to specific projects, thematic areas or fully unconditional. New Zealand's VC are funded through Vote Foreign Affairs (International Development Cooperation) and are tagged to humanitarian and development initiatives.

8. While the COVID-19 pandemic led to a record number of VC, the constraints of earmarking funding to specific projects and short-term funding cycles, combined with very limited growth in predictable sources of financing, have limited WHO's ability to deliver on its mandate.

9. From the record high level of revenue of US$4,364 million reached in 2022, revenue in 2023 decreased by US$1,013 million. Of the total 2023 revenue of US$3,341 million, US$2,746 million (82%) came from VC, US$494 million (15%) from AC, US$55 million from in-kind revenue and US$46 million from other sources. The Top 10 donors in 2023 are included in Appendix A, Table 2.

10. Challenges with the WHO funding model were highlighted by an Independent Panel on Pandemic Preparedness and Response and a G20 High-Level Independent Panel in 2020-2021. Recommendations from these reports resulted in renewed calls to strengthen WHO financing, including the establishment of a Member State led Working Group on Sustainable Financing (WGSF). Following 18-months of consultations, the WGSF work led to a consensus decision at the 75th World Health Assembly in May 2022.

11. Member States agreed, by consensus, to improve the WHO's sustainability by incrementally increasing the level of AC to reach a level of 50% of the WHO's 2022-2023 core baseline budget, by the biennium 2030-2031 (with the aim of achieving this by the biennium 2028-2029). In line with WHO's rules and procedures, this would still be subject to Member States approval as a component of WHO's programme budget process every two years.

New Zealand's position on sustainable financing of the WHO

12. Sustainable financing of the WHO was a key global health priority for New Zealand as confirmed by the former Minister of Health, Hon Andrew Little and former Minister of Foreign Affairs, Hon Nanaia Mahuta in response to a series of Ministry of Health briefings during 2021 and 2022.

13. In addition, the former Prime Minister, Rt Hon Jacinda Ardern confirmed New Zealand's support for an increase in ACs to the WHO Director-General in December 2021.

14. In 2022, New Zealand supported a consensus decision taken by the World Health Assembly to increase ACs over time to fund 50% of the WHO core budget.

Financial implications of the increase in WHO Assessed Contributions

15. The intended phased increase is outlined below:

Table 1: Phased increase proposed for assessed contributions to WHO

Biennium	Total Assessed Contributions USD$m	Increase	% of base budget 2022 – 2023*
2022 - 2023	956.900	baseline	22%
2024 - 2025	1,148.300	20%	26%
2026 - 2027	1,550.200	35%	36%
2028 - 2029	2,182.000	40%	50%

* base segment of approved programme budget 2022 – 2023 USD$4,364 million

16. At the WHA in 2023, Member States agreed to the first AC increase for the 2024-2025 biennium (calendar years 2024 and 2025).

17. Although the WHA took a decision in 2022 to incrementally increase the AC over time, Member States consider future increases every two years in the context of the approval of the WHO's biennium programme of work and budget. The next increase for the 2026-2027 biennium will be proposed at the 78th World Health Assembly in May 2025.

18. AC are invoiced in US dollars (USD) and Swiss Francs (CHF) and invoiced to the Ministry in January for each calendar year.

Forecast Vote Health appropriation shortfall

19. The Government has provided funding to Vote Health for the Ministry of Health to manage New Zealand's annual ACs to the WHO via the International Health Organisations Non-Departmental Other Expense Appropriation. The current appropriation has funding available of $2.230 million per annum in 2024/25 and in baselines for the outyears.

20. However, this was not adjusted in previous budgets to meet the agreed increase in WHO Assessed Contributions referred to in paragraph 15 above.

21. The Ministry reprioritised $0.500 million from Departmental baselines in 2023/24 to address the impact of the increased WHO contributions in that year and avoid incurring unappropriated expenditure.

22. The impact of the increase in WHO contributions is fully detailed in Appendix B, but in summary, the Ministry expects that should future increases be agreed at future World Health Assembly's as has previously been proposed, the increased contributions to the WHO will result in expenditure exceeding the funding available in the International Health Organisations appropriation and outyear baselines as follows:

Table 2: Forecast funding shortfall for New Zealand's assessed contributions to WHO

$m	2024/25	2025/26	2026/27	2027/28	2028/29 & Outyears
Forecast expenditure	2.926	3.379	3.839	4.621	5.403
Foreign exchange - 15% contingency*	0.219	0.672	0.907	1.092	1.277
Adjusted forecast expenditure	3.145	4.051	4.746	5.713	6.680
International Health Organisations appropriation limit	2.230	2.230	2.230	2.230	2.230
Cost pressure	**(0.915)**	**(1.822)**	**(2.516)**	**(3.483)**	**(4.450)**

*The $15% contingency for foreign exchange risk is only applied from calendar 2025 as the invoice for calendar 2024 has already been paid

23. Decisions made to increase the WHO contribution by Member States for the first AC increase for the 2024-2025 biennium (calendar years 2024 and 2025) mean that the current appropriation will have shortfall in funding of between $0.696 million and $0.915 million, depending on the impacts of foreign exchange movements.

24. The Ministry has sought joint Ministers approval to reprioritise $0.300 million in 2024/25 from its departmental baselines in the October Baseline Update (OBU) to address the immediate risk of unappropriated expenditure in 2024/25 and provide time for a longer-term solution to address the cost pressure. This funding is sufficient to address the need until April 2025, but further decisions will be required in the 2025 March Baseline Update (MBU) or as part of Budget 2025, to avoid residual unappropriated expenditure risks in 2024/25.

Options to address the current funding shortfall.

25. The Ministry has considered a range of options to address the funding shortfall for 2024/25 and outyears. These are outlined below:

Option A: *Reprioritise funding from within Vote Health or alternative funding sources to cover the 2024 – 2025 AC increase only*

26. The Ministry is increasingly constrained in its ability to reprioritise funding within Vote Health as most of the funding is allocated to Crown entities in the health sector. We know that they are already under significant pressure (especially Health NZ). This leaves the Ministry's departmental baselines as the other potential source of funding available for reprioritisation. s 9(2)(f)(iv)

27. s 9(2)(f)(iv)

28. If sufficient savings do not eventuate to support this transfer, then other corrective actions may be required such as reviewing and reprioritising the Ministry's work programme.

29. The amount being transferred excludes any contingency for foreign exchange movements. Once the payment for 2025 is made and the final NZ dollar amount determined, then the actual impact of the cost pressure in 2024/25 will be known.

30. s 9(2)(g)(i)

31. In addition, the Ministry asked MFAT to consider the possibility of supporting the WHO AC shortfall for 2024/25 from Vote Foreign Affairs (International Development Cooperation) in time for 2024/25 Supplementary Estimates.

32. In considering this option, MFAT has advised that AC are the responsibility of the agency that holds both New Zealand's main interest in membership of the organisation and the associated balance of responsibilities. MFAT has also noted that VC to multilateral organisations such as WHO is not interchangeable, as the basis and purpose for AC and VC is different. s 9(2)(g)(i)

33. MFAT also noted that the Minister of Foreign Affairs has decided that New Zealand's multilateral allocation within the International Development Cooperation programme will be significantly reduced from this financial year (from 15 to 10% of overall International Development Cooperation funding). Accordingly, MFAT does not expect any underspend in the multilateral allocation.

Option B: *Seeking new funding from Cabinet for 2024/25 and outyears*

34. An alternative option is to seek new funding to manage the shortfall in 2024/25 and outyears through an out-of-Budget-cycle paper to Cabinet seeking funding from the between-Budget contingency or as a pre-commitment against Budget 2025.

35. Alternatively, an initiative could be submitted seeking this funding through Budget 2025.

36. Either of these options would require engagement with the Minister of Finance. However, the Ministry understands that only initiatives invited by the Minister of Finance will be considered in Budget 2025 and an invitation to increase the funding for WHO is not expected at this stage.

37. An out-of-Budget-cycle Cabinet paper may be preferable to give earlier certainty of funding availability, as if the initiative failed to attract funding in Budget 2025, it may be too late to take remedial action to avoid unappropriated expenditure in 2024/25. However, this would still require support from the Minister of Finance that this would have been considered in Budget 2025.

38. A Cabinet paper may also provide the government with the opportunity to become conversant with the funding arrangements for WHO, including the proposed increases in assessed contributions for the 2026-2027 biennium which will be considered at the 78th WHA in May 2025.

Option C: *Only paying to the current appropriation limit for 2025/26 and outyears*

39. The appropriation limit for the WHO AC is $2.230 million per annum. If New Zealand were to make future payments at the current level of AC funding only and the WHA biennially approves the expected financial increases, New Zealand would fall into arrears for the increases agreed from the calendar year 2024 for 2024/25 and outyears.

40. This partial payment option would demonstrate a level of ongoing commitment to WHO as the lead international health agency, while ensuring that the WHO contribution is within the current and forecast appropriation amount.

41. It could be noted that additional funding from New Zealand to the WHO via VC has been increasing (see Appendix A). This contributes to WHO financing overall, however, it is earmarked to specific, time-bound development and humanitarian projects and doesn't support WHO's base budget. As noted previously, the Vote Foreign Affairs International Development Cooperation appropriation does not include provision for AC funding to the WHO in 2024/2025 or outyears.

42. The disadvantages of this option are the potential membership implications if New Zealand falls into arrears and the reputational risk.

43. WHO's constitution states that if a Member State fails to meet its financial obligations, the WHA may suspend voting privileges. The threshold is an amount that equals or exceeds the contributions due for the preceding two full years.

44. This provision has been used to suspend voting privileges for: Afghanistan, Central African Republic, Comoros, Dominica, Lebanon, Lesotho, Somalia, South Sudan, Venezuela and Yemen.

45. If New Zealand were to maintain the current level of AC in the appropriation (or a new baseline at the 2024/2025 level) and not meet the increased financial commitment made in 2022, it would take to 2029 to meet the threshold for the WHA to consider suspending New Zealand's voting rights. However, at some stage during this period we would need to seek funding as part of a budget round to meet the obligations.

46. Table 3 below shows the period over which New Zealand might reach the threshold to impact membership rights (based on the current appropriation and current foreign exchange rates):

By Calendar Year	2025	2026	2027	2028	2029
Beginning balance	-	689,628	2,298,395	3,907,162	7,080,535
Assessed contribution obligation	2,919,628	3,838,767	3,838,767	5,403,373	5,403,373
Payment at current appropriation amount	(2,230,000)	(2,230,000)	(2,230,000)	(2,230,000)	(2,230,000)
Amount in arrears	**689,628**	**2,298,395**	**3,907,162**	**7,080,535**	**10,253,908**
Suspension of voting priveleges?		*No*	*No*	*No*	*Yes*

47. The WHO publishes detailed information on contributions by Member States on its website and in World Health Assembly documents. If New Zealand were to fall into arrears this would be visible internationally and would present serious reputational and foreign policy risks.

48. MFAT endorses this assessment, noting that AC, including New Zealand's AC to WHO, are non-discretionary payments resulting from formal obligations arising from membership of international organisations or Treaties. They are a legal obligation that has been willingly assumed by Cabinet to enable New Zealand to engage with influence and benefit from an organisation's work. s 9(2)(g)(i)

s 9(2)(g)(i)

49. s 9(2)(g)(i)

50. s 9(2)(g)(i)

Future Member State decisions on the WHO budget

51. As noted in para 17, Member States will have the opportunity to take decisions on WHO's biennium 2026-27 programme and budget at the WHA in May 2025. The proposed increase in ACs (as a component of the overall budget) may therefore be considered again within that context.

52. In preparation for WHA, it is possible that other Member States will also deliberate the affordability of decisions taken in 2022. Ministry officials will therefore seek to understand the position of likeminded countries in the coming months, including at the WHO Regional Committee Meeting in October, the Programme and Budget and Administrative Committee in late January and the Executive Board meeting in early February.

Equity

53. Equity is a consideration in all WHO programmes so the AC supports WHO to achieve equitable outcomes across its global programme of work.

Next steps

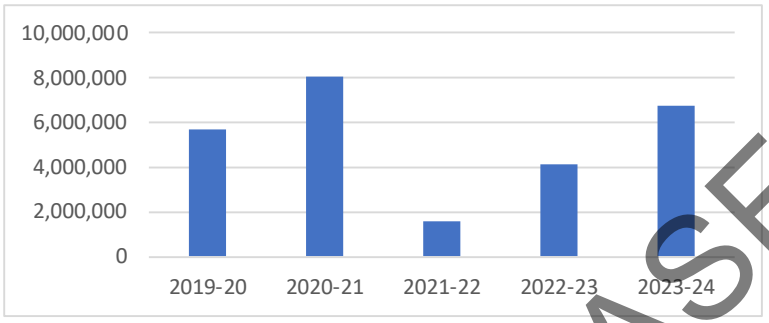
54. Ministry officials propose a two-step approach to the issue of increased AC. The first step is to address the shortfall in the payments due in 2024/25 as outlined in option A and B by March 2025 and Rec f).

55. The second step is to determine the best course of action for the proposed increases in outyears as outlined in options A, B and C. This requires further information, including clarity on the WHO's 2026-27 budget and the position of other Member States for future contribution increases. Subject to your decision this may require a Cabinet paper prior to the WHA in May 2025. This is outlined in rec g).

Appendix A

Table 1: New Zealand's Voluntary Contributions to the WHO – Vote Ministry of Foreign Affairs (International Development Cooperation)

Year	$NZ
2019-20	5,645,436
2020-21	8,055,228
2021-22	1,550,615
2022-23	4,104,836
2023-24	6,769,085



Source: MFAT/DEVPP October 2024

Table 2: WHO Top 10 Donors in 2023

Country	**AC (US$ millions)**	**VC (US$ millions)**
USA	113	368
Bill and Melinda Gates Foundation	0	356
GAVI, the Vaccine Alliance	0	260
Germany	30	229
UK and Northern Ireland	22	189
European Commission	0	189
World Bank	0	90
China	76	4
Canada	13	65
UN Central Emergency Response Fund	0	74

Appendix B

The impact of the increase in WHO Assessed Contributions for New Zealand over three bienniums is based on a consensus decision taken in 2022 by the World Health Assembly. The decision to increase ACs over time to fund 50% of the WHO core budget is outlined in Table 3 below.

Table 3: WHO Assessed Contributions for New Zealand by calendar year

Assessed contributions

Members	Scale of assessments	Currency	2024-2025		2026-2027		2028-2029	
			2024	2025	2026	2027	2028	2029
Total	100%	USD	574,139,997	574,139,997	775,088,996	775,088,996	1,090,999,994	1,090,999,994
New Zealand	0.2910%	USD	1,670,854	1,670,854	2,255,654	2,255,654	3,175,014	3,175,014
New Zealand	0.3090%	USD	1,774,206	1,774,206	2,395,179	2,395,179	3,371,407	3,371,407
Final NZ assessed contribution		**USD**	**1,774,206**	**1,774,206**	**2,395,179**	**2,395,179**	**3,371,407**	**3,371,407**
Calculated at current FX								
50% invoiced in USD		USD	887,120	887,115	1,197,589	1,197,589	1,685,703	1,685,703
50% invoiced in CHF		CHF	793,972	793,968	1,017,417	1,017,417	1,432,096	1,432,096
Converting USD to NZD		NZD	1,450,491	1,421,744	1,919,329	1,919,329	2,701,609	2,701,609
Converting CHF to NZD		NZD	1,482,675	1,497,884	1,919,438	1,919,438	2,701,764	2,701,764
Total NZD		**NZD**	**2,933,165**	**2,919,628**	**3,838,767**	**3,838,767**	**5,403,373**	**5,403,373**
Calculated at current FX + 15% rate change contingency								
50% invoiced in USD		USD	887,120	887,115	1,197,589	1,197,589	1,685,703	1,685,703
50% invoiced in CHF		CHF	793,972	793,968	1,170,029	1,170,029	1,646,910	1,646,910
Converting USD to NZD		NZD	1,450,491	1,635,005	2,207,228	2,207,228	3,106,851	3,106,851
Converting CHF to NZD		NZD	1,482,675	1,722,567	2,538,457	2,538,457	3,573,082	3,573,082
Total NZD		**NZD**	**2,933,165**	**3,357,572**	**4,745,685**	**4,745,685**	**6,679,933**	**6,679,933**

Table 4: WHO Assessed Contributions for New Zealand by financial year

NZD	2024/25	2025/26	2026/27	2027/28	2028/29 & Outyears
Forecast expenditure	2,926,397	3,379,197	3,838,767	4,621,070	5,403,373
Foreign exchange - 15% contingency	218,972	672,431	906,918	1,091,739	1,276,560
International Health Organisations appropriation limit	2,230,000	2,230,000	2,230,000	2,230,000	2,230,000
Cost pressure	**(915,369)**	**(1,821,629)**	**(2,515,685)**	**(3,482,809)**	**(4,449,933)**

Aide-Mémoire

Crown Response to the Abuse in Care Inquiry – Ministerial Group meeting

Date due to MO:	2 December 2024	**Date of Meeting:**	3 December
Security level:	SENSITIVE	**Reference:**	H2024057511
To:	Hon Matt Doocey, Minister for Mental Health Hon Dr Shane Reti, Minister of Health Hon Casey Costello, Associate Minister of Health		
Consulted:	Health New Zealand: ☐		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
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Emma Prestidge	Group Manager, Primary, Family and Community Health Policy, Strategy Policy and Legislation	s 9(2)(a)

Aide-Mémoire

Crown Response to the Abuse in Care Inquiry – Ministerial Group Meeting

Date due:	2 December 2024
To:	Hon Matt Doocey, Minister for Mental Health Hon Dr Shane Reti, Minister of Health Hon Casey Costello, Associate Minister of Health
Security level:	SENSITIVE
Reference:	H2024057511

About the Meeting

Purpose of Meeting

This meeting is for the Ministerial Group for the Crown Response to the final report of the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions. The agenda items are:

- High-level information on the Crown Response Budget approach
- Whanaketia Draft Full Response Plan
- Other business

Details of Meeting

Date: 3 December 2024
Time: 5.00 -6.30pm
Venue: TBC

Comment:

Item 1: Approach to creating a package of initiatives for Budget 25

1. The Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Abuse in Care has been invited by the Minister of Finance to coordinate a package of survivor-focussed initiatives for Budget 2025.
2. The invitation requests that placeholder initiatives should be submitted by 1pm on 23 December 2024 with final submissions being made by 18 January 2025.
3. The budget bid may cover initiatives in the following areas:
    a. Redress, including:

i. monetary payments for survivors;
ii. enhanced support and services for survivors
iii. the operational costs

b. The establishment of the Crown Response Office
c. Initiatives to future-proof the care system

4. This will be a joint package across the relevant Vote and operationally responsible Ministers. The Ministry will be working closely with other agencies and the Crown Response Unit while this budget bid is being developed.

Redress

5. The Ministry is working with other care agencies on the redress related items of the budget bid, including the assumptions for costing redress options. We have reviewed and provided feedback on one briefing and expect to review two more this week. Overall, the Ministry is satisfied with the process and will continue to work with and feed back to the Crown Response Unit.

Future proofing the care system

6. The Ministry has been asked to identify possible initiatives to support the 'future proofing the care system' item in a budget bid. It is the Ministry's understanding that this part of the budget package is intended to invest into the current and future care system to prevent abuse and neglect in the future.

7. The Ministry notes that we are still in an early stage of analysing and responding to the recommendations of the final report, therefore, identifying specific initiatives will be challenging. There is a risk that without the appropriate consideration and discussions with affected groups, decisions may be seen as rushed and may be criticised by survivors and the public.

8. In order to prevent this, the Ministry is considering putting forward the option of a contingency fund that is tied to improving the care system, with funding to be drawn down by Ministers/Cabinet over the next 18 months as they make specific policy decisions on recommendations from the inquiry. This would demonstrate the government's commitment to responding to the final report, while also recognising the need to take time to work through the recommendations thoughtfully and engage with survivors and other affected groups.

9. The Ministry is examining some specific initiatives that could be put forward as part of the initial stages of the budget bid planning. For instance, around safeguarding and infrastructure, noting that there are some parameters that we are not able to estimate in the timeframe we have been given.

10. The Ministry will continue discussions with other care agencies and the Crown Response Unit in developing initiatives for the budget bid and provide updates to your offices.

11. We understand that a further meeting with responsible Ministers is planned to agree what will go into this package, possibly around 18 December though details are still to be confirmed. A further meeting may be scheduled during January to finalise the content of the bid though this is not yet confirmed.

Item 2: Whanaketia Draft Full Response Plan

12. The Crown Response Unit is developing a draft response plan for Ministers which will set out how the government plans to work through and consider the recommendations of the final report. The Crown Response Unit is planning to provide this advice to key Ministers, including you before Christmas for your holiday reading.

13. This advice will include some key considerations for Ministers, such as how they would like to scope the work around the response to the final report. For example, the Royal Commission excluded people over 65 from their scope of people in care, but many people who receive care (including those with disabilities) are over 65 years old, with numbers to increase in coming years.

14. Once finalised, the response plan will go to Cabinet in February or March 2025 for approval.

15. The Crown Response Unit has begun initial thinking with agencies about possible workstreams and projects. The Ministry has provided advice to the Crown Response Unit and will continue working closely with them in coming weeks to develop this advice further.

Maree Roberts
Deputy Director-General
Strategy, Policy and Legislation

Briefing for information

Identifying potential health components for a Budget package responding to the Abuse in Care inquiry recommendations

Date due to MO:	5 December 2024	**Action required by:**	N/A
Security level:	SENSITIVE	**Reference:**	H2024057679
To:	Hon Dr Shane Reti		
Copy to:	Hon Matt Doocey, Minister for Mental Health Hon Casey Costello, Associate Minister of Health		
Consulted:	Health New Zealand: ☐		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)
Geoff Short	Deputy Director-General, Clinical Community and Mental Health	s 9(2)(a)

Minister's office to complete:

☐ Noted ☐ Seen

☐ Needs change ☐ Withdrawn

☐ See Minister's Notes ☐ Overtaken by events

Comment:

Briefing for information

Identifying potential health components for a Budget package responding to the Abuse in Care inquiry recommendations

Security level:	SENSITIVE	**Date:**	5 December 2024
To:	Hon Dr Shane Reti		

Purpose of report

1. This briefing provides you with a brief update on work that the Ministry is doing to input into a Budget 2025 bid covering the Government's response to recommendations from the Royal Commission of Inquiry into abuse in care and faith-based institutions.

Content

Background on the recommendations of the final report

2. As you know, Royal Commission of Inquiry made 138 recommendations in their final report aimed at the Government and faith-based care organisations. The recommendations are broad-ranging and have a particular emphasis on machinery of government matters, care safety standards, workforce, complaints processes, enforcement, and the justice sector.

3. Most of the recommendations of the Royal Commission of Inquiry are designed to apply across all care settings (state and non-state) rather than being specific to a particular context such as youth justice or disability-related care. Therefore, many of the recommendations will require cross-agency collaboration, and we expect that if the recommendations are adopted Health will be part of a wider agency response.

4. To support the initial planning of the response the Crown Response Unit has divided the recommendations into groups, these groups are:

    - Care safety
    - Monitoring and oversight
    - Prevention and empowering people in care and their communities
    - Redress
    - Justice sector
    - Implementation
    - Faith-based recommendations

5. Appendix A is a full list of the recommendations of the final report. The Ministry has included sections on the recommendations that relate directly to health, those that require significant input from Health, and those that will likely require little input from Health. These sections have been divided into the groupings outlined above.

6. The response related to the redress related recommendations is being progressed jointly by agencies, with the responsible Vote Ministers, including you, being asked to make decisions on assumptions to be used to cost a potential redress package. One briefing has been provided to you on this, with two further briefings to follow over the next few days.

7. There is a significant suite of justice related recommendations that don't directly involve Health, except Recommendation 30 which relates to the Victims' Rights Act as the Ministry has delegated responsibilities under this. The justice related recommendations will likely be led by the Ministry of Justice and the Ministry will provide support as required.

8. There are several recommendations related to records that will need to be considered from both a cross-government perspective, and a health system perspective, though the health sector specifically may be better placed than other sectors given obligations related to patient records, supported by regulations, the Health Information Privacy Code 2020, and other frameworks and accountability mechanisms in the health system.

Budget bid

9. As outlined to you in a recent aide-memoire (H2024057511), the Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Abuse in Care has been invited by the Minister of Finance to coordinate a package of survivor-focussed initiatives for Budget 2025.

10. The Ministry of Health, along with other care agencies, has been asked to contribute draft initiatives that could be included as part of the initial planning stages of the 'future proofing the care system' component of the budget bid.

11. The focus of this part of the Budget bid is on recommendations that cover 'Care safety and empowering communities' group of recommendations.

12. These recommendations are broad and wide reaching, meaning the Ministry and other agencies have not been able to do policy analysis on all of them in the time available. We have identified some potential initiatives that could address some of the recommendations, based on some known areas of weakness within care settings in health. Please see the table below for details of these initiatives.

Initiative	**Description**	**Recommendation the initiative aligns with**
Bolstering independent oversight of compulsory mental health care	This initiative would increase capacity and capability of independent statutory roles and bodies under the Mental Health (Compulsory Assessment and Treatment) Act 1992.	• Recommendation 39 • Recommendation 71 • Recommendation 86(b)
s 9(2)(f)(iv)	s 9(2)(f)(iv)	s 9(2)(f)(iv)

s 9(2)(f)(iv)	s 9(2)(f)(iv)	s 9(2)(f)(iv)
Safer environments through capital investment (tagged contingency)	This initiative would support an in-depth review and scoping of mental health inpatient facilities from the perspective of modernising safety features. The objective of this work would be to improve the environments of mental health inpatient units to ensure care settings are safer and more responsive. Note there is an associated initiative seeking operating funding below.	• Recommendation 74 • Recommendation 75
Safer environments through operational investment	Similarly to the capital investment initiative, this initiative would support an in-depth review and scoping of mental health inpatient facilities from the perspective of modernising safety features. The objective of this work would be to improve the environments of mental health inpatient units to ensure care settings are safer and more responsive. Note there is an associated initiative seeking capital funding above.	• Recommendation 74 • Recommendation 75

s 9(2)(f)(iv)	s 9(2)(f)(iv)	s 9(2)(f)(iv)
s 9(2)(f)(iv)	s 9(2)(f)(iv)	s 9(2)(f)(iv)

13. We are still refining these, including the potential costs and scaling options.

14. In addition to these, the Ministry is working with other agencies to develop proposals that would involve setting aside tagged contingency funding to address some of the recommendations where agencies know there will be costs, but where significant work will be required to develop advice and support Ministers to decide on what is required.

15. Setting aside funding for this work through the Budget would demonstrate the Government's commitment to improving the care system as part of its response, while recognising the need to take time to develop advice, consider options, and work with affected communities before making decisions. Tagged contingency funding could be drawn down by Ministers/Cabinet over the next 18 months as specific policy decisions on certain recommendations from the inquiry are made.

16. We are currently working with other agencies to determine which recommendations it might be appropriate to address in this way through the Budget process.

Next steps

17. The Ministry of Health provided the draft initiatives and costings to the Crown Response Unit on 4 December. Following this, a draft briefing will be prepared by the Crown Response Unit. Agencies are to provide feedback on the briefing, joint initiatives, and costings by 6 December. The final sign off by Deputy Chief Executives on the briefing and the package of initiatives will occur by 11 December.

18. The relevant Ministers, including you, will receive the draft briefing for the 'future proofing the care system' budget items on 12 December.

19. The placeholder initiatives should be submitted by 1pm on 23 December 2024 with final submissions being made to Treasury by 18 January 2025. We understand that the Crown Response Unit is asking for the final submission date to be extended a week so Ministers can meet in January to finalise the submissions.

20. The Ministry understands that there is a Ministerial meeting for the Crown Response to the Abuse in Care Inquiry on either 11 or 17 December, to be confirmed.

We recommend you:

a) **Note** you will receive a briefing regarding the 'future proofing the care system' budget items on 12 December 2024 **Yes/No**

b) **Note** that final submissions for the budget bid are required by 18 January, however, the Crown Response Unit is seeking an extension so Ministers can meet to finalise the submissions. **Yes/No**

Maree Roberts
Deputy Director-General
Strategy, Policy and Legislation
Date: 5 December 2024

Hon Dr Shane Reti
Minister of Health
Date:

Aide-Mémoire

Approach to Budget 2025 investment in making the care system safe

Date due to MO:	16 December 2024	**Date of Meeting:**	17 December 2024
Security level:	BUDGET SENSITIVE	**Reference:**	H2024058571
To:	Hon Dr Shane Reti, Minister of Health		
Copy to:	Hon Matt Doocey, Minister for Mental Health Hon Casey Costello, Associate Minister of Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
Emma Prestidge	Group Manager, Family and Community Health, Strategy Policy and Legislation	s 9(2)(a)
Maree Roberts	Deputy Director-General, System, Strategy and Policy	s 9(2)(a)

Aide-Mémoire

Approach to Budget 2025 investment in making the care system safe

Date due:	16 December 2024		
To:	Hon Dr Shane Reti, Minister for Mental Health		
Security level:	BUDGET SENSITIVE	**Reference:**	H2024058571

About the Meeting

Purpose of Meeting

This meeting is for the Crown Response Budget Ministers Group to discuss the approach to Budget 2025 investment to ensure the safety of people in the current care system in response to the Royal Commission of Inquiry's final report *Whanaketia*.

Details of Meeting

Date: 17 December 2024
Time: 5.45
Venue: TBC

Comment/ Summary:

Budget 2025 Care System Safety package

1. As you will know, the Crown Response Office is coordinating a Budget package to respond to the Royal Commission of Inquiry's (the Royal Commission's) recommendations focused on ensuring the safety of people in the current care system. Crown Response Agencies have developed a placeholder Budget 2025 Care System Safety package for submission to Treasury on 23 December 2024.
2. Crown Response Agencies, including the Ministry of Health and Health New Zealand, have identified s 9(2)(f) agency specific initiatives across six investment areas. This 'Care System Safety' package proposes a total investment of s 9(2)(f)(iv) across four years.
3. The s 9(2)(f) agency-specific initiatives have been scoped and can be progressed with limited or some further work. Work is still underway across agencies to finalise these specific initiatives.
4. In addition to the s 9(2)(f) agency-specific initiatives, there are two tagged contingencies to support cross-system initiatives for agencies to drawn down funding over several financial years. The contingency funds will allow for work to be scoped further and for advice to be provided to Ministers.

5. The Ministry of Health and Health New Zealand have proposed five Health-led initiatives and have worked with the Ministries of Education, Social Development and Justice and Oranga Tamariki on two tagged contingency initiatives. These initiatives are outlined in the section below.

6. Ministry of Health officials along with the other care agencies will continue to refine the potential initiatives before the final bid is submitted 23 January 2025.

7. Ministers have been asked to make decisions on the proposed Care System Safety package and approach at the Crown Response Budget Ministers meeting on 17 December. The Crown Response Office has provided discussion questions in *Appendix One of the briefing Placeholder submission – Crown Response to Abuse in Care Budget '25 package* which may be helpful when considering your priorities for his budget package.

8. You may also wish to consider whether your preference is to submit agency-specific Budget initiatives with funding tied to individual Votes or cross-agency tagged contingency initiatives to allow funding to be drawn-down over the course of the year for initiatives that are supported by Ministers and Cabinet. Contingency funding would enable further progress to be made on the recommendations over the next 12-18 months. The current Budget package proposes a mix of both agency-specific and contingency initiatives.

9. The Ministry notes that the health-specific initiatives are well developed, as they align with the extensive policy work on the new Mental Health Bill. The Bill has been identified as a core component of the Government's response. The proposed Health-specific initiatives provide the certainty of being backed by a confirmed policy direction, while directly supporting but not being reliant on or pre-empting final decisions about the Government's response. The initiatives represent new and strengthened activity above business as usual.

Ministry of Health initiatives included in the placeholder Care System Safety Budget 2025 package

10. *Improve the built environment of mental health inpatient units to ensure safer care settings for tāngata whaiora – operating* s 9(2)(f)(iv)

11. *Improve built environments of mental health inpatient units to ensure safer care settings for tāngata whaiora – capital (tagged contingency) $50m across four years*

a. These two initiatives would support an in-depth review and scoping of mental health inpatient units focusing on modernising safety features.

b. There are a number of inpatient units that are aging and require maintenance and safety upgrades that exceed what is possible within baseline funding. These facilities are not consistent with best practice standards. Improvements are needed to ensure inpatient rooms and environments have appropriate features to support the safety, privacy and dignity of patients. These initiatives would provide a prioritised assessment of safety upgrades required to bring units in line with modern best practice.

c. It is proposed to establish a tagged contingency for capital investment to support the implementation of immediate improvements and installation of modern safety features in units based on the review and scoping exercise.

12. s 9(2)(f)(iv)

13. *Bolstering independent oversight of compulsory mental health care – $9.36m (scalable initiative)*

a. This initiative will improve models of care and increase capability and capacity of independent statutory roles and

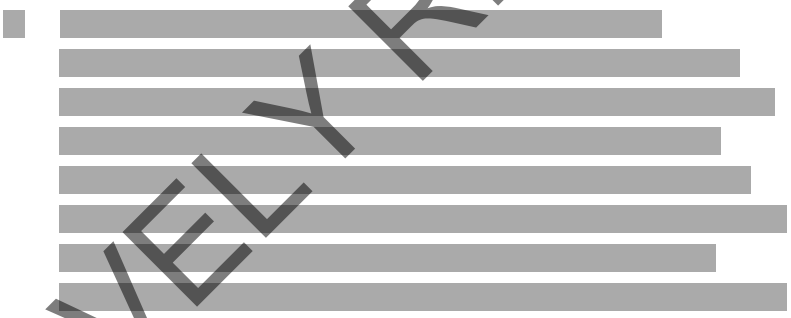
models under mental health, addiction and intellectual disability legislation.

b. The role of oversight bodies and effective complaints processes were highlighted by the Royal Commission. District inspectors and review tribunals are critical safeguards in compulsory care.

c. Funding rates for district inspectors has not been reviewed or adjusted in over 10 years, despite activity increasing and increasing expectations for safeguarding. Insufficient funding for these roles may also be contributing to issues of finding sufficient people and people with the right perspectives and expertise to fulfil these roles. If this is not addressed, this will result in gaps in key safeguards for people in compulsory care.

d. This investment is necessary to strengthen existing care oversight mechanisms but will also help future-proof the care systems.

14. s 9(2)(f)(iv)



There is further detail on these initiatives, the gap that they fill in the system and costing in one of the briefings provided to you for this meeting by the Crown Response Office: *Approach to Budget 2025 investment in making the care system safe, Appendix One: Summary table of B25 Care System Safety initiatives and costings [Report number: CRACI 24/103]*.

Next steps

15. If Ministers agree to the proposed approach to Budget 2025 investment and placeholder Budget 2025 package, this package will be submitted to Treasury by 23 December 2024.

16. Agencies will continue to refine and confirm approaches ahead of the final package being submitted by 1pm on 23 January 2025.

17. The Crown Response Office is planning to schedule another Ministers meeting prior to 23 January 2025 to provide an

opportunity to review and approve the final Budget package before submission.

Emma Prestidge

Group Manager, Family, Community and Primary Health Policy

Strategy, Policy and Legislation

Aide-Mémoire

Discussion on options for aged care initiatives for Budget 2025

Date due to MO:	13 December 2024	**Meeting:**	16 December
Security level:	BUDGET SENSITIVE	**Reference:**	<H number>
To:	Hon Casey Costello, Associate Minister of Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director General, Strategy Policy & Legislation	s 9(2)(a)
Emma Prestidge	Group Manager, Primary, Family and Community Health Policy	s 9(2)(a)

Aide-Mémoire

Discussion on options for aged care initiatives for Budget 2025

Date due:	13 December 2024		
To:	Hon Casey Costello, Associate Minister of Health		
Security level:	BUDGET SENSITIVE	**Reference:**	H2024058516

Meeting

Purpose of Meeting Meeting with officials to discuss and confirm package of aged care initiatives to put forward for Budget 2025.

Comment: This Aide-Mémoire provides information to support a discussion with officials on your preferred package of aged care initiatives for Budget 2025, along with next steps. It sets out the following four options that could be progressed individually or combined as a package of aged care initiatives:

a. Option one: Supporting the timely transfer of patients from acute hospital care to aged residential care

b. s 9(2)(f)(iv)

c. s 9(2)(f)(iv)

d. s 9(2)(f)(iv) .

Context

1. You have been invited to submit an aged care bid for Budget 2025. The focus of this bid will depend on what you are seeking to achieve from additional investment in this space. Minister Reti has indicated support for this bid and has indicated that he would like the bid to clearly quantify the savings to the health system and be clear on how much is needed.

2. We understand that you are interested in options to relieve pressure on the health system by releasing hospital beds currently being used by older people. This can be achieved by supporting timely discharge from hospital into aged residential care (ARC), s 9(2)(f)(iv)

3. Budget 2025 presents an opportunity for interim investment to support aged care and relieve wider health system pressures.

4. Each of the options presented in this paper, to a greater or lesser extent, support the following criteria:

   a. invest to save

   b. relieve pressure on the aged care system

   c. s 9(2)(f)(iv)

   d. relieve pressure in other parts of the health system, such as hospital and specialist services.

s 9(2)(f)(iv)

5. As the final steps of phase two of the Aged Care Funding and Service Models Review are yet to be completed, such as financial modelling and design, officials have identified options for initiatives as an interim measure that could complement potential future changes and address some known pressures on the system now.

6. As the Minister of Finance outlined at the bilateral meeting on 5 December, the fiscal context for Budget 2025 is very tight and new funding for Vote Health will be carefully considered in the wider context. s 9(2)(f)(iv)

7. s 9(2)(f)(iv)

Option one: Supporting the timely transfer of patients from acute hospital to aged residential care

Initiative description

8. This initiative would support the transfer of patients from acute hospital to ARC with a focus on complex discharges. The aim of this initiative is to reduce the pressure from delayed discharges from hospitals and help free up acute hospital beds.

9. The funding would be used to support aspects of care not covered by existing agreements that will facilitate timely discharge from hospital, prevent readmission and fund support for the person. The funding would be used to:

   a. support patients with exceptional needs that sit outside of existing agreements to enable their discharge, such as bariatric patients, including equipment needed for their transition to ARC

   b. provide additional support (one to one watch) for a new or returning resident with challenging behaviors during a settling down period in a new ARC facility

   c. enable ARC-based staff (healthcare assistants and/or registered nurses) to visit a complex patient in hospital prior to discharge and receive any necessary training and advice on the patient's care

d. enable hospital-based staff (healthcare assistants and/or registered nurses) to support transition into ARC if required

e. support discharge to the community via a short term stay in ARC for patients who are able to transition back into the community with support, including monitoring and follow up

f. support establishing an Enduring Power of Attorney (EPOA) or Protection of Personal and Property Rights (PPPR orders) in exceptional circumstances as appropriate

g. provide services and items that will address an unfunded barrier to discharge, such as an environmental clean of home deemed unsafe to enable Home and Community Support Services (HCSS) delivery.

Problem definition and rationale

10. Older people have high health needs and spend far longer in hospital than others. The average hospital bed days per 1,000 population was 440 days in 2023. For people over 65 years of age it was 529 bed days per 1,000 and for people over 85 years it was 3,831 bed days per 1,000 population. The pressure on hospital beds is set to increase with our ageing population.

11. Once hospitalised, many older people stay longer than clinically necessary and encounter delays in discharge from hospitals. Delayed discharges not only place pressures on hospitals and drive increased length of stay but also place pressure on the health system in general.

12. Some ARC do not have the capacity or capability to manage complex discharges or residents with high levels of need and this leads to people remaining in hospital even longer. For complex discharges, there is a need for support to enable safe and timely discharges. This includes comprehensive handovers and having staff go in and assess the resident and understand their needs prior to discharge.

Expected outcomes

13. Expected outcomes of providing additional discharge support include:

a. timely discharge of older people from hospitals and reduced inpatient length of stay

b. increased capacity of acute hospital beds and increased acute hospital flows

c. reduction in the clinical and social risks to older people associated with prolonged hospital admission and delayed discharge

d. more older people return to living in their community.

14. An evaluation could seek to understand the expected savings and benefits from freeing up acute hospital beds and provide evidence and data for more investment.

Costs

15. This builds on a previous initiative developed with the sector in 2023. Current funding ends in June 2025. It would cost approximately $6.0 million per year from 2025/26 to support timely transfer of patients from acute public hospital to ARC. This would be time limited funding for four years ending in 2028/29 and would be able to support learnings for future changes to aged care.

s 9(2)(f)(iv)

s 9(2)(f)(iv)

s 9(2)(f)(iv)

[redacted]

Next steps

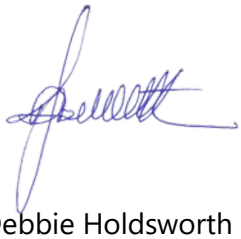
38. Following discussion and confirmation of your preferred initiative(s) to be put forward for Budget 2025, officials will:

    a. undertake any further detailed costing that is needed, including attempting to understand projected savings to the health system, and confirm yearly costs for the package (see **Appendix One** for current operating cost estimates)

b. provide Treasury with a high-level submission on Monday 23 December. This will feed into Treasury advice to the Minister of Finance with aggregate numbers and will include title, description, and figures (including a year-by-year funding profile)

c. provide Ministers draft final initiative templates on Monday 13 January and submit the draft final template to Treasury on Friday 17 January.

39. Officials will keep you updated on progress.



Emma Prestidge
Group Manager, Primary, Family and Community Health Policy
Strategy Policy & Legislation
Ministry of Health

Debbie Holdsworth
Co-Director of Funding for Community and Mental Health
Planning, Funding and Outcomes
Te Whatu Ora | Health New Zealand

Appendix One: Estimated operating costs

Initiative	2024/25 ($m)	2025/26 ($m)	2026/27 ($m)	2027/28 ($m)	2028/29 & outyears ($m)	Total over Budget 2025 forecast period ($m)
Option 1: Timely transfer of patients from acute hospital care to aged residential care	-	6.0	6.0	6.0	6.0[1]	**24.0**
s 9(2)(f)(iv)						

[1] The estimated costs for this initiative are time-limited and end in 2028/29

Briefing for decision

People in Mental Distress Presenting via 111: Transitioning to a Multi-Agency Response

Date due to MO:	16 December 2024	**Action required by:**	24 December 2024
Security level:	BUDGET SENSITIVE	**Reference:**	H2024058409
To:	Hon Matt Doocey, Minister for Mental Health Hon Mark Mitchell, Minister of Police		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☒		

Contact for telephone discussion

Name	Position	Telephone
Geoff Short	Deputy Director General, Clinical Community and Mental Health | Te Pou Whakakaha	s 9(2)(a)
Jeremy Wood	Executive Director, Policy and Partnership New Zealand Police	s 9(2)(a)

Minister's office to complete:

☐ Noted ☐ Seen

☐ Needs change ☐ Withdrawn

☐ See Minister's Notes ☐ Overtaken by events

Comment:

Briefing for decision

People in Mental Distress Presenting via 111: Transitioning to a Multi-Agency Response

Security level:	BUDGET SENSITIVE	**Date:**	19 December 2024
To:	Hon Matt Doocey, Minister for Mental Health Hon Mark Mitchell, Minister of Police		

Purpose of report

1. This paper provides information you may wish to share with a small set of interested Ministers to address the report back requirement from the May 2024 Cabinet paper [SOU-24-MIN-0039] about developing a Transition Plan for transitioning to a multi-agency response for people in mental distress presenting via 111.

2. Your agreement is sought to request a cancellation of the report back from the Chair of the Cabinet Social Outcomes Committee.

Background

3. The Minister for Mental Health and the Minister of Police took a paper to Cabinet on the Transition Plan in May 2024. The Cabinet minute had the following invitation:

> *invited the Minister of Police and the Minister for Mental Health to report back to SOU by November 2024 with more detail on years two to five of the Transition Plan including the investment required to implement a fit-for-purpose multi-agency response and any other interventions*.

4. Officials provided a draft Cabinet paper titled *Report back: People in Mental Distress Presenting via 111: Transitioning to a Multi-Agency Response* to Ministers in November 2024, which responded to the Cabinet invitation. It provided information about the data work that enabled agencies to design the proposed suite of responses to support the transition from a Police-led to a multi-agency response to people calling 111 in mental distress. It also noted that the Transition Plan cannot be implemented without investment through Budget 2025.

5. The Cabinet paper followed a series of sessions held with the Minister for Mental Health to explore options for a package of actions to support a redesigned crisis system. The proposed actions include improvements to prevention; better triaging; enhanced emergency responses; referral and follow-up options for callers with mental health needs and alternative mental health crisis recovery responses; and referral and follow-up options for callers with cross-sector needs.

6. The intention was for the November 2024 Cabinet paper to go to the Cabinet Social Outcomes Committee, but it was delayed several times for various reasons. It is largely a noting paper, providing an update on the Transition Plan activities. There has been advice that only necessary proposals should be considered by Cabinet Committees at

this point in the year, so we have proposed to circulate a briefing paper to interested Ministers and seek agreement from the Chair to cancel the report back.

7. The information invited by the Cabinet Committee for the report back is included in this briefing for forwarding to interested Ministers. As it contains Budget Sensitive information, it will need to be on limited circulation and will need to comply with the appropriate handling instructions.

8. We recommend you forward this briefing to:

   a. Hon Nicola Willis, Minister of Finance, Minister for Social Investment, Minister for the Public Service

   b. Hon Shane Reti, Minister of Health

   c. Hon Louise Upston, Minister of Social Development

   d. Hon Paul Goldsmith, Minister of Justice.

9. You may also wish to forward the briefing to Hon Karen Chhour (outside Cabinet) as Minister for Children and Minister for the Prevention of Family and Sexual Violence. Note that Hon Mark Mitchell, Minister of Corrections, is the joint lead Minister of this work in his role as Minister of Police.

Next steps

10. The Ministry of Health, working with Health New Zealand and New Zealand Police, is developing a bid for consideration through Budget 2025 in line with the package and initial costings outlined in the November 2024 Cabinet paper.

11. If you agree to circulate this briefing paper to a limited set of interested Ministers, your Office will need to make arrangements to provide copies in a manner that complies with the handling instructions for Budget Sensitive material.

Recommendations

We recommend you:	Minister of Police	Minister for Mental Health
a) **Note** that a Cabinet paper titled *Report back: People in Mental Distress Presenting via 111: Transitioning to a Multi-Agency Response* was drafted to fulfil the report back requirement from May 2024 [SOU-24-MIN-0039]	**Yes/No**	**Yes/No**
b) **Note** that since the Cabinet paper was drafted, the Minister of Finance has invited a bid for this work to be considered through the Budget 2025 process	**Yes/No**	**Yes/No**
c) **Note** that you have requested a version of the Cabinet paper to be repurposed for circulation to interested Ministers to close off the report back requirement – this is attached in an Appendix	**Yes/No**	**Yes/No**
d) **Agree** to requesting the Chair of the Cabinet Social Outcomes Committee cancel the report back	**Yes/No**	**Yes/No**
e) **Forward** this briefing to interested Ministers.	**Yes/No**	**Yes/No**

Geoff Short
Deputy Director-General
Clinical, Community and Mental Health | Te Pou Whakakaha
Date: 16 December 2024

Hon Matt Doocey
Minister for Mental Health
Date:

Jeremy Wood
Executive Director
New Zealand Police
Date: 16 December 2024

Hon Mark Mitchell
Minister of Police
Date:

Report back: People in Mental Distress Presenting via 111: Transitioning to a Multi-Agency Response

Proposal

1 This paper provides a report back on work to further develop the five-year plan to transition from a Police-led response to a multi-agency response to 111 calls for people in mental distress [SOU-24-MIN-0039].

Relation to Government priorities

2 The proposals in this paper contribute to the Government's priority of delivering better health outcomes, in particular improving mental health. The proposals also align with the Government Policy Statement on Health 2024–2027 and the Mental Health portfolio priorities, which include timely access to effective services, workforce development, and prevention and early intervention [SOU-24-MIN-0054].

3 The proposals in this paper align with the letter of expectations to the Commissioner of Police from the Minister of Police, which calls for a stronger Police focus on core policing.

Executive summary

4 Since May 2024 agencies have progressed a series of actions to improve the 111 system to enhance responses to mental distress and reduce calls that are not threats to life and/or property. These initial actions are on-going, have not required additional funding and are expected to make some improvements to crisis responses and free up Police time.

5 Officials from the Ministry of Health listened to 300 calls to 111 and 105 coded 1M and 1X (mental distress and suicide respectively) to better understand why people are calling Police.

6 The analysis showed that, Police responses are still needed for 60 - 65% of the calls made due to the risk to life and/or property. However, Police find that often upon attendance, the safety risk is lower than at the time of the call. This reflects the dynamic nature of emergency responses, and mental health. However more improvements can be made to mental health led responses to transition to a system that better responds to mental distress during crisis.

7 This paper reports on a proposed package of actions to support a redesigned crisis system, to transition from a Police-led to a multi-agency response to support people currently calling 111 in distress. The actions include: improvements to prevention; better triaging; enhanced emergency responses; referral and follow-up options for callers with mental health needs and alternative mental health crisis recovery responses; and referral and follow-up options for callers with cross-sector needs.

8 Many of these improvements can be achieved by bolstering elements of existing services, trialling or building new pathways where there are gaps or missed opportunities to provide support (both in the immediate response and shortly after the 111 call) and a focus on areas or cohorts for which the Government may prioritise efforts to make the biggest difference,

including a focus on prevention. Critical to achieving these changes will be considering proposals to expand telehealth; expand co-response teams; expand mental health crisis responses; and improve and grow multi-agency information sharing and community assessment teams.

9 s 9(2)(f)(iv) [redacted]

10 The expected costs to implement the proposed improvements to the crisis system and give effect to the transition plan supporting a multi-agency response to 111 calls are estimated to be s 9(2)(f)(iv) [redacted] Costs will also be incurred as a result of the Police operational changes. These will be quantified through the budget process.

Background

11 In May 2024, Cabinet agreed to a high-level five-year plan to transition from a Police-led response to a multi-agency response to 111 calls for people in mental distress [SOU-24-MIN-0039].

12 The purpose of this transition is two-fold: to ensure that people with mental health concerns and those in distress due to a broad range of social issues who are presenting via 111 receive the support they need; and to reduce calls to 111 that are not threats to life and/or property. Both of which free up Police resources to focus on core policing.

Initial improvements to crisis responses

13 Since May 2024, work has been undertaken, primarily by Police and Health to advance early actions agreed by Cabinet that could be progressed in the first year of this plan and without further investment. These actions included:

13.1 Improving the responsiveness of the Earlier Mental Health Response (EMHR) clinical telephone service

13.2 Promoting alternatives to calling 111

13.3 Police introducing new 111 triage responses and dispatch decision-making

13.4 Reducing Police time in emergency departments

13.5 Improving safety for people in emergency departments and hospital spaces (noting this work is broader than mental health and addiction)

13.6 Trialling peer support in some emergency departments

13.7 Exploring the feasibility of a fourth option (as an alternative to choosing Police, Fire or Ambulance) when people call 111.

14 A short report back on these items can be found at **Appendix One.**

15 The previous Cabinet paper also noted that data limitations about callers' needs constrained the ability to design a fit-for-purpose multi-agency response. Cabinet invited the Minister of Police and the Minister for Mental Health to report back with more detail on the transition plan, including financial implications, following further data work.

The current crisis response system is not meeting New Zealanders' needs

16 The level of mental distress experienced by New Zealanders is increasing and the demand for support is not being met by our existing supports. We have set targets to improve wait times to primary and specialist mental health services, however we will need to do more to improve crisis responses to mental distress.

17 The crisis response system (crisis system) for mental distress has two main avenues of access: Health New Zealand's 24/7 crisis assessment and response teams, which are focused on the most urgent mental health presentations; and responses provided via Emergency Services including calls to Police and Ambulance through the 111 line.

18 New Zealanders can struggle to get the right support through the crisis system when they experience distress. There is significant unplanned regional variation in crisis responses and there has not been meaningful investment in these services for a significant period of time. The lack of investment means the crisis system has not kept pace with population increases, and this coupled with the increasing complexity of cases and workforce shortages has resulted in crisis teams seeing reduced numbers of people, despite increasing numbers calling the Police in distress, and increasing psycho-social distress reported.

19 Budget 2019 saw significant investment into the mild to moderate part of the mental health and addiction continuum, particularly through the implementation of Access and Choice. Funding the crisis system to be more responsive to New Zealanders in acute distress, and ensure people are not phoning 111 unless it is a threat to life or property has become even more important as numbers of people presenting to Police through the 111 system and at emergency departments continues to climb.

What the data shows about the nature of 111 calls related to mental distress

20 More than 73,000 calls per year are received by Police the that are subsequently coded by them as relating to mental distress. These include 1X calls (suicide) and 1M calls (mental distress). Officials from the Ministry of Health listened to 300 calls to 111 and 105 coded 1M and 1X to better understand why people are calling Police. The table in **Appendix Two** sets out the nature of calls observed within the sample and the typical current response to each cohort.

21 It is important to note the limitations of this analysis – listening to a sample provides some insight into why people call in distress but does not present a full picture of underlying needs. The underlying drivers of distress become increasingly understood over time as engagement and trust increases. This is supported by evidence from cross-sector work in South Auckland, and elsewhere across the country. This review did not capture what was found on scene for those events Police attended, it was a review of the calls themselves.

22 Officials have drawn from the findings of this analysis, alongside other data sources, evaluations of response models, and related analysis, to get a better understanding of needs and inform the design of fit-for-purpose multi-agency response pathways. Of note is that:

22.1 A large portion of 1M and 1X calls involved the call taker determining a sufficient safety risk to dispatch a Police officer (up to an estimated 60–65% based on the sample of 300 calls). It is unknown what the safety risk was found to be when the officers attended. On attendance, Police often find the safety risk is lower than when assessed by the call taker. These calls were listened to before Police implemented their new triage model, which is intended to more effectively assess risk and reduce deployment to low risk situations

22.2 Within the call sample, around 18–28% of calls appeared to involve a mental health component without an apparent immediate safety issue. This cohort of people often does not receive a follow-up response following the initial discussion with the Police call taker and may have complex needs that require both health and social support. Many of these are likely to be repeat callers

22.3 Police data indicates that up to 40% of calls coded 1M and 1X are closed at the call centre with no further action taken

22.4 Based on the call sample, officials estimate that approximately 65-70% of calls coded by Police as 1M or 1X indicate a formal mental health assessment may be appropriate. This included all the calls that involved an urgent safety issue discussed in 22.1 above

22.5 Evaluation of co-response models found that of the calls that resulted in a Police/mental health co-response (where these exist), evaluations indicate that 75% of people who receive a co-response were currently or recently using mental health services

22.6 At least half also receive Ministry of Social Development income supports. It is likely that for some people, there is significant underlying psychosocial distress that requires more than a Police/mental health response

22.7 This observation is supported by other evidence, including from existing multi-agency family violence response models, where a high proportion of family violence calls to Police reflect underlying psychosocial stressors (such as housing insecurity), frequently not evident at the point of the initial call. These models include the cross-sector MDCATs in South Auckland and the Integrated Safety Responses (ISRs) multi-agency response models in Canterbury and Waikato.

23 This analysis highlights elements of existing services that could work better or differently; gaps or missed opportunities to provide support (both in the immediate response and shortly after the 111 call) where new referral pathways need to be trialled or built; and areas or cohorts for which government may prioritise efforts to make the biggest difference, including a focus on prevention.

Redesigning the crisis response system to better address mental distress

24 A redesigned crisis system is depicted at **Appendix Three**. It will do four things: improve telehealth responses, expand Police and mental health co-response teams (CRTs), improve and expand crisis responses and expand multi-disciplinary community assessment teams through the SAM tables.

25 **Appendix Four** sets out in detail activities across a range of response pathways that will be required to transition from a Police-led to a multi-agency response to support people currently calling 111 in distress. There are five main components:

25.1 *Prevention*: People need to receive appropriate support before they reach a point of calling 111, clear guidance needs to be provided to the public and health and social sectors about when to call 111 and other options available for support to help reduce demand. It is proposed that s 9(2)(f)(iv) is invested to broaden access to and increase responsiveness of telehealth.

25.2 *Triaging*: Police 111 call takers need to have a priority focus on assessing callers' emergencies efficiently and effectively with seamless and quick transfers to other options if further assessment or support is needed. No additional investment is sought.

25.3 *Emergency responses*: People who call 111 with safety issues, need to receive an appropriate response, including a mental health response for people with mental health needs. s 9(2)(f)(iv) Police will have faster handovers with the EMHR line, so that they can focus on the calls that are threats to life and/or property. s 9(2)(f)(iv)

25.4 s 9(2)(f)(iv)

25.5 s 9(2)(f)(iv)

Police operational changes

26 Concurrent to developing the transition plan, Police have initiated a phased operational change programme to increase thresholds for attendance and reduce time spent at some mental health-related events. It is intended that the full set of changes will be in place by September 2025, some of which accelerate the components of the transition plan.

27 The implications of these changes are distinct from this paper in that they relate primarily to requests for Police support by the health sector itself, rather than requests from the public via 111. For example, Police are frequently called to attend mental health assessments, or to support the transportation of mental health patients between different sites in the health system and asked to wait in Emergency Departments (or other locations) until a mental health assessment has been undertaken. The operational change programme seeks to limit Police involvement in these situations to where there is an identified risk to safety or some form of criminality.

28 s 9(2)(f)(iv)

29 Police is trialling a new risk assessment and triage model in its Emergency Call Centres. This model extends across all Police 111 calls not just those calling with signs of mental distress. This new model is intended to more accurately identify whether sufficient risk is present to require a physical police attendance. It is intended to enable the transfer of non-emergency calls to the 105 non-emergency system and to other agencies where possible. It is expected that this new triage response will reduce the proportion of 1M and 1X calls that receive a physical Police response.

s 9(2)(f)(iv)

d

s 9(2)(f)(iv)

Implementation and phasing

33 **Appendix Five** sets out the package of investment required to give effect to the suite of activities to transition from a Police-led to a multi-agency response.

34 There are choices in relation to the scale, mix of interventions, phasing and priorities within the proposed investment and transition package. Implementation considerations will also need to be worked through. For example:

34.1 Providing people in mental distress with the right response at the right time, and taking demand out of the 111 system, requires a range of interventions that have been developed to be mutually reinforcing. Choosing only some of the proposed interventions needs careful consideration to avoid unintended consequences

34.2 Because of the regional differences in existing responses, some interventions will need to be designed and tailored to local needs and the local service landscape, particularly in rural areas

34.3 While Police's operational changes are distinct from this work, there will be flow-on impacts on other areas of the crisis response system. If Police attend fewer mental health-related events, there will be a corresponding resource draw from health and social supports that will need to be factored into the investment and transition package

34.4 Additionally, the Police operational changes will have cost implications for Health s 9(2) security in emergency departments (particularly in smaller and rural hospitals where there will be a decreased Police attendance), s 9(2)(f)(iv) Crisis response and assessment teams are also experiencing increased impact.

34.5 As Health New Zealand transitions to a regional model, consideration is needed as to the national, regional and local components of the health system contribution to a multi-agency response.

35 Consideration of the financial implications, trade-offs and options within the context of wider Government priorities, the investment to support a multi-year transition will be in the Budget process.

36 Further work is needed to identify the best models of care, relevant staffing implications and the phasing of implementing any of the proposed components in **Appendix Five** (noting this will have planned regional variation based on existing service levels and models). This will be built into the work carried out as part of the Budget process.

Next steps

37 Officials are developing a bid for consideration through the Budget 2025 process.

Appendix 1: Table of progress towards Year One activities in the Transition Plan

Year 1 Activities	Progress
Improving the responsiveness of the Earlier Mental Health Response (EMHR) clinical telephone service	**Status:** In progress **Months to completion:** ongoing for quality improvement processes National Telehealth Services Review will have new contracts in place July 2026. This workstream was slowed earlier this year as Police requested time to develop their programme of change. Regular meetings resumed between Police, Whakarongorau and Health New Zealand in October with the next meeting scheduled for 8 November.
Promoting alternatives to calling 111	**Status:** In progress **Months to completion:** ongoing The Ministry of Health has reviewed its website and provided alternative options instead of suggesting people call 111 (unless it is a true emergency).
Police introducing new 111 triage responses and dispatch decision-making	s 9(2)(f)(iv) Police is trialling a new risk assessment and triage model in its Emergency Call Centres – the Risk Harm Attendance Framework. This framework extends across all Police 111 calls not just those calling with signs of mental distress. This new model is intended to more accurately identify whether sufficient risk is present to require a physical police attendance. It is intended to enable the transfer of non-emergency calls to the 105 non-emergency system and to other agencies where possible. It is expected that this new triage response will reduce the proportion of 1M and 1X calls that receive a physical police response. The trial commenced on 11 September 2024 with one section in Emergency Communications and one section in 105 (non-Emergency) to test and refine the tools. s 9(2)(f)(iv)
Reducing Police time in emergency departments	**Status:** In progress **Months to completion:** completion expected September 2025 Phase one of Police's operational change programme went live on 4 November 2024. This sees Police limiting their stay at EDs with patients who are waiting to undertake a mental health assessment voluntarily. Phase two will see Police remain in EDs for 60 minutes with patients awaiting assessment under the Mental Health Act. This will go live in March 2025 (date in March to be finalised). Phase three reduces the time Police wait in EDs from 60 minutes to 15 minutes. The date for this to go live is likely to be June 2025 but this has not been finalised. Planning between Health New Zealand and Police to implement these changes continues to progress well. Planning between Health New Zealand and Police to implement these changes continues to progress well.
Improving safety for people in emergency departments and hospital spaces (noting this work is broader than mental health and addiction)	**Status:** In progress **Months to completion:** the ED Security Improvement Programme will finish on 30 June 2028 Additional ED security guard FTE are now in place at North Shore, Waitakere, and Waikato, with recruitment ongoing in Auckland, Middlemore, and Wellington. We are supporting Christchurch to address a contract variation issue and Dunedin is set to begin recruitment. Interviews for eight Security Instructors and four Violence Reduction Specialists are complete and nine candidates have accepted employment offers. This recruitment will enhance capacity to train security staff and reduce workplace violence in high-priority EDs.
Trialling peer support in some emergency departments	**Status:** In progress **Months to completion:** peer support specialists implemented in the first 5 EDs by April 2025 and the remaining 3 EDS by June 2026 Peer support is being trialled at 8 EDs. The first 5 are: • Services commenced in Middlemore ED in September 2024. • Auckland City Hospital: Implementation planning underway. Aim to have Peer Support Specialists in ED 31 January 2025. • Waikato Hospital: Implementation planning underway with aim to have Peer Support Specialists in ED in March 2025. • Christchurch Hospital: Implementation planning underway with aim to have Peer Support Specialists in ED in March 2025. • Wellington Hospital: Implementation planning underway with aim to have Peer Support Specialists in ED in late March/early April 2025. • Project Managers have been appointed at all of the first 5 sites. • National working group established. • Work will commence with the Tranche 2 sites in early 2025 (funding for these 3 sites becomes available in July 2025).
Considering the feasibility of a fourth option (as an alternative to choosing Police, Fire or Ambulance) when people call 111	**Status:** Closed Some early, high-level scoping of setting up an option that physically responded to callers (as the Police, Ambulance and Fire options do) was found to be costly, requiring responders in all parts of the country, 24/7. There were significant trade-offs that required consideration, particularly in regard to the workforce as the staffing requirement cannot be made available without affecting other functions in the crisis system. Given the significant workforce shortages that crisis teams across the country face, staffing this response in addition to crisis teams was not considered possible in the near term without significantly reducing crisis response teams. s 9(2)(f)(iv)

Appendix 2: Data analysis findings

The table below sets out the nature of 1M and 1X calls observed in a sample of 300 and a description of the current responses. Calls were assessed against a rubric that considered eleven areas from who the primary caller was and whether they were alone, to what the call was about, whether suicide was discussed, whether they had attempted to call a crisis team first and the outcome and length of the call.

Note: there are limitations to the reliability of this exercise, given the small sample size of 300 calls (not unique individuals) out of a total of approximately 73,000 calls per year. The rubric was developed by clinicians and there was clinical oversight of the exercise.

Note: that unless a serious safety risk to self or others, people with mental health and/or addiction concerns can refuse services – they can't be forced into service use.

There are also limitations to information elicited during a brief 111 call. For example, similar analysis of a small sample of Family Violence-related calls in South Auckland showed that only a limited understanding of the true drivers of the call were obtained in the initial call. The breadth and contribution of psychosocial stressors became more evident than what was reported in the initial call over time.

These findings have been used to guide design thinking, but it is important to consider this information alongside other data sources, evaluations of response models, and related analysis. Further research into callers' circumstances would be required to get a fuller picture of needs.

Category	Description	Percentage of call sample	Current typical response
Calls involving safety issues that immediately relate to mental health issues	Calls by the person or family/ friends/public relating to imminent risk due to suicidal intent	25-35%	Police attend around 75% of calls that relate to imminent risk due to suicidal intent (if multi-agency response teams are in the region, and it is in the hours that they are functioning, they attend) Police may take the person to ED, in which case there may be health-led follow-up. If Police attend and do not go to ED, then follow-up is unlikely (or uncertain)
	Hospitals or other health settings (e.g. inpatient units, NGOs, other types of care) calling because of safety needs (i.e. risks of violence or damaging property)	10-20%	Police typically attend and contain the situation
Calls involving mental health components without apparent immediate safety issues	People calling with unusual claims. These appear to be most often delusional or paranoid in natur A smaller group of people calling in an elevated emotional state. These calls are most often verbally abusive to the call taker, with no clear event to report, just speaking and then hanging up	18-28%	Police call taker may offer to transfer to EMHR, however sometimes this is refused. If no EMHR transfer, the call taker typically ends the call with no follow-up. These calls seem to correlate with longer calls and repeat callers
Calls requesting support with Mental Health Act provisions	Duly Authorised Officers calling Police for assistance under Section 41 of the Mental Health (Compulsory Assessment and Treatment) Act 1992	<5%	Police call taker takes call and Police typically attend
Calls involving distress without safety concerns or a clear mental health component	People calling in distress, reporting financial or housing issues or homelessness	<5%	Police call taker generally ends call with no follow-up, typically these calls take time to find a resolution at point of call
Calls involving immediate safety concerns without a clear mental health component	Calls related to people who appear to be disoriented, lost, or confused that presents as vulnerability (e.g. people who are wandering) Parents calling for Police help to contain a family member (often) who is presenting with behavioural disturbance (i.e. may be destroying the house and/or violent. May have mental health issues, often have concurrent disabilities)	5-10%	Police typically attend, generally with no follow-up. Coding for these are mental health, but need to consider how to code for a medical response (e.g. Hato St John may be involved in a solution for this group, as acute confusional state is a medical issue). Sometimes parents report having called the mental health crisis team and have been told to call the Police or not received a response

Note: 15% of calls were categorised as 'other' and approximately 3–4% of the calls were miscoded
The analysis also found:

- 3 out of 4 calls ended within 10 minutes. Police ECC resource modelling has an average talk time of 5 minutes 30 seconds (plus 1 minute 30 seconds clerical time) which averages 7 minutes per call.
- Some calls were miscoded as relating to mental health, including family violence calls, suspicious behaviour and intoxicated persons (an estimated 3–4%).
- Police have stated that the 1M code can be something of a catch all when calls do not neatly fit into other codes.
- There will also be calls which have a mental health component or may benefit from mental health support which are not coded as 1M or 1X.
- Many callers in the sample were currently or recently involved with mental health services.
    - At least one in five calls related to people who stated they were currently using a specialist mental health service or were by a Duly Authorised Officer seeking assessment under the Mental Health (Compulsory Assessment and Treatment Act) 1992.
    - One in 10 callers mentioned they had tried to call a mental health crisis team first and either not had a response or were told to call 111. Advice to call 111 would likely reflect a threat to life or property that is appropriate for the Police to attend.
- At least one in seven calls in the sample of 300 were from frequent callers. This data is supported by evidence from Whakarongorau (who delivers the National Telehealth Service) which has found that across all of their mental health lines of 104,000 calls from 58,000 unique users, 57 people created 8% of all calls.

Appendix 3: The crisis system s 9(2)(f)(iv) required for implementation

Prevention

Ensure people receive appropriate support before they reach a point of calling 111 and provide clear guidance to the public and health and social sectors about when to call 111 and other options available for support to help reduce demand

Current state.
EMHR is used by Police and Ambulance for calls that require clinical expertise and are not an emergency. There is often a wait time for Police to hand callers over.

1737 clinical line operates 24/7, the peer support line has limited hours.

Work to be done: shorten wait times and handovers and improve integration with Police and other services.

What will be there in 5 years?

Telehealth

- EMHR: Improved wait times, hand overs and integration with Police and other services
- Public facing lines: improved wait times, extended hours where required

Other activities

- Work with Police and Whakarongorau to identify repeat callers and develop plans to prevent calls for non-Police matters
- Undertake a campaign which tells provides people with telehealth numbers
- Update website advice to provide telehealth and other support first for mental distress (not Police)

s 9(2)(f)(iv)

Emergency Response

For people who call 111 with safety issues, we want to ensure they receive an appropriate response, including a mental health response for people with mental health needs

Current state.
There are six co-response teams across the country. All have Police and mental health staff, and some have other roles, such as cultural support workers.

Work to be done: implement across the country, extend hours where teams only work business hours.

What will be there in 5 years?

Co-Response Teams

- Implement CRTs in every district (currently 6 districts in place) with hours in line with crisis teams. Provide sustainable funding for all agencies. This will require appropriate models to be developed for each district, with particular considerations for rural areas

s 9(2)(f)(iv)

Referral + follow Up for callers with mental health needs & alternative crisis recovery responses

Bolster the capacity of community-based mental health supports and telehealth services to provide alternative options and follow-up support

Provide alternative community-based support options for people experiencing a mental health and addiction-related crisis

Current state.
Significant regional variation for Crisis Response and Assessment Teams and the availability of acute alternatives.

Work to be done: develop nationally consistent telephone triage, expand responses depending on local need and models of care.

What will be there in 5 years?

Crisis Response & Assessment Teams

- Specialist mental health services in each region provide direct availability to specialist crisis teams, as well as crisis lines for after-hours triage, with variation of models and availability by region, and evidence of increasing demand.

What will be there in 5 years?

Acute Residential Alternatives

- Implement in districts where these don't currently exist.

Crisis Cafes

- Currently six districts funded, roll out to further 12 for nationwide coverage

s 9(2)(f)(iv)

Referral + follow Up for callers with cross sector needs

Establish clear referral pathways to social supports and build on existing multi-agency information sharing mechanisms and response approaches to support people with multiple and complex needs

Current state.
There are 40 SAM tables across the country and MDCATs in place in Auckland and Tairāwhiti. These do not currently have a mental health component.

Work to be done: following social sector work to determine best use of tables and how to strengthen and leverage these, work with agencies to determine when and how mental health cases will be looked at.

What will be there in 5 years?

SAM Tables
(Safety Assessment Meeting)

- Expand to areas that currently don't have, with Ministry of Health and Health New Zealand input

What will be there in 5 years?

Multi-Disciplinary Community Assessment Team

- Roll out nationally, with mental health and addiction service provision at the tables.

s 9(2)(f)(iv)

Appendix 4: Range of response pathways and response components for the crisis continuum

Crisis response pathways	Response components	Description	Actions: Maintain/Bolster/Build	Fiscal implications
Prevention We want to ensure people receive appropriate support before they reach a point of calling 111 and provide clear guidance to the public and health and social sectors about when to call 111 and other options available for support to help reduce demand	Clear communications to health and social sector workforces and organisations about when to call Police	Currently, public advice from Health New Zealand (HNZ) and relevant service providers recommends calling the Police in distress. This advice would be changed to advise the public of options before 111, and to only call 111 in a threat to life or safety.	**Build** • Advice updated on HNZ's website that does not refer people to the Police • Advice shared with health and social sector workforces and organisations about when to call Police and steps to undertake before they call Police	Baseline – no funding required
	s 9(2)(f)(iv)			
	Enhanced support and planning for repeat callers to reduce engagement via 111	Evidence shows up to 10% of callers are frequent callers	**Bolster** • Work with Police and Whakarongorau to identify repeat callers and develop plans so they stop calling for non-Police matters	Baseline – no investment required
Triaging of calls We want to ensure Police 111 call takers have a priority focus on assessing callers' emergencies efficiently and effectively with seamless and quick transfers to other options if further assessment or support is needed	Efficient and effective coding within Police call centres	Up to 5% of calls coded 1M were miscoded. Work with Police to ensure call takers understand what codes to use as 1M is a broad category	**Build** • Provide training for Police call takers • Provide training for Police call takers on what 1M is for and how coding can be improved	Baseline – no investment required
	Enhanced call triage processes	Police are undertaking a pilot using a risk, harm and attendance framework to better understand the nature of the code and whether to dispatch staff to a call. s 9(2)(f)(iv)	s 9(2)(f)(iv)	Baseline – no investment required
Emergency response For people who call 111 with safety issues, we want to ensure they receive an appropriate response, including a mental health response for people with mental health needs	Police/Ambulance response for 111 callers with a threat to life or safety	Calls to 111 that go to Police, Ambulance or Fire. Note: Police is the default option if the caller hasn't selected an option or if they tell the Spark operator they are having mental health issues.		
	Co-response teams (CRTs) for 111 callers with a threat to life or safety relating to mental health (composition of teams to be further developed typically include Police and Mental Health clinicians,+/- ambulance, support worker, Iwi and others)	Six districts have piloted CRTs (Mental health and Police +/- ambulance /support workers). These teams provide mental health clinical input and advice to first responders as well as attending callouts as needed. Evaluations of CRTs across pilot sites demonstrate positive feedback from stakeholders, a better experience for service users and better connections with mental health services. Learnings from evaluations and subsequent initiatives suggest expanding these teams to include other agencies based on local need	**Bolster** • Implement CRTs s 9(2)(f)(iv) This will require appropriate models to be developed for each district, with particular considerations for rural areas	Investment required, see Appendix 5
	Earlier Mental Health Response (EMHR) line	The EMHR line is a part of the National Telehealth Service provided by Whakarongorau and provides for direct referral for mental health clinical assessment from 111 call takers (Police and Ambulance) Telehealth services are currently being reviewed (see below)	**Bolster** • Explore options to reduce EMHR wait times for transferred calls and improve integration with other services and agencies including Police	Investment may be required, see Appendix 5
s 9(2)(f)(iv)				
				s 9(2)(f)(iv)

Crisis response pathways	Response components	Description	Actions: Maintain/Bolster/Build	Fiscal implications
			s 9 (	
	s 9(2)(f)(iv)			

Note: As part of planning, consideration was given to the feasibility of a fourth option when people call 111 [SOU-24-MIN-0039]. It was assessed that this would require significant upfront and ongoing investment and cross-government coordination beyond multi-agency model partners. It would also likely exacerbate workforce constraints in responding agencies and providers. Therefore, the investment proposed here is giving effect to the fourth option through existing system infrastructure.

Further work is warranted to explore support pathways for the needs of specific groups that may result in distress that contributes to 111 demand, such as needs related to disability or cognitive impairment.

Appendix 5: Investment required to implement a redesigned crisis system

Component	Description	Investment requirements	Approximate cost s 9(2)(f)(iv)
Telehealth	**Earlier Mental Health Line (EMHR):** The EMHR line is a part of the National Telehealth Service (NTS) provided by Whakarongorau and provides for a warm handover to a mental health clinician from 111 call takers (Police and Ambulance). This service is part of a review underway led by Health New Zealand which is likely to provide opportunities to further develop and reconfigure EMHR in the future **Mental health, gambling and AOD lines:** A range of telehealth lines to support people who phone independently. Lines can provide clinical or peer support to callers	Additional Resource to boost the capacity of EMHR (or its equivalent) to enable higher volume of calls without compromising call wait times Additional funding to boost broader MHA lines e.g. 1737 (including peer support), and AOD and Gambling helplines to ensure sufficient capacity to respond to calls in a timely manner	Health – medium s 9(2)(f)(iv)
Co-Response Teams (CRTs)	CRTs for 111 callers with a threat to life or safety relating to mental health (composition of teams to be further developed typically include Police and Mental Health clinicians,+/- ambulance, support worker, Iwi and others)	Expand CRTs s 9(2)(f)(iv)	
s 9(2)(f)(iv)			
s 9(2)(f)(iv)			
s 9(2)(f)(iv)			
		s 9(2)(f)(iv)	
POLICE OPERATIONAL CHANGES COSTS:			
s 9(2)(f)(iv)			
Security	As a result of the Police operational changes, there will be an impact on smaller and rural hospitals requiring increased security. These costs are being worked through and will included in the budget process/.	Ensure all hospitals are safe and able to manage security concerns.	To be finalised

s 9(2)(f)(iv)

Briefing for decision

Approach to Budget 2025 investment in making the care system safe

Date due to MO:	13 January 2025	**Action required by:**	14 January 2025
Security level:	BUDGET SENSITIVE	**Reference:**	H2025059112
To:	Hon Matt Doocey, Minister for Mental Health		
Copy to:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☐		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
Geoff Short	Deputy Director-General, Clinical, Community and Mental Health	s 9(2)(a)
Steve Barnes	Acting Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)

Minister's office to complete:

☐ Noted	☐ Seen
☐ Needs change	☐ Withdrawn
☐ See Minister's Notes	☐ Overtaken by events

Comment:

Briefing for decision

Approach to Budget 2025 investment in making the care system safe

Security level:	BUDGET SENSITIVE	**Date:**	13 January 2025
To:	Hon Matt Doocey, Minister for Mental Health		
Copy to:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This briefing provides you with an overview of the Vote Health initiatives within the Crown Response Budget 2025 Care System Safety package and seeks your agreement to submit the initiatives to the Crown Response Office for inclusion in the final package.
2. It also includes information on key meetings and decision points for approving the Budget 2025 Care System Safety package alongside other Crown Response Ministers.
3. While the decisions sought in this briefing fall within your Mental Health portfolio responsibilities, this briefing is copied to the Minister of Health as the Minister responsible for Vote Health.

Summary

4. The Crown Response Office is coordinating a Budget 2025 package to respond to the recommendations in the Royal Commission of Inquiry's (the Royal Commission's) final report, *Whanaketia*, that are focused on ensuring the safety of people in the current care system. A placeholder Care System Safety package was submitted to the Treasury on 23 December 2024 totalling s 9(2)(f)(iv) over four years. This included the following s 9(2)(f)(iv) mental health initiatives, totalling s 9(2)(f)(iv) over four years:
   a. Safer mental health and addiction environments (operating and capital)
   b. s 9(2)(f)(iv)
   c. Bolstering independent oversight of compulsory mental health care
   d. s 9(2)(f)(iv)
5. In advance of officials finalising the Care System Safety package for submission to the Treasury by 23 January 2025, we are seeking your confirmation of the mental health initiatives to be included. This briefing attaches detailed information about the proposed mental health initiatives and notes considerations to support your decision. Since the placeholder package was submitted, we have refined the costings which decreased the level of funding sought through the s 9(2)(f)(iv) mental health initiatives to s 9(2)(f)(iv) over four years.
6. You are meeting with Ministry of Health (Ministry) officials on 14 January 2025 to discuss your priorities and preferred approach to Budget 2025 mental health initiatives, including those proposed for the Care System Safety package. Following this meeting, Ministry officials will confirm with the Crown Response Office the mental health initiatives to include in the final Care System Safety package.

7. The Crown Response Office is planning to provide the draft Budget package to Ministers on 15 January 2025. There will be a joint Ministers meeting on 21 January 2025 to review and approve the final Budget package before submission.

8. This briefing complements separate advice you are receiving today on the Vote Health Budget 2025 Submission Package (H2024058891).

Recommendations

We recommend you:

a) **Note** that the Minister of Finance invited the Lead Coordination Minister for the Crown Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions to coordinate the development of a package of Royal Commission initiatives for Budget 2025 investment;

b) **Note** that a placeholder Budget 2025 Care System Safety package was submitted to the Treasury on 23 December 2024 totalling s 9(2)(f)(iv) over four years which included s 9(2)(f)(iv) mental health initiatives costed at s 9(2)(f)(iv) over four years;

c) **EITHER**

Agree that the mental health initiative templates at **Appendix A** totalling s 9(2)(f)(iv) over four years be provided to the Crown Response Office for inclusion in the final Care System Safety package; **Yes/No**

OR

Direct the Ministry to withdraw and/or make adjustments to initiative templates and confirm with your office before submission; **Yes/No**

d) **Note** the proposed Care System Safety package also seeks tagged contingencies for two cross-system initiatives for agencies to draw down funding over several financial years, including funding for Vote Health;

e) **Agree** to confirm with the Minister of Health, as the Minister responsible for Vote Health, his comfort with the submission of the mental health initiatives as agreed via recommendation C above; **Yes/No**

f) **Note** that pending recommendation C, the Ministry will provide the attached templates to the Crown Response Office for it to be incorporated into combined Budget bid templates for consideration by joint Ministers at a meeting on **21 January 2025**;

g) **Note** that the final Care System Safety package is due to submission to the Treasury on **23 January 2024**.

Steve Barnes
Acting Deputy Director-General
System, Strategy and Legislation
Date: 13/01/2025

Hon Matt Doocey
Minister for Mental Health
Date:

Approach to Budget 2025 investment in making the care system safe

Background

9. The Crown Response Office is coordinating a Budget 2025 package to respond to the recommendations in the Royal Commission's final report, *Whanaketia*, that focus on ensuring the safety of people in the current care system. The conditions for initiatives to be included in the package are that they must:

   a. demonstrably contribute to the goal of improving the safety of people in care

   b. align with and respond to the Royal Commission's vision, findings, and/or recommendations

   c. not be something that could (or should) be done as 'business as usual'

   d. not be able to be funded through baseline reprioritisation.

10. Ministers considered a draft cross-agency Care System Safety package in December 2024 with initiatives totalling s 9(2)(f)(iv) over four years [*Placeholder Submission - Crown Response to Abuse in Care Budget '25 Package CRACI 24/204* from the Crown Response Office refers]. The Minister of Finance requested that the level of funding for the 'Care System Safety' package be reduced prior to submission. Following the Minister of Finance's request and Ministers' discussions, several initiatives were withdrawn from the draft package, which took the total investment of s 9(2)(f)(iv) across four years to s 9(2)(f)(iv) across four years.

11. The draft package considered by Ministers in December 2024 included s 9(2)(f)(iv) Vote Health mental health-focused initiatives totalling s 9(2)(f)(iv). Following Ministers' discussions, your office confirmed your preference to maintain all s 9(2)(f)(iv) mental health initiatives with no further scaling to the initiatives in the draft package.

Placeholder Care System Safety package

12. The Crown Response Office submitted a placeholder Budget 2025 Care System Safety package to the Treasury on 23 December 2024 which sought a total investment of s 9(2)(f)(iv) over four years. Included in this package were s 9(2)(f)(iv) mental health initiatives seeking s 9(2)(f)(iv) over four years (including a $50 million contingency for capital investment). Since the submission of the placeholder package, we have refined the costings of the mental health initiatives and this has brought the funding sought down to s 9(2)(f)(iv) over four years. The refined totals are reflected in the table below.

13. The placeholder package focusses on initiatives across six investment areas:

Investment area	Initiatives
Investment Area 1: Empowering families, whānau and communities to prevent entry into care	Refer to paragraph 14 for information on cross-agency tagged contingencies related to this investment area.

Investment area	Initiatives
Investment Area 2: Preventing, recognising and responding to abuse in care	a) **Vote Health** s 9(2)(f)(iv) **and $50.00 million (capital) tagged contingency: Review and improve mental health inpatient units to ensure care settings are safe and responsive to people's needs** b) s 9(2)(f)(iv) c) Vote Social Development ($6.00 million across four years): Audits d) Vote Social Development ($2.80 million across four years): Improving ou critical incident and complaints system e) Vote Oranga Tamariki ($7.15 million across four years): Reducing abuse and harm to children and young people cared for by individual caregivers f) Vote Oranga Tamariki ($13.25 million across four years): Reducing abuse and harm to children and young people in the community and remand homes
Investment Area 3: Building a diverse, capable and safe care workforce	**a)** s 9(2)(f)(iv) b) s 9(2)(f)(iv) Refer also to paragraph 14 for information on cross-agency tagged contingencies related to this investment area.
Investment Area 4: Monitoring the provision of care by providers and individuals	**a) Vote Health** s 9(2)(f)(iv) **over four years): Bolster safeguards and oversight of compulsory mental health and addiction care by expanding independent statutory roles and enhancing capability through improved models of care**
Investment Area 5: Supporting people in care to have their voices heard and through advocacy	**a)** s 9(2)(f)(iv) b) s 9(2)(f)(iv)
Investment Area 6: Recordkeeping to connect people in care to their families, whakapapa and whenua	a) Vote Social Development ($0.50 million over four years): Provider records b) s 9(2)(f)(iv) c) s 9(2)(f)(iv) d) s 9(2)(f)(iv)

14. In addition, under Investment Area 1 and 3, there are two cross-agency initiatives for contingent funding to support a cross-system response to Whanaketia for agencies to draw down funding over several financial years. This will allow for work to be scoped further

alongside confirmation of the Government's response to the Royal Commission recommendations and for definitive policy decisions to be made by Cabinet. The two initiatives are for the following tagged contingencies:

a. $25.00 million across four years: *Early Intervention*

b. $75.00 million across four years: *Workforce training* (note: this includes a $73.00 million contingency for multiple votes including Vote Health and a $2.000 million contingency specific to Vote Justice).

Confirming mental health initiatives for inclusion in the final Care System Safety package

15. There are s 9(2)(f)(iv) mental health initiatives proposed for inclusion the Care System Safety Budget package as outlined above. The s 9(2)(f)(iv) initiatives total to s 9(2)(f)(iv) across four years (including a $50 million contingency for capital investment).

16. **Appendix A** contains s 9(2)(f)(iv) draft Budget templates for the mental health initiatives including detailed costings and scaling options. The information in these templates is intended to be used by the Crown Response Office to prepare consolidated cross-agency Budget templates that combine all agency initiatives under each of the six investment areas of the Budget 2025 Care System Safety package.

17. We are seeking your confirmation of the mental health initiatives for inclusion in the final Care System Safety package. Key considerations to inform your decision include the following:

a. The mental health initiatives are well-developed in the context of the wider policy work on the Government's Royal Commission response. The initiatives are informed by the extensive policy work on the new Mental Health Bill, which has been confirmed as a core component of the Government's response to the Royal Commission's recommendations.

b. The proposed initiatives reflect the changes necessary to address statutory expectations of existing services and facilities that are experiencing increased demand and to increasingly comply with relevant human rights obligations. Taken collectively they are expected to reduce adverse events for patients in compulsory care, such as self harm and suspected suicides.

c. While there is existing investment and effort across the focus areas of the proposed initiatives (eg, s 9(2)(f)(iv) , independent oversight, and mental health infrastructure), the initiatives represent new and strengthened activity above business as usual that cannot be absorbed within already stretched baselines. In the case of the proposed capital investment, the initiative would enable immediate and short-term safety upgrades to mental health facilities, as opposed to the medium- to long-term nature of current mental health infrastructure projects.

d. Mental health facilities are a key care setting and are a strong focus within *Whanaketia*. This is reflected in the balance of the proposed Care System Safety package, with a strong focus on mental health initiatives.

e. Any new investment will have an impact on your mental health targets, including the expectation to increase investment in prevention and early intervention within the mental health and addiction ringfence. Capital funding is not captured within the ringfence, so the proposed capital investment in mental health facilities will not impact the target. The operating initiatives are expected to have minimal impact on the

investment target, but will indirectly contribute to your faster access targets, for example through s 9(2)(f)(iv) .

18. While the Lead Coordination Minister, Minister Stanford, has been invited to coordinate the development of the of Royal Commission initiatives for Budget 2025 package, the coordination role does not supersede individual agencies' and Ministers' accountabilities. The Minister of Finance's expectation is that relevant Ministers will remain responsible for approving financial or policy decisions relation to their own portfolios.

19. We understand that the fiscal environment of Budget 2025 is very tight and new funding for Vote Health will be carefully considered in the wider context. You are meeting with Ministry officials on 14 January 2025 to discuss Budget 2025 mental health initiatives, including the s 9(2)(f)(iv) proposed for inclusion in the Care System Safety package, where we can discuss and confirm your priorities and preferred approach.

Next steps

20. The Crown Response Office is planning to provide the draft Budget package to Ministers on 15 January 2025. There will be a Ministers meeting on 21 January 2025 (to provide an opportunity to review and approve the final Budget package before its final submission to the Treasury on 23 January 2025.

21. Ministry officials, along with the other care agencies, will continue to work with the Crown Response Office to refine the proposed Budget package and incorporate your feedback prior to its final submission.

ENDS.

Briefing for decision

Implementation of increased access to cancer treatments and other medicines – proposed drawdown from tagged operating contingency

Date due to MO:	18 March 2025	**Action required by:**	31 March 2025
Security level:	IN CONFIDENCE	**Reference:**	H2025059160
To:	Hon Simeon Brown, Minister of Health Hon Nicola Willis, Minister of Finance		
Consulted:	Health New Zealand: ☒	Cancer Control Agency: ☒	Treasury: ☒
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☒		
Author:	Geethma Weliwatta, Policy Analyst, Strategy, Policy and Legislation		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General Strategy, Policy and Legislation	s 9(2)(a)
Allison Bennett	Group Manager Health Systems Settings	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Overtaken by events
☐ Needs change	☐ Seen	
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Briefing for decision

Implementation of increased access to cancer treatments and other medicines – proposed drawdown from tagged operating contingency

Security level:	IN CONFIDENCE	**Date:**	18 March 2025
To:	Hon Simeon Brown, Minister of Health Hon Nicola Willis, Minister of Finance		

Purpose of report

1. This report seeks joint Ministers' (Minister of Health and Minister of Finance) agreement to draw down on the tagged contingency for Health New Zealand's implementation costs associated with delivering new medicines funded as part of increasing access to cancer treatments and other medicines.

Summary

2. In June 2024, the Government announced an increase in funding for Pharmac to deliver on the election commitment to fund new cancer medicines. It is estimated that 92,240 patients will access the medicines funded within the first year.
3. Alongside this funding, the Government also announced an additional $210 million for Te Whatu Ora | Heath New Zealand (Health NZ) to deliver the medicines funded and to change the delivery model for cancer treatment to a community-based model.
4. Of the $210 million, $38 million was appropriated to cover costs in 2024/25 with the remaining $172 million placed into a contingency. Health NZ is currently forecasting $24.194 million underspend against the $38 million made available for 2024/25 due to a more gradual demand for the new medicines than modelled. This remainder is recommended to be returned to the Crown.
5. Health NZ is expecting a significant increase in activity in the 2025/26 period as more patients access the new medicines funded and is seeking to drawdown the contingency in full for 2025/26.
6. Health NZ is building capacity and capability to deliver the newly funded cancer medicines and move to a community-based model of care, closer to where people live. To achieve this, Health NZ needs to increase infusion capacity, address workforce shortages, provide for the increase in community pharmacy dispensing, update electronic prescribing services and increase molecular pathology testing.
7. Whilst Health NZ has developed plans for 2025/26 to deliver the new medicines, it is still establishing the detailed regional plans to bring care closer to the patient and building the permanent workforce. Therefore, the Ministry of Health (the Ministry) recommends that the contingency is drawn down for 2025/26 period only ($52 million). The remainder of the contingency for 2026/27 and outyears would then be drawn down prior to Budget 2026, when Health NZ has the detailed regional plans in place and provide regular monitoring on the progress of delivering services.

8. During 2025/26, the Ministry will monitor the delivery, implementation and expenditure against the new cancer medicines and provide regular reporting to the Minister of Health for assurance.

Recommendations

We recommend you:		Health	Finance
a)	**note** that on 24 June 2024, Cabinet:	**Noted**	**Noted**

agreed to fund additional medicines and increase health service capacity to deliver the additional treatments;

agreed to establish a tagged operating contingency titled "Implementation of Increased Access to Cancer Treatments and Other Medicines" of 172 million, as per the table below;

	$millions – increase/ (decrease)				
	2024/25	**2025/26**	**2026/27**	**2027/28 & outyears**	**Operating total**
Tagged operating contingency - Implementation of Increased Access to Cancer Treatments and Other Medicines	-	52.000	60.000	60.000	172.000
Total	**-**	**52.000**	**60.000**	**60.000**	**172.000**

authorised the Minister of Finance and the Minister of Health (Joint Ministers) to jointly draw down funding from the above tagged contingency, subject to the report back from Health New Zealand on the entity's delivery of this policy and implementation planning and costing for 2025/26 onwards [CAB-24-MIN-0226 refers];

b)	**note** due to slower release of medicines than modelled, Health NZ have not spent all of the 2024/25 allocation to deliver new medicines;	**Noted**	**Noted**
c)	**agree** the underspend of $24.194 million from funding allocated to Health NZ in 2024/25 for the delivery of medicines be returned to the Crown;	**Yes/No**	**Yes/No**
d)	**agree** that the $24.194 million will be managed against the Budget 2025 operating allowance;		**Yes/No**
e)	**agree** to seek Cabinet agreement to the financial recommendation to give effect to your decision in recommendation d) as part of the Budget 2025 Cabinet paper;		**Yes/No**

f)	**note** the increased access to infusion cancer treatments allows the move to a more community delivered based model, which benefits both the patient and the system;	**Noted**	**Noted**
g)	**note** if the contingency in recommendation a) is reprioritised, Health NZ will have costs associated with the delivery of the new medicines that will need to be met within its baselines;	**Noted**	**Noted**
h)	**note** that Health NZ is expecting significantly more demand for the medicines fund in 2025/26 and the Ministry supports the detailed costing forecasted/modelled for 2025/26 onwards;	**Noted**	**Noted**
i)	**note** that Health NZ is still developing the regional implementation planning for 2025/26 onwards to understand detailed resourcing requirements;	**Noted**	**Noted**
j)	**note** the Ministry recommends the drawdown of $52 million allocated in the contingency for 2025/26 only with the drawdown in outyears contingent on the funding for 2025/26 being spent and implementation of increased capacity being delivered to the plan outlined in this paper;	**Noted**	**Noted**
k)	**agree** to drawdown the $52 million allocated in the contingency for 2025/26 only to increase health service capacity to support the increased availability of cancer medicines and other pharmaceuticals;	**Yes/No**	**Yes/No**
l)	**approve** the following changes to appropriation to give effect to the decision in recommendation k) above, with a corresponding impact on the operating balance and net core Crown debt;	**Yes/No**	**Yes/No**

Vote Health	**$m – increase/(decrease)**				
Minister of Health	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29 & outyears**
Non-departmental Other Expense: Delivering Hospital and Specialist Services	-	52.000	**-**	**-**	**-**
Total Operating	**-**	**52.000**	-	-	-

m)	**agree** that the proposed change to appropriation for 2025/26 above be included in the 2024/25 Estimates;	**Yes/No**	**Yes/No**
n)	**agree** that the expenses charged in recommendation l) above be charged against the tagged operating contingency - Implementation of Increased Access to Cancer Treatments and Other Medicines described in recommendation a) above;	**Yes/No**	**Yes/No**
o)	**note** that, following the adjustment detailed in recommendation m) above, the remaining balances and indicative phasing of the tagged operating contingency in recommendation a) above will be:	**Noted**	**Noted**

	$millions – increase/ (decrease)				
	2024/25	**2025/26**	**2026/27**	**2027/28**	**2028/29 & outyears**
Tagged operating contingency - Implementation of Increased Access to Cancer Treatments and Other Medicines	-	-	60.000	60.000	60.000
Total	**-**	**-**	**60.000**	**60.000**	**60.000**

p) **Agree** to extend the expiry date of the tagged contingency described in recommendation a) above to 1 February 2027 so decisions on the utilisation of the remaining contingency can be taken prior to the end of the 2025/26 fiscal year. **Yes/No** **Yes/No**

Maree Roberts
Deputy Director-General
Strategy, Policy and Legislation
Date: 19 March 2025

Hon Simeon Brown
Minister of Health
Date:

Hon Nicola Willis
Minister of Finance
Date:

Implementation of increased access to cancer treatments and other medicines – proposed drawdown from tagged operating contingency

Background

9. In June 2024, Cabinet approved a $604 million out-of-cycle funding increase over four years to Pharmac's Combined Pharmaceutical Budget to achieve the Government's commitment of increased access to more cancer treatments. Pharmac stated this would fund approximately 26 cancer and 28 non-cancer treatments.

10. Pharmac and Te Whatu Ora | Health New Zealand (Health NZ) also received funding for implementation costs, recognising the cost of delivering a large number of medicines would be unable to be absorbed within baselines. This funding over four years included $210 million for Health NZ to provide the necessary expansion of oncology and other supporting health services, and establish a new community centred model of delivery.

11. Of the $210 million to fund Health NZ's implementation costs, initial funding of $38 million was appropriated to cover costs in 2024/25 with the remainder of $172 million placed into contingency.

12. The initial costing for 2024/25 was based on rapid estimates, with the expectation that more detailed costing for the delivery of medicines and an implementation plan to move to a community-based care model would be completed before contingency funding would be drawn down for costs in 2025/26 and onwards. Table 1 below outlines the costing breakdown over the four years.

Table 1. Funding agreed by cabinet for the new medicines over the four years

Funding ($million)	2024/25	2025/26	2026/27	2027/28 & outyears	Operating total
Combined Pharmaceutical Budget	108.000	146.000	175.000	175.000	**604.000**
Pharmac operating	2.000	3.000	3.000	3.000	**11.000**
Health NZ Hospital Services	38.000	*52.000**	*60.000**	*60.000**	**210.000**
Total ($m)	**148.000**	**201.000**	**238.000**	**238.000**	**825.000**

**Funding currently held in the contingency and is proposed to be drawn down.*

Delivery and implementation progress to date – 2024/2025

Availability of new medicines

13. As of 11 March 2025, Pharmac has funded 22 cancer medicines and 22 non-cancer medicines from the additional budget allocation and 10,464 people have benefited from new medicines.

14. Pharmac is currently considering another 7 cancer medicines and 6 non-cancer medicines and consulting on one non-cancer medicine. The final medicines to be funded through this initiative will become publicly available by August 2025.

15. It is estimated that 92,240 patients will access the medicines funded within the first year.

Implementation: tranche by tranche approach to the delivery of initial medicines

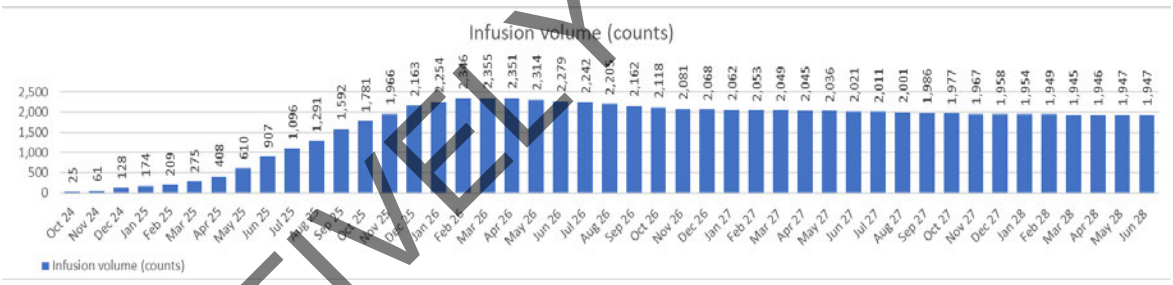
16. Health NZ carried out rapid modelling of the activity and resource implications associated with the initial tranches of cancer medicines funded in October and November 2024. Funding was quickly allocated to regions to cover costs of additional staffing, imaging and molecular pathology requirements for implementation of the cancer medicines, as well as the community pharmacy costs for non-cancer medicines during 2024/25.

17. Health NZ hospital services funding enabled workforce recruitment and imaging capacity to be increased through a mix of approaches that involve both internal employment and outsourcing. Additional national workforce recruitments including clinical oncologists, pharmacists, administration and infusion staff have been added to the list of 'national areas of need' to enable immediate recruitment.

Return of $24.194 underspend to the Crown

18. Initial forecasts outlined in the June 2024 Cabinet paper were based on high level assumptions about the nature of each medicine and the timing of their release. Due to demand from patients for the new medicines occurring more gradually than Health NZ had modelled initially, the implementation funding was spent more slowly than Health NZ had anticipated. Updated projected infusion volume is outlined in the figure below, showing that delivery will significantly increase from July 2025.

Figure 1: Nationwide projected additional infusion volume (counts) from Oct 24 - Jun 28[1]



19. In 2024/25, $13.806 million of the $38.000 million of Health NZ implementation fund has been allocated for the delivery of medicines and for national commissioning of workforce recruitment and upgrade e-prescribing services. If you agree, Health NZ will return the $24.194 million underspend from the 2024/25 to the Crown.

20. The Deputy Commissioner – Finance at Health NZ has confirmed that this extra funding has not been accounted for in the reset savings plans, and that their monthly reporting at the end of February 2025 has not recognised the receipt of this funding, which would allow it to be returned with no impact upon their reported results year-to-date.

21. However, in the forecast produced in February, Health NZ have assumed that they will be allowed to keep this revenue. This means that the forecast $1.175 billion deficit may be under pressure due to not receiving this revenue, even though there will be no costs incurred against it.

[1] The demand profile outlined in Figure 1 is expected as people already living with the disease enter the system and then levels out as many of newly funded cancer medicines are administered over a 12-month period.

The requirements for delivery and implementation - 2025/26

22. Health NZ has worked with the Cancer Control Agency to develop a comprehensive activity and resource forecast model to give a view of resource impacts of funded medicines at a national, regional and district level, which includes:

    a. a **25% increase in ongoing infusion capacity** is required to deliver the new medicines, regardless of the setting. This includes trained health professionals, infusion chairs, diagnostics and patient coordination, monitoring and support;

    b. increased **community pharmacy dispensing** costs.

23. These increases to permanent capacity and capability within Health NZ services will be gradual over the 2025/26 period. However, delivery of medicines to patients will take place regardless by utilising transitional arrangements such as outsourcing, use of temporary workforces, extra-duties allowances and reducing non-clinical hours for key workforces.

24. Transitional arrangements are unsuitable long-term, as they rely on re-prioritisation of workforces and use of outsourced, often more expensive, services.

Table 2: Milestones to increase Health NZ capacity for ongoing delivery of new medicines to patients

June 2025	An increase of 907 (10.3%) infusions during June 2025 compared with 2023/24 average monthly volume.
	New capacity developed in local delivery units in two regions Development of new sites beginning in Northern and Te Manawa Taki.
October 2025	An increase of 1,781 (20.2%) infusions during October 2025 compared with 2023/24 average monthly volume.
	Three new local delivery sites within Northern and Te Manawa Taki in place and providing new and existing medicines.
December 2025	An increase of 2,163 (25.6%) infusions during December 2025 compared with 2023/24 average monthly volume.
	Previously established sites will be stabilising.
February 2026	An increase of 2,346 (26.6%) infusions during February 2026 compared with 2023/24 average monthly volume.
	Six further units will be established and delivering care (new and existing medicines) throughout New Zealand with a focus on community or primary care providers.

Increased infusion capacity

25. Many of the newly available medicines, which have the benefits for patients of fewer side-effects and greater efficacy, require infusion treatments.

26. Infusions require clinical capacity and capability to be delivered safely for the patients. They require specialty diagnostics, prescribing systems and trained health professionals including oncologists, clinical pharmacists, oncology trained nurses and skilled community support.

27. In community settings, with specialist oversight, infusions are also more affordable, require lower levels of capital investment and use a multidisciplinary community and rural workforce, supported by the specialist cancer workforce in specialist regional centres.

28. Health NZ has started increasing infusion capacity, with new services available for patients from June 2025, with major increases occurring in:

    a. **October 2025** with a 20% increase in infusions and three new delivery sites in rural hospitals;

    b. **February 2026** up to a 27% increase in infusions and another six new community delivery sites.

29. The proportion of chemotherapy services delivered outside of New Zealand's six major cancer centres will shift from 40% to 50% by the end of 2026/27. Table 3 below shows volume across the regions.

Table 3: infusion delivery milestones by region and year

	Actuals/ Forecast 2024/25	Forecast 2025/26	Modelled 2026/27	Modelled 2027/28
Northern	928	7,891	8,340	7,825
Te Manawa Taki	498	4,231	4,471	4,195
Central	628	5,344	5,648	5,300
Te Waipounamu	743	6,322	6,682	6,269
Total	2,797	23,788	25,141	23,589
Increase on baseline (2023/24) values	2.6%	22.4%	23.7%	22.2%
Target: Proportion delivered at a non-major cancer centre	40%	45%	50%	50%

Workforce recruitment

30. To deliver the new cancer medicines and support the increase in infusion capacity, an additional 115 FTE is required by 2026/27 including clinical oncology practitioners (33.1 FTE by 2026/27), pharmacy, administration and infusion staff. This is the main cost for the delivery of new medicines.

31. To recruit, Health NZ:

    a. has in place a nationally coordinated international recruitment campaign

    b. has streamlined pathways for recruitment of these critical workforces.

32. As at mid-March, 11 medical oncologists have responded to the recruitment campaign and are engaging with Health NZ. One has been appointed, two have completed formal interviews and supervision requirements are being explored. The remainder are going through screening and interview processes. Twenty-five pharmacists have also responded.

33. Recruiting the workforce required is the biggest risk to implementation. Moving to community models where delivery is less reliant on highly-specialised workforce mitigates some of this risk. However, it cannot remove the risk entirely, especially as another 33.1 FTE clinical oncology practitioners are required by 2026/27.

34. As required, challenges in recruiting new people will be resolved through a range of operational approaches including seeking additional duties from existing employees and outsourcing. In many scenarios these approaches, including outsourcing for imaging and paying overtime, are more costly than the ideal approaches.

35. In addition, the Cancer Control Agency is developing a national advanced nurse education and training pathway for registered nurses to progress from novice to advanced oncology nurse roles.

Increase in community pharmacy dispensing

36. The current modelled community dispensing fees for 2025/26 and outyears s 9(2)(j) , noting that approximately half of the medicines funded by this initiative are non-cancer medicines.

37. Estimates of the impact on health system capacity have been developed from summary information provided by Pharmac. For many of these medicines the impact is net zero (i.e. a transfer of one type of activity for another) or marginal. s 9(2)(j) in community pharmacy dispensing activity which is funded through Health NZ's contracts with community pharmacies.

Funding required to deliver the new medicines

38. Health NZ has outlined the actual/forecasted and modelled costing for 2024/25 onwards in Table 4 below. Health NZ has forecasted an additional $8.160 million in 2025/26 which will be covered by Health NZ baseline funding.

Table 4: Total funding summary from 2024/25 to 2027/28

Funding ($ millions)	Actuals/ Forecast 2024/25	Forecast 2025/26	Modelled 2026/27	Modelled 2027/28
Funding available				
Appropriation in 2024/25 and held in contingency form 2025/26	**38.000**	**52.000**	**60.000**	**60.000**
Nationally Commissioned	**0.486**	**0.583**	**0.216**	**0.216**
International workforce recruitment campaign	s 9(2)(j)			
Electronic prescribing – Operational Expenditure				
Direct Service delivery funding	**13.320**	**59.578**	**58.976**	**56.044**
Community pharmacy dispensing fees of self-administered medicines	s 9(2)(j)			
Regional clinical leadership and operational management of cancer services	s 9(2)(j)			
Regional infusion and cancer workforce stand-up including training	s 9(2)(j)			
Molecular Pathology for Patients	s 9(2)(j)			
Clinical Service delivery expenditure *(eg imaging, FSA, infusion, direct consumables, treatment of adverse events)*	s 9(2)(j)			

Coordination services to ensure patients access and complete treatment	s 9(2)(j)			
Community services setup costs for training and minor equipment	s 9(2)(j)			
Total allocated	**13.806**	**60.160**	**59.192**	**56.260**
Currently unallocated	**24.194**	**-8.160**	**0.808**	**3.740**

39. The Ministry supports the costing details outlined above and recommends the drawdown of the contingency based on these costings.

Moving to a community-based model for delivery and implementation

40. The funding to implement the new medicines also provides an opportunity to move to a community-based model of care. Community-based models of care are the most effective way to achieve increased cancer service capacity that is clinically and financially sustainable.

41. Delivery of services in community settings, with specialist oversight, is more affordable, requires lower levels of capital investment and uses multidisciplinary community and rural workforces, supported by the specialist cancer workforce in specialist regional centres. This also relieves capacity pressure in hospital day stay units which will improve patient wait times and service delivery efficiency.

42. Commencing and completing infusion treatments in community settings enables patients to maintain employment, be close to their loved ones and reduce the burden and stress of transport and other costs on them and their families.

43. Current provision of systemic anti-cancer therapy largely relies on patients and whānau coming into hospital settings to receive treatment every few weeks for up to six months. The geographic distribution of current systemic anti-cancer therapy (SACT) services in main centres means that many patients experience barriers to access treatment and can come at considerable personal and financial cost to patients. Some regions are also experiencing severe limitations in the physical infrastructure and capacity.

44. Health NZ's four regions[2] have been asked to collaborate with key stakeholders to produce service development plans outlining the service changes and/or innovations for each of their regions to move to a community-based model.

45. There are two key system changes required for the successful implementation of nationally consistent SACT services. These include implementing electronic prescribing at all SACT sites and progressing a national approach to molecular testing capacity.

46. Appendix one attached includes further details of Health NZ's work to move to a community-based model for delivery and implementation of the new medicines.

47. While Health NZ regions developed the plans for each region to move to a community-based model, the Ministry recommends drawdown of the contingency for 2025/26 only.

Financial implications

48. This paper request joint ministers to agree to drawdown on the contingency referred to as "Implementation of Increased Access to Cancer Treatments and Other Medicines".

[2] **Health NZ four regions – Northern, Te Manawa Taki, Central and Te Waipounamu.**

49. The joint Ministers could agree to drawdown the funding for 2025/26 only, and re-assess outyears prior to Budget 2026. This option creates uncertainty for Health NZ but provides Ministers a further level of assurance allowing more time for Health NZ to develop detailed regional planning.

50. Alternatively, joint Ministers could agree to draw down the contingency in full of $172.000 million from 2025/26 onwards to support Health NZ implementation.

51. If the contingency is unable to be drawn down for implementing the cancer treatments, Health NZ will be required to either absorb the funding to their baseline funding, leading to an increased deficit, or reappropriate funding from other areas sacrificing delivery of other care.

52. Health NZ will cover the forecasted additional $8.160 million required to deliver the new cancer treatments in 2025/26 from its baseline funding.

53. Any capital expenses, for example, capital support for e-prescribing and molecular pathology will be funded from Health NZ baselines.

The Ministry position

54. The Ministry recommends the drawdown of $52.000 million allocated in the contingency for 2025/26 only. This allows Health NZ to deliver the new medicines and move towards a community-based delivery model as outlined in the advice above. However, we note there is still delivery risks in particular relating to establishment of regional plans and managing workforce requirements. The Treasury supports this position.

55. During 2025/26, the Ministry will monitor the delivery, implementation and expenditure against the new cancer medicines and provide regular reporting to the Minister of Health for assurance. The Ministry will support drawdown of the remainder of the contingency for 2026/27 and outyears once Health NZ has delivered detailed regional plans and has confirmed delivery of services as forecast.

56. The Ministry supports the movement of Health NZ cancer delivery into a more community-based service. The rationale is clear through the SACT report by the Cancer Control Agency, which has been supported by clinical experts and patients themselves.

Reporting and monitoring

57. Health NZ has set up comprehensive monitoring programme for the delivery of services which will take effect from 1 July 2025. Health NZ will provide regular reporting on:

    a. number of new medicines delivered against expected volumes estimated by Pharmac,

    b. movement of care into the community,

    c. improved equity of access to cancer care for those groups that are demonstrated to experience inequitable access including rural people, and those people less likely to enter and complete cancer treatment.

58. The reporting will be completed monthly for the Executive Oversight Group which includes the Health NZ Board, Cancer Control Agency and the Ministry.

59. The Ministry will ensure this reporting is included in regular monitoring updates to the Minister of Health.

Equity

60. Increasing availability and access to cancer treatment is a priority for this Government. Cancer has a disproportionate impact on Māori, Pacific peoples and other priority populations resulting in avoidable inequities. Investments in increasing in capacity and allowing key system changes within Health NZ cancer services ensure that greater number of New Zealanders with cancer are able to access newly funded cancer treatments.

61. Ensuring access to cancer treatments closer to where people live is critical for reducing disparities in health outcomes for New Zealanders. When, where and how access is provided to new treatment options is critical to achieving value for money from new investments in the health sector. Providing care closer to where people live ensures that geography, time and travel costs are not a barrier in access to cancer services.

Next steps

62. If you jointly agree to drawdown the tagged contingency for 2025/26, the Ministry will provide regular reporting to the Minister of Health on the progress of the implementation against the metrics of the monitoring programme outlined above.

ENDS.

Appendix one: Further details on the move to a community-based model for delivery and implementation

Systemic anti-cancer therapy (SACT)

- In 2023/2024, the Cancer Control Agency undertook a review of the current service provision of SACT. This work included extensive engagement with patients and those working in the sector to understand what was working well and what could be improved, as well as looking at how New Zealand compared to international best practice.
- SACT refers to medicines that are used in the treatment of cancer, and includes chemotherapy, immunotherapy, targeted therapies, and hormone therapy.
- The current model of care for SACT delivery largely relies on patients and whānau coming into hospital settings to receive treatment. This may be every few weeks for up to six months.
- The geographic distribution of current SACT services in main centres means that many patients experience barriers to access treatment and can come at considerable personal and financial cost to patients. For example, a clinic established in Whanganui in 2023, has prevented patients from needing to travel to Palmerston North Hospital for care (a 2 hour, 150km round-trip).
- Some regions are also experiencing severe limitations in the physical infrastructure and capacity, challenging their ability to deliver more treatment to patients and to deliver care in a patient-centred way.

Plans to deliver SACT in the regions

- Health NZ has worked with the Cancer Control Agency to develop the National Service Delivery Model Guide and Blueprint checklist from the SACT model. Utilising these documents, Health NZ's four regions have been asked to collaborate with key stakeholders to produce service development plans outlining the service changes and/or innovations for each of their regions. These plans will be finalised and in place for 2025/26, but implementation will begin during 2024/25.
- To support community delivery, Regional Cancer Clinical Leads will work together, alongside the National Clinical Network co-leads to provide national oversight and enable consistency in the implementation of the new medicines. The Cancer National Clinical Network is now established and will lead work to improve health outcomes and reduce variations in access to cancer care that many people and whānau experience.

Key enablers to delivering more SACT in the community

Electronic prescribing

- Electronic prescribing (e-prescribing) is critical to the successful implementation of nationally consistent SACT services that are provided closer to where people live. It will not be possible to deliver community-based infusions safely and effectively without this technology in place nation-wide.
- Implementation of e-prescribing at all SACT sites will enable SACT services to prescribe and administer treatment with increased accuracy, safety, and visibility. It enables real time access to prescribing data, improved patient safety, standardisation of documentation,

remote access for off-site clinicians, and accurate collection of data for service planning and funding.

- Currently Te Manawa Taki, Nelson-Marlborough and Canterbury regions are either without e-prescribing or have inconsistent coverage to support oncology services. National implementation planning is in progress for system support to ensure access to electronic prescribing in these regions is brought into line with the rest of the country.
- All planned SACT sites will have e-prescribing by the end of 2025/26.

Progressing a national approach to molecular testing capacity

- Safely and effectively delivering SACT requires very specific molecular (biomarker) tests to be performed. Many of these tests are not currently publicly funded nationally.
- If molecular testing requirements are not met:
    - some patients will be unable to be prescribed treatment, as biomarker information is a special authority requirement;
    - there is a risk that inequities will be increased, as only those who can afford to pay for testing will be able to access medicines;
    - patients may be prescribed a medicine that is less effective for their cancer. If testing is not available, the medicine may be given to all patients with a specific cancer in the hope that some will benefit, which would come at considerable cost and patient exposure to unnecessary harm/side effects.
- Implementing a multi-gene panel using next-generation sequencing is now cost effective in many cancer types. Moving from the current methods of sequential single-gene testing for these cancer types is likely to save money. The current approach to molecular testing in New Zealand is largely based around single-gene testing.
- Internationally, utilising multi-gene panels is now standard of care in most countries, which is when a patient's cancer tissue is tested for multiple genes at one time. Multi-gene panels use next-generation sequencing (NGS) and are more complex to run and interpret. They require specialist laboratory equipment and while they are more expensive than a single gene test, they offer better value for money than requesting multiple single-gene tests.
- Given the range of targeted therapies available for different cancers, the 'equation' of when it becomes cost-effective to shift from single gene testing to a broad panel varies by cancer type. Having both options readily available allows laboratories providing this testing to make decisions including cost effectiveness of the various testing strategies.
- Health NZ is commissioning the testing required for the new medicines from existing laboratories, both Health NZ owned and outsourced, delivering best value for money. Laboratories in New Zealand are working towards developing capability in NGS testing. One provider has limited NGS testing in place and is developing a proposal to increase its capability and capacity, another is working towards putting NGS technology in place late in 2025 and a third is currently considering its future approach.

Briefing for decision

Health and Disability Commissioner funding and operational proposals

Date due to MO:	4 April 2025	**Action required by:**	7 April 2025
Security level:	BUDGET SENSITIVE	**Reference:**	H2025062289
To:	Hon Simeon Brown, Minister of Health		
Consulted:	Health New Zealand: ☐		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☐		

Contact for telephone discussion

Name	Position	Telephone
Simon Medcalf	Deputy Director-General, Regulation and Monitoring | Te Pou Whakamaru	s 9(2)(a)
John Hazeldine	Group Manager, Health System Monitoring, Regulation and Monitoring | Te Pou Whakamaru	s 9(2)(a)
Kevin Davies	Deputy Chief Financial Officer, Finance and Performance, Corporate Services | Te Pou Tiaki	s 9(2)(a)

Minister's office to complete:

☐ Noted	☐ Seen
☐ Needs change	☐ Withdrawn
☐ See Minister's Notes	☐ Overtaken by events

Comment:

Briefing for decision

Health and Disability Commissioner funding and operational proposals

Security level:	BUDGET SENSITIVE	**Date:**	4 April 2025
To:	Hon Simeon Brown, Minister of Health		

Purpose of report

1. This report advises you on the Health and Disability Commissioner's (HDC) proposals for changes to live within its funding from 2025/26 and provides a proposal for you to consider some additional funding to HDC.

Summary

2. In 2021/22, HDC received a funding increase of $2.9 million per year for three years, bringing its total Crown funding to $17.6 million. This time-limited funding was due to expire in June 2024 but was extended by a further 12 months by Ministers s 9(2)(g)(i) This funding will now expire on 30 June 2025, leading to a decrease of 16.5% of its current baseline.

3. HDC is planning for a reduced baseline s 9(2)(g)(i) .

4. HDC is additionally working to make efficiency improvements to the complaints resolution process by purchasing new customer relations management (CRM) software. The Ministry of Health (Ministry) is supportive of this initiative and has agreed to reprioritise funding of $500,000 in 2024/25 only for HDC for this purpose out of forecast Ministry underspends. We expect that this investment will lead to improvement in the timeliness of complaints in the future.

5. The Minister of Finance recently wrote to you requesting that you address the shortfall of funding in HDC in 2025/26 ("address the HDC funding cliff") by reprioritising Ministry baseline funding.

6. HDC has prepared three budget scenario options, which lay out what could be achieved through the provision of different levels of additional funding. Each of these options seeks to protect the advocacy service, support the roll out of the new CRM software, and tackle the backlog of complaints.

7. The Ministry recommends additional funding for HDC of $1.00 million in 2025/26 only, funded from the Ministry's baseline. This option balances the protection of HDC's core statutory functions with affordability to the Ministry. It will support the HDC to smooth the transition to a sustainable baseline over a two-year period, avoiding a funding cliff, and reduce its forecast deficit in 2025/26.

8. s 9(2)(g)(i)

s 9(2)(g)(i)

9. More broadly, there are further options that could be progressed over the coming year.

10. s 9(2)(f)(iv)

11. s 9(2)(f)(iv)

Recommendations

We recommend you:

a) **note** that time limited funding of $2.9 million provided to the HDC is coming to an end in the 2024/25 financial year

b) **note** that HDC is planning to live within its means in 2025/26, s 9(2)(g)(i)

c) **agree** to reprioritise funding of $1.0 million from Ministry of Health baselines in 2025/26 only **Yes/No**

OR

indicate if you wish to reprioritise a different amount of funding

d) s 9(2)(f)(iv) **Yes/No**

e) s 9(2)(f)(iv) **Yes/No**

Audrey Sonerson
Director-General of Health
Date: 4 April 2025

Hon Simeon Brown
Minister of Health
Date:

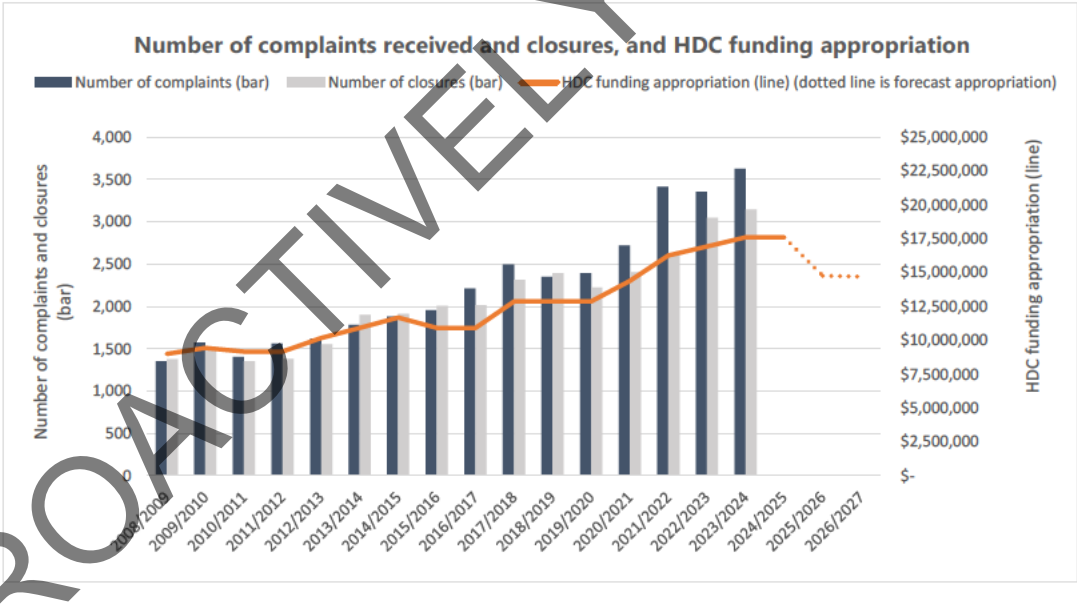
Health and Disability Commissioner funding and operational proposals

Background

1. The Health and Disability Commissioner is an independent Crown entity whose purpose is to promote and protect the rights of consumers of health and disability services. HDC's statutory requirements and functions are set out in **Appendix 1.**

2. From 2021/22, HDC received a funding increase of $2.9 million per year for three years, bringing its total Crown funding to $17.6 million. This increase was to support rising complaint volumes following the onset of the COVID-19 pandemic and to support the implementation of the End of Life Choice Act 2019. This funding enabled HDC to hire 21 new staff and enhance education, advocacy, and consumer rights initiatives. The $2.9 million funding was time-limited and intended to expire at the end of 2023/24.

3. Complaint volumes have continued to increase, as shown in Figure 1 below, and are currently 52% above pre-COVID-19 levels. This has created additional pressures for HDC and led to an increased backlog in open complaints. Ahead of Budget 2024, HDC requested a cost pressure increase, but this was not progressed.



4. s 9(2)(g)(i)

5. In August 2024, the Minister of Finance and the then Minister of Health jointly agreed to a one-off funding increase to HDC core functions of $2.9 million for 2024/25 only to mitigate the immediate risk to their functions and allow time for planning for a reduced

baseline. This additional funding came from the 'Delivering Hospital and Specialist Services' appropriation with the transfer occurring at the October 2024 Baseline Update.

6. HDC has achieved cost savings through the 2024/25 financial year by holding vacant positions, reducing external legal support for proceedings, and overall discretionary spending reductions. These savings have allowed the HDC to progress the development of a new complaints management system from their baseline while forecasting a 2024/25 year-end surplus of $0.170 million (H2025059494 refers).

7. With the expiry of this funding and no bid being progressed at Budget 2025, from 1 July 2025 HDC's budget will decrease to $14.7 million, or by 16.5 per cent. HDC has shared a plan incorporating proposals for re-structuring its expenditure with reduced revenue.

HDC's plan for living within budget

HDC proposes a two-year path to financial break-even

8. HDC has indicated that it will need to implement a phased strategy to manage the funding reduction, to mitigate the risk to its complaints resolution function. HDC's Quarter 2 reporting showed a two-year path to break-even, with a forecast deficit of $2.3 million in 2025/26 as initial steps are taken to manage the reduction, s 9(2)(f)(iv)

HDC forecast	24/25	25/26	26/27	27/28
Profit & Loss				
Total revenue	20,043,302	17,121,500	s 9(2)(f)(iv)	
Personnel costs	12,990,300	12,691,048	s 9(2)(f)(iv)	
Non-Personnel costs	6,882,682	6,717,123	s 9(2)(f)(iv)	
Total expenditure	19,872,982	19,408,171	s 9(2)(f)(iv)	
Surplus/(deficit)	**170,320**	**- 2,286,671**	s 9(2)(f)(iv)	s 9(2)(f)(iv)
Equity				
Total Assets	4,014,763	1,358,723	1,359,646	1,343,492
Total Liabilities	1,409,633	1,040,264	1,048,983	1,066,929
Net Assets	2,605,130	318,459	310,663	276,563

Note the above combines HDC and Aged Care Commissioner funding as well as non-Crown revenue.

s 9(2)(g)(i)

9. In response to the reduction in budget, HDC has identified complaints resolution as its core strategic priority. The Commissioner has assured the Ministry that it remains committed to addressing urgent public protection issues and its role in quality and safety improvement.

10. s 9(2)(g)(i)

11. s 9(2)(g)(i)

12. HDC contracts the National Advocacy Trust (the Trust) to provide the Nationwide Health and Disability Advocacy Service at a cost of about $3.5 million per annum. The Trust manages up to 3,000 complaints per year and has an integral role in resolving complaints before they are escalated to HDC. s 9(2)(j)

Investment in new complaints management software will mitigate some risk

13. HDC has informed the Ministry of its intention to use its current in-year surplus of $600,000 to purchase new customer relationship management (CRM) software. Currently, HDC relies on Lotus Notes for complaint management, which is outdated and inefficient. Upgrading to a modern system is expected to improve efficiencies, enhance data analysis, and facilitate better communication with complainants and providers.

14. HDC has completed the request for proposal process for the CRM software. s 9(2)(j) HDC aims to confirm the preferred provider by May 2025 and implement the CRM within 8–10 months.

15. As part of the Budget 25 process, the Ministry has agreed to provide additional funding to HDC of $500,000 in 2024/25 only out of the forecast Ministry underspends to support progressing this project. This upgrade will reduce some of the risk associated with the funding reduction, and may result in future cost savings.

Direction from the Minister of Finance and funding proposal

16. The Minister of Finance wrote to you on Monday, 31 March 2025 directing you to "address the HDC funding cliff". Whilst there was not a requirement to fully fund the $2.9 million gap, the direction is to ensure that you take steps to limit the impact of the reduction in funding.

17. HDC have provided a number of options that present the impacts of providing various levels of additional funding. More detail on these is presented in **Appendix 2**.

18. For each of these options, HDC will undertake to maintain the funding available for the advocacy service s 9(2)(f)(iv) and meet the ongoing costs of the upgrade to the CRM software ($0.25 million), with the remaining funding directed to address the backlog of complaints. s 9(2)(g)(i)

19. As of Quarter 2 2024/25, HDC has a backlog of 2,801 open complaints. The rate at which the backlog is cleared is dependent on the number of new complaints received, which cannot be estimated accurately. Clearing the backlog will be a multi-year task under any realistic funding scenario, but should be supported by the new CRM system in due course.

20. At Quarter 2 2024/25, HDC reported 180 fewer open complaints than the previous quarter. This is the first time in recent years that HDC have reported a reduction in the

backlog over a quarter. This is a promising step that indicates that HDC's business improvement actions may be having an impact, and improves the context for a decision on additional funding.

We recommend one-off funding to smooth the funding cliff and allow time for system improvements to have an effect

21. Our recommended approach is to provide one-off funding in 2025/26 from the Ministry's baseline. This is on the basis that:

    a. Funding in 2025/26 will smooth the funding cliff and provide a graduated profile to a lower baseline over two years, reducing the risks of a faster reduction.

    b. The impact of the new CRM system on HDC's productivity remains uncertain, but promises improvements that will affect its ongoing financial needs. It would be prudent to understand this impact before longer-term financial decisions are made.

    c. Committing to ongoing funding from the Ministry's baseline creates an open-ended cost risk that cannot be justified against present or future ministerial priorities.

22. s 9(2)(f)(iv)

23. **We recommend additional funding of $1.00 million is provided to HDC in 2025/26.** This option would cover a proportion of the funding gap, while balancing the impact on the Ministry. We believe that this level of funding would be sufficient to:

    a. maintain funding for the advocacy service at current levels s 9(2)(g)(i)

    b. maintain the current rate at which complaints are closed, while supporting steps to reduce the backlog during 2025/26

    c. support ongoing business improvement and the implementation of the new CRM, which should lead to efficiency benefits.

24. The recent improvement in clearing complaints gives some confidence that HDC will be able to maintain this function, if prioritised within a reduced baseline. s 9(2)(g)(i)

25. s 9(2)(g)(i)

Other options to support financial sustainability

s 9(2)(f)(iv)

26. s 9(2)(f)(iv)

s 9(2)(f)(iv)

27. s 9(2)(f)(iv)

Next steps

33. Final budget decisions and draft budget recommendations must be completed by 10 April 2025. Once you have communicated your preference as to the level of funding that should be reprioritised from within the Ministry's baseline, we will ensure that this forms part of the recommendations for Cabinet for Budget 2025.

34. If approved by Cabinet, you will be able to request permission to communicate the decision with the Health and Disability Commissioner so that the necessary steps for planning can be put in place at the HDC to meet its new funding level in 2025/26.

35. HDC is due to submit a draft Statement of Performance Expectations (SPE) for 2025/26 in late April 2025.

36. s 9(2)(f)(iv)

ENDS.

Appendix 1 – HDC funding Scenarios

HDC has provided three budget scenarios below.

Option 1: Current baseline funding with an additional $1.00 million

- Implementation of CRM ($0.5m in first year plus on-going licence costs of $0.25m).
- Retaining the current level of funding for the Advocacy Service ($0.5m).

The Advocacy Service has a highly valuable role in facilitating the early resolution of complaints and managing demand on HDC. s 9(2)(b)(ii), s 9(2)(j)

Option 2: Current baseline funding with an additional $1.50 million

- Implementation of CRM plus on-going licence costs.
- Retaining the current level of funding for the Advocacy Service.
- Provide resources to focus on clearing the backlog of complaints at a more rapid pace and significantly reducing the number of complaints aged over 2 years.

s 9(2)(g)(i)

Option 3: Current baseline funding with an additional $2.00 million

- Implementation of CRM plus on-going licence costs.
- Retaining the current level of funding for the Advocacy Service.
- Provide resources to focus on clearing the backlog of complaints
- Provide resource to undertake rapid commissioner-initiated inquiries into systemic issues.

The value of these investigations is in highlighting key systemic issues, creating stimulus for change and restoring public trust in the system.

Appendix 2 – Summary of HDC's statutory requirements

The purpose of the Health and Disability Act 1994 (the Act) is to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights.

Summary of HDC's statutory functions

- **Code of Rights** – Develop, review, and recommend changes to the Code of Health and Disability Services Consumers' Rights (the Code).
- **Education & Awareness** – Promote understanding and enforcement of consumer rights through education and public statements.
- **Handling Complaints** – Receive, assess, and ensure proper handling of complaints against healthcare and disability service providers.
- **Investigations** – Investigate potential breaches of the Code, either on complaint or independently.
- **Legal Actions & Recommendations** – Refer cases to the Director of Proceedings and suggest resolutions to prevent future breaches.
- **Advocacy & Guidelines** – Develop guidelines for advocacy services and provide recommendations to improve consumer rights.
- **Ministerial Advice & Reporting** – Advise the Minister on consumer rights issues and suggest legislative or administrative changes.
- **Public Engagement** – Gather information and consult with the public, community groups, and relevant organizations.
- **Collaboration** – Work with agencies like the Ombudsmen, Human Rights Commission, and Privacy Commissioner.
- **Independence** – Operate independently, except where otherwise specified by law.

Summary of the roles and responsibilities the advocacy service according to the Act

The Commissioner appoints a Director of Health and Disability Services Consumer Advocacy who acts independently but remains accountable for efficient service management.

- **Functions of the Director** - The Director is responsible for managing advocacy service agreements, promoting advocacy, overseeing advocate training, monitoring services, and reporting to the Minister.
- **Independence of Advocacy Services** - Advocacy services operate independently of the Commissioner, Ministry, healthcare providers, and disability service providers.
- **Procurement and Monitoring of Advocacy Services -** The Director negotiates contracts for advocacy services and ensures compliance with established guidelines. These agreements require adherence to section 28 guidelines but do not override other legal provisions.

- **Guidelines for Advocacy Services** - The Commissioner issues guidelines on advocacy operations, with Ministerial approval, including special procedures for specific groups. Consultation with stakeholders ensures diverse perspectives in guideline development.
- **Functions of Advocates** - Advocates support health and disability service consumers by:
    - Raising awareness of consumer rights and complaint procedures.
    - Ensuring informed consent for healthcare procedures.
    - Educating providers on consumer rights.
    - Assisting consumers in resolving complaints and representing them if needed.
    - Reporting to the Director of Advocacy and the Commissioner on advocacy services and consumer rights issues.
- The advocacy service plays a crucial role in protecting consumer rights, resolving complaints, and promoting awareness within the health and disability sectors.