Template 1: Manifesto Initiative Template

Section 1: Overview and Context

<table>
<thead>
<tr>
<th>Vote</th>
<th>Health</th>
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</thead>
<tbody>
<tr>
<td>Responsible Minister</td>
<td>Hon Dr David Clark, Minister of Health</td>
</tr>
<tr>
<td>Initiative title</td>
<td>Free health check for SuperGold card holders</td>
</tr>
<tr>
<td>Initiative description</td>
<td>This funding will contribute to equitable access to primary health care for older people by providing one free visit to a General Practitioner per year to all SuperGold card holders (approximately 700,000 New Zealanders).</td>
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<tr>
<td>Workstream</td>
<td>Manifesto</td>
</tr>
<tr>
<td>Responsible Vote Analyst</td>
<td>[Please provide your name and extension number]</td>
</tr>
</tbody>
</table>

1.1 EXECUTIVE SUMMARY

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

The proposed primary health care initiative will provide one free annual visit to a primary health care provider to all (approximately 723,000 as of 2017) SuperGold card holders.

Access to primary health care is of particular importance for older people as the burden of long-term conditions and frailty increases with age. Frailty, multimorbidity and disability often lead to restrictions in social participation, reduced self-reliance and care dependence, which in turn may lead to an increase in demand for secondary health services, the utilisation of long-term care and support, and an increase in health spending.

It is generally accepted that early diagnosis and management of illness and long-term conditions is part of quality health care. The combination of early diagnosis and our population’s increasing life expectancy means we have more chronic conditions being managed for longer, consuming a growing amount of health resources for their management. Furthermore, inequities exist within our older population, with Maori and Pasifica peoples reporting higher levels of unmet health need, and experiencing a disproportionate burden of many long-term conditions.

People can still lead a good life with one or more long-term conditions if their health needs are well managed. However, without good management, illness and long-term conditions can escalate quickly.

Prevention of illness and delaying the onset of multimorbidity can mean more time spent in better health for our older people. Increased access to primary health care is therefore an important component in maintaining health, reducing healthcare costs, and increasing equity within ageing populations.

<table>
<thead>
<tr>
<th>Funding Sought ($m)</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22 &amp; outyears</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>Operating</td>
<td></td>
<td>1,000</td>
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<tr>
<td>Capital¹</td>
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¹ The first 10 years of capital investment is counted against the capital allowance. Additional FY columns are to be added to funding table above to reflect the full capital costs of an initiative.
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<td>Capital</td>
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**Three components required:** See Vote Analyst Assessment Guidance.

1. [Support in full/Partial support and Scale/Defer]
2. [Please provide a two sentence summary to explain your recommendation above]
3. [Provide a succinct overall assessment which outlines the key judgements which support your two sentence summary (above)].

This will be entered into CFISnet and used in the supporting comment next to initiative assessments in advice to Ministers.

This will be used in the Treasury moderation process and package development stages.

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### 1.2 CONTEXT

A. Has the initiative been stated in Labour’s Fiscal Plan, Coalition agreement, or Confidence and Supply Agreement?  
   Y

B. Has the initiative been jointly developed with other agencies?  
   N

C. Have you attached the supporting Better Business Case, Regulatory Impact Assessment, etc. (if applicable)?  
   N/A

G. If required, please provide additional information to support your answers above.  
   This initiative was included in the Labour – New Zealand First Coalition Agreement as “Annual Free Health Check for Seniors including an eye check as part of the SuperGold Card”.
## Section 2: Problem / Opportunity & Strategic Alignment

### 2.1 Problem Definition or Opportunity

<table>
<thead>
<tr>
<th>A. Describe the problem or opportunity that this initiative seeks to address.</th>
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<tbody>
<tr>
<td>Increasing access to primary health care for older people is of particular importance as our population ages and health inequities persist. The proposed free visit to a primary health care provider is part of a suite of initiatives aimed at increasing access to primary health care and addressing these inequities.</td>
</tr>
</tbody>
</table>

**New Zealanders are living longer but more time is spent in poorer health**

New Zealanders are living longer and health expectancy is improving. However, life expectancy is increasing faster than health expectancy which means on average New Zealanders are living for around a decade in declining health. Only 70–80% of the years of life gained over the past quarter century have been years lived in good health: our health system and wider society have proved more adept at preventing early death than at avoiding or ameliorating morbidity. While in many ways the situation is improving for Māori and Pasifika peoples, inequities persist, with higher levels of unmet health need reported within these communities, and a disproportionate burden of many long-term conditions experienced by both Māori and Pasifika peoples.

An ageing population will inevitably increase demand pressure on the health system, but the level of this impact will depend on how healthy future cohorts of older people are. A greater focus on addressing the impact of long-term conditions, multimorbidities and frailty, through both prevention and improved management, will enable people to live more of their ‘extra’ years of life in better health.

This initiative to increase access to primary health care for older people, with its focus on the early detection of illness and the management of long-term conditions, is closely aligned to the New Zealand Health Strategy (2016 to 2026), the Healthy Ageing Strategy (2017), and the findings of the Health and Independence Report (2015) which all include a focus on access, equity, the management and prevention of long-term conditions, and support for the health of older people.

**Age related illness and long term conditions are rising, and needs are increasingly complex**

As the population ages, rates of chronic pain and arthritis (a cause of chronic pain) rise, as do the number of people living with long-term conditions and illnesses and disabilities frequently associated with ageing and the ageing process. Health needs are also increasingly complex.

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Some of these age related illnesses and long term conditions are not being identified early enough and complexity is sometimes not adequately managed. There are still a number of older people who have trouble accessing the health services they need. With an ageing population, unmet health need is expected to increase in the absence of a targeted intervention.

Of New Zealanders aged 65-74 years, 19.8% (approximately 79,000 older people) and 17.6% of those aged 75 years and older (51,000) reported unmet primary health need in the last 12 months. Cost currently poses a barrier to accessing primary health care for approximately 8% of 65-74 year olds, and 5.2% of 75+ year olds (2015/16). Māori and Pasifika peoples generally experience a higher level of unmet need for health services, an earlier onset of long-term conditions, and a disproportionate burden of disease than non-Māori/Pasifika peoples. This initiative will increase access and therefore reduce unmet health need for our older populations.

Inadequately managed long-term conditions are leading to poorer health outcomes and rising health costs

The presence of multiple chronic conditions is usually associated with worse health outcomes, greater utilisation of healthcare services and higher healthcare costs. Transitioning the health system to respond to multimorbidity is a key challenge.

The steeply increasing prevalence of multiple long-term conditions amongst older people is reflected in increasing all-cause DALY rates in older people, particularly in the rapidly growing 75+ age group. Our health system is currently oriented to managing single diseases individually and will struggle to cope as rates of multimorbidity continue to rise. Through the provision of one free annual visit to a primary health care provider, the proposed initiative looks to prevent, delay and manage this increasing complexity in our older population by increasing their access to primary health care.

Poor eye health and vision loss can exacerbate poor health

Eye health and vision are hugely important for general health and independence as we age. Cataracts, macular degeneration and glaucoma are common eye conditions affecting older people. New treatments are being developed and health professionals now have ways to detect these conditions earlier so vision can be protected for longer. Increasing access to health care so that vision and eye health can be evaluated may lead to early detection of degeneration and vision loss.

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*(2015/2016 data presented from Health Survey as a break-down of age groups is currently not available for 2016/17)*


Compared to people with good vision, people with low vision are less able to live independently, have poorer quality of life, rank their health as worse, are more likely to get depressed, and have more falls and fractures. In older people, falls are associated with significant mortality and morbidity and frequently lead to a decline in physical and/or psychological function, ultimately encroaching on independence and autonomy. In addition to the costs to the individual and immediate carers, falls consume significant resources in terms of hospital admissions, bed utilisation, and use of other health and allied services.

Compared to 50 – 64 year olds, people aged 85+ were twice as likely as to have an ACC claim for a fall-related injury in 2014. One in four people in this older age group (21,854) had an accepted ACC claim for a fall-related injury, equating to 60 ACC claims per day. They were also 17 times more likely to be admitted to hospital as a result, had more hip fractures (49% percent of all hip fractures) and stayed in hospital three times longer (average of 15.5 days compared with 4.6 days). About one in 20 of those who fall will have a fracture or other serious injury requiring hospital admission, with the likelihood of injury increasing with age.

With an ageing population, the problems associated with falls and injury will escalate unless there is a coordinated and effective approach to prevention and intervention. Early detection of risks, the promotion of positive behavioural change and early intervention, achieved through an increase in access to health care can delay or even reduce frailty and disability.

<table>
<thead>
<tr>
<th>B. What inputs will the preferred option buy and why?</th>
<th>The requested funding will fully subsidise one free annual visit to a primary health care provider for all SuperGold card holders.</th>
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</thead>
</table>

One aim related to the implementation of this initiative, at the clinical level, is to ensure the content of the free visit is determined by both the patient and health practitioner, and is flexible enough to meet the needs of the individual. This flexibility will allow for a tailored, individualised consultation, informed by individual health records which best meets the needs of those eligible.

The free annual visit will be available to all SuperGold card holders and may consist of a health practitioner-led targeting of priority long-term conditions, or chronic, non-communicable diseases addressed in the New Zealand Health Strategy and the

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Health and Independence Report (2016), a frailty or psychosocial assessment, an eye and vision check, or a patient-specific visit to address any given concerns.

The annual visit may also provide useful baseline data for practitioners in informing their care provision, to jointly develop care plans with the older person and their whānau and for ongoing monitoring of health from which improvements and outcomes can be gauged.

The input this initiative will buy is an increased capitation payment to practices for each 65+ year old enrolled as a SuperGold card holder. The terms of this capitation will be subject to negotiation through the Primary Health Care Services Agreement Amendment Protocol (PSAAP) (see section 4.1A).

Of the 723,000 SuperGold card holders, 368,000 are in a Very Low Cost Access (VLCA) practice or have a Community Services Card (CSC). For this group the price will take into account the reduced co-payment that they would be paying ($8 due to VLCA and CSC subsidies). For this group the co-payment is $8, so buying out the copayment for this group is $2.944 million.

The price of the average co-payment for non-VLCA and non-CSC holders will be set to $38 per person, as this takes into account the $10 co-payment reduction, and is set at a price that will ensure about 80% of practices will opt in. This means practices will be paid $38 per person for around 355,000 SuperGold card holders ($13.49 million).

C. What options were considered to achieve the Government's manifesto commitment and why did you choose your preferred option?

Three options were considered to achieve the Government's manifesto commitment:

1. free annual health check as one free visit to a local primary health care provider for all SuperGold card holders
2. free annual health check, provided by a General Practitioner, consisting of a semi-standardised screening and health assessment
3. free annual health check, provided by a nurse or nurse practitioner, consisting of a semi-standardised screening and health assessment.

Option (1) was chosen as the preferred option because:

- it will provide a flexible and individualised service which recognises the heterogeneity of the older population and the fact that needs vary drastically within this group
- various forms of screening and assessments are already undertaken by health professionals in a primary health care setting
- the review of primary health care funding set to begin in 2018 may change the way the health of older people is funded within primary care
- a free annual visit is expected to lead to high levels of patient satisfaction and quality of care.
### 3.4 Funding Implications

A. Provide option(s) for scaling, phasing and this initiative.
   Builds on information provided in section 2.1.B of this template.

<table>
<thead>
<tr>
<th>Phasing</th>
<th>Scaling</th>
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<tbody>
<tr>
<td>There are several possible options available for the implementation of the initiative.</td>
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<tr>
<td>1. A phased roll-out over three successive years, with year one providing the free annual visit to 75+ year old SuperGold card holders, year two increasing eligibility to all 70+ year old card holders, and finally, year three increasing eligibility to all SuperGold card holders.</td>
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<tr>
<td>2. A phased roll-out which targets DHB catchment areas. Over three successive years, the free annual visit would apply to all eligible SuperGold card holders of a predetermined number of DHBs, increasing each year until all SuperGold card holders from all twenty DHB were eligible for the check.</td>
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<tr>
<td>3. A two-phase roll-out, with scoping and development work (including analytics and services specification) commencing 2018/19, followed by full implementation beginning 2019/20.</td>
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<tr>
<td>1. The free visit could only apply to SuperGold card holders enrolled at Very Low Cost Access (VLCA) practices.</td>
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<tr>
<td>2. The free visit could be implemented according to need, based on deprivation, the number of chronic or long-term conditions and levels of polypharmacy. Multi-morbidity and polypharmacy would be identified through the patient’s electronic medical record.</td>
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<tr>
<td>3. The free visit could take the form of the interRAI assessment tool which is currently used in New Zealand in home and residential support of older people. It is currently required that those receiving home support and in residential care receive one interRAI assessment. The provision of one free visit during which an interRAI assessment is undertaken would ensure that the needs of individual older people are re-assessed and that care can be adjusted accordingly.</td>
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</tbody>
</table>

Preferred option
The preferred option for how this initiative will be delivered is by **phasing, option (3)**. A two phased roll-out with scoping and development work (including analytics and service specification) commencing 2018/19 acknowledges administrative and workforce challenges, while allowing for further development of the scope, details and service specification of the check itself. Systems of implementation and evaluation can be developed during this initial phase, while allowing for time to properly gauge uptake.
B. Outline how the costs compare to those outlined in Labour’s Fiscal Plan (if applicable)?

The initiative was a part of the Labour–NZ First coalition agreement and is not outlined in Labour’s Fiscal Plan.

C. Describe the implications on service delivery and risks/trade-offs for each of the scaled, phased or deferred scenarios section 3.4.A.

The key risk is whether one free visit to a primary health care provider meets the commitments made by the government and is in the spirit of the manifesto commitment.

### Phasing

1. The highest proportion of older people are between 65 – 75 years. Rolling the initiative out beginning with the older population will mean that by year three, demand may be extremely high as the roll-out is applied to the more populace groups. If this coincides with full or near-full utilisation of other primary care initiatives, demand may exceed the capacity of health practitioners to provide care. This option would meet the manifesto commitment.

2. A rolling programme which targets DHB catchment areas would need to be negotiated in relation to Government-DHB agreements and primary health organisations. This option would meet the manifesto commitment.

3. While time is allocated in this option for further definition and development of the free visit, allowing for the development of analytics, risks associated with increased demand for services and pressures placed on the primary health care workforce remain.

### Scaling

1. VLCA practices are a blunt targeting tool, and are likely to be a focus of the upcoming primary health care funding review as they do not always reflect the level of need of the people they serve, and are already under considerable demand and cost pressures. This option also does not meet the manifesto commitment.

2. Scaling the initiative based on need assumes that levels of need and unmet need are known. By targeting those we know have unmet or high needs, the initiative may miss those whose unmet need is not identified. This option would not meet the manifesto commitment.

3. While this option would support and increase current use of a largely successful yet under-used assessment tool, scaling in this manner may be received as being less in-line with the spirit of the initial coalition agreement. This option would not meet the manifesto commitment.

The strain associated with increased demand applies to all of the above options, and may be lessened applying **phasing option (3)** which has the benefit of allowing efficiencies in implementation and operations to develop while also adhering to the manifesto commitment.
Have credible choices and implications been set out? Is it clear how costings differ from Labour’s Fiscal Plan? If this initiative is prioritised down or scaled to fit within the draft package, do you have sufficient information to make these judgements? At a minimum, can you provide to Ministers:

- What are the most valuable components?
- What is the de-minimum/point at which no worth doing?
- What are the risks or impacts of scaling?
- An understanding of why this needs to be funded for 2018/19?

The development of the Budget package will require trade-offs and prioritisation across initiatives. Advice to Ministers will need to set these choices (and the risks/consequences) out.
## 3.1 Expected Impacts

### A. What are the costs and benefits of this initiative compared to the counterfactual?

This initiative has the potential to reach approximately 723,000 SuperGold card holders and is expected to result in an increased number of older people visiting a primary health care provider at least once per year.

The main anticipated outcomes of this initiative are earlier identification, management and possibly delayed onset of illnesses and long-term conditions. Assuming the provision of one free annual visit increases access to primary health care, this initiative is also expected to result in the following benefits *(based on evidence/references provided in section 3.1B)*:

- **Reduced Mortality** – Numerous studies have indicated that all-cause mortality and mortality for specific conditions such as cancer and cardiovascular disease can be reduced through better primary care access.
- **Reduced Emergency Department (ED) Visits** – Prior experience with introduction of low-cost care, as well as international literature, indicates greater GP utilisation should lead to a fall in ED visits.
- **Reduced Health Costs for Outpatient and Inpatient Care** – A proportion of ED visits will result in additional hospital care on an inpatient or outpatient basis. However, increased detection of illness may also lead to higher demand for secondary and specialist services.
- **Reduced Ambulance Call-outs** – In a similar way, fewer ED visits should correspond to fewer ambulance call-outs.
- **Reduced Pressure on Acute Services**
- **A Small Increase in Referrals for Minor Elective Surgery** – As problems may be dealt with earlier rather than later and at a greater cost to individual health and the system.
- **Improved Quality-Adjusted Life Years (QALYs)** – (excluding premature mortality) due to better care – in addition to avoided and delayed mortality, improved access to primary care should lead to lower morbidity and corresponding gains in QALYs.
- **Improved Mental and Social Wellbeing** – And the prevention or delaying of psychological morbidity.

Screening for specific long-term conditions presents immediate impacts on the health of older people. Following the proposed suite of possible assessments there may be any number of recommendations for the patient in question. Recommendations may include referral to a specialist for management of a specific condition, advice on polypharmacy, recommendation for positive behavioural change (including smoking cessation), or referral to a community or non-governmental organisation for social support.

**Counterfactual**

Without this intervention, most older people would continue to access primary health care services, however some would not, as the New Zealand Health Survey unmet...
need figures illustrate. Of those who do access primary health care services, many are expected to have long-term conditions identified and addressed and some may have eye health checked. For those whose needs are not currently met, this proposal will provide an important and free opportunity to visit a health provider at least once a year and reduce a key barrier in attending follow-up consultations.

It is assumed that a proportion of older people who report unmet health need will choose to engage with primary health services following the offer of one free annual health check. If this initiative did not ahead in Budget 2018 then levels of unmet need for this older population would likely remain at the levels described by the NZ Health Survey, meaning continued poor management of long-term health conditions for those not accessing primary care, and a missed opportunity for prevention and early identification of a number of both physical and psychosocial conditions.

VOTE ANALYST COMMENT

[Please rate this initiative on a scale from 0-5 to reflect Value for money. Please explain your rating and provide a short comment on the quality of the cost-benefit analysis and the reliability of the inputs. See section 3.2.2 of the September guidance.]

Has a compelling counterfactual been provided? Or if not, have the risks and implications been made clear?

The prompts above should be completed at a minimum by the agency to ensure a consistent assessment across initiatives.

3.2 ASSUMPTIONS AND UNDERLYING EVIDENCE

A. Outline the assumptions underpinning the impacts described above.

Many of the positive outcomes assumed of this initiative, also assume increased access as a result of the provision of a free annual visit. Evidence cited therefore relates to previous studies which have sought to determine the impact of increased access to primary health care.

B. What evidence supports the assumptions and impacts?

There is strong evidence that cheaper co-payments increase GP visits

There is strong local and international evidence to support the assumption that cheaper co-payments increases primary care utilisation, as listed below. It can therefore be assumed that a free health check would also increase utilisation. Furthermore the assumption that a free annual health check for older people would increase utilisation can be observed in previous changes in utilisation in the New Zealand context such as that which resulted from implementing free doctor’s visits for under-13s.

Some key papers and data sources include:


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• Ministry of Health, *Annual Update of Key Results 2015/16: New Zealand Health Survey* (Wellington: Ministry of Health, 2016) [in draft, being prepared for publication].


• Unpublished data held by the Ministry of Health on utilisation of GP services by under-13s.

**Evidence that increased GP visits will lead to reduced ED and hospital visits**

Local evidence from the introduction of free GP visits for under-13s demonstrated a 4.7% reduction in the number of lower-acuity ED visits as a result of the initiative.

At least one international study has shown a statistically significant link between patients deferring GP care due to cost, and higher numbers of hospitalisations:


More generally, evidence exists linking stronger primary care provision and greater access with reduced hospital visits, including both ED visits and ambulatory-sensitive admissions. Some key papers and data sources are:


• Amal N. Trivedi et al., “Hospitalizations for Chronic Conditions Among Indigenous Australians After Medication Copayment Reductions: the
Evidence that increased GP visits will lead to lower mortality

Some international evidence has shown an inverse relationship between GP utilisation and mortality rates:


In a cross-sectional and longitudinal study of industrialised countries Machinko et al. (2003) found a weak relationship between physician visits and mortality, equating to a reduction of 3 in the mortality rate per 100,000 people for each extra visit per year; in the New Zealand context, this would mean a reduction of around 1% in the mortality rate. More generally, other international evidence indicates that stronger and more readily available primary care leads to improved mortality rates:


### Evidence that increased GP visits will lead to gains in QALYs

There is limited evidence on the relationship between GP utilisation and QALYs. This stands as an aspirational assumption.

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<th>VOTE ANALYST COMMENT</th>
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| Provide an assessment of the assumptions and judgements related to the expected returns. Are these clearly stated and reasonable and appropriate given the proposal’s intended outcomes?  
Does the evidence (qualitative and/or quantitative) provide reasonable certainty and confidence? Why/why not? |

### 3.3 Sensitivity Analysis

**A. Provide examples or scenarios to show how impacts change with different assumptions or policy settings.**

The details of this initiative assume current (2017) numbers of older people, however, population change resulting from our increasingly older population may mean that this initiative gets more expensive over time.  

How this initiative is funded may also change with the coming review of primary health care funding.

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| Has the agency completed sensitivity analysis which steps through the impact of different elements on the initiative?  
This type of information will be critical when outlining choices and impacts/risks associated with trade-offs as the draft package is developed and advice is provided to Finance Ministers. |
Section 4: Implementation, Risk Management and Evaluation

4.1 IMPLEMENTATION

A. How will this initiative be delivered?

The mechanism for implementing the package is the Primary Health Organisations Services Agreement (PHO Services Agreement). This is an agreement between DHBs and PHOs for the delivery of primary health care services. This Agreement is negotiated via the PHO Services Agreement Amendment Protocol (PSAAP) involving representatives from DHBs, PHOs, Contracted Providers and the Ministry of Health. Introducing this initiative means there will need to be a change to this Agreement for the 2018/19 financial year.

The initiative will be delivered after the following steps have been undertaken:

1. Service specifications and scope of the initiative will first be determined by the Ministry of Health in dialogue with the health sector.
2. Costs associated with the initiative will be negotiated with the health sector through PSAAP.
3. Systems will be put in place to tie PHO enrolment and SuperGold card data to frequency of utilisation to ensure those eligible receive only one free annual visit.
4. Systems will be put in place to collect data for evaluation of the programme.
5. Public information will be distributed to inform the eligible population, their whanau and carers of the availability of the free annual visit.

B. Description of engagement with other agencies impacted by this initiative (if applicable).

N/A

C. How does this initiative relate to current activity undertaken by your agency and/or by others across the State Sector?

The proposed free annual visit to a primary health care provider for SuperGold card holders is one of a suite of primary care initiatives for Budget 2018 which focuses on addressing financial barriers to primary health care. Similar initiatives in this suite include the provision of a full subsidy of primary health care for 13 year olds, and extended use of the Community Services Card to target subsidies for non-VLCA GP consultations.

There are currently means to provide low cost GP services to certain groups. One of which is the VLCA scheme for primary health care, which offers low maximum payments for practices where the combined numbers of Māori, Pasifika people and deprivation quintile 5 are greater than 50 per cent of the total enrolled population.

The interRAI assessment is currently used in New Zealand in home and residential support of older people, however no such assessment exists in a clinical setting for primary health care. This initiative looks to address this gap in need by extending a suite of assessment specific to an older population into a community setting.

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<thead>
<tr>
<th>Risk Description</th>
<th>Impact or Consequences</th>
<th>Likelihood</th>
<th>Severity</th>
<th>Overall Risk</th>
<th>Mitigation / Controls</th>
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</table>
VOTE ANALYST COMMENT

The implementation assessment will form a critical piece for the advice on the manifesto initiatives. In particular aspects such as the ability of the Government to ramp up for delivery, agency and market capacity and risks to the delivery need to be considered.

Please provide a brief comment on the agency’s capability to deliver the initiative and ensure that the expected outcomes are achieved.

Has your agency set out the potential barriers or roadblocks expected in implementing the initiative and whether a plan exists to mitigate these? (This could include, for example, limited supply in the market for resources required to deliver the initiative, access to the target population/self-selection issues, and/or ability of agency to contract with providers)

[Please rate this initiative red, amber or green according to your assessment of risks associated with the delivery of this initiative. Consider the size of the proposal relative to the agency’s activity, any cross agency impacts, and impacts to front-line service delivery.]

4.2 LEGISLATIVE AND REGULATORY IMPLICATIONS

A. Please detail any legislative implications and whether the Regulatory Impact Assessment (RIA) requirements apply.  

N/A
4.3 PERFORMANCE MONITORING AND EVALUATION

A. Performance measures/indicators.

Performance measures will be determined with stakeholders before their implementation, and will initially include indicators with a greater emphasis on process and pathways, such as:

- utilisation rates and trends
- health data gathered
- patient journey (i.e. follow-ups)
- costs
- wait times and delays.

Over time, as outcomes become available and better understood, performance measures will focus on health outcomes and the wider impact of the initiative (see B and C below).

B. Outline how the implementation and performance of the initiative will be regularly monitored.

Implementation and performance will be monitored through:

1. a post-implementation review to see to what extent the implementation is consistent with policy intent and programme design, challenges, success factors and areas of risk
2. regular performance reporting on key indicators (both quantitative and qualitative) and any unexpected consequences.

C. Describe the method proposed to evaluate the impact of the initiative [if appropriate].

An impact evaluation focusing on the mental, physical, social, whānau and community impact. The area of focus for evaluation can be further specified in relation to earlier monitoring and evaluation findings.

The impact of the initiative can be evaluated using mixed research methods such as:

- stakeholder surveys
- administrative data analysis.

A propensity matching technique may then be used to identify suitable groups for comparative analysis. Comparisons can be made between similar groups of people (i.e. age, sex, ethnicity) before and after the implementation, and between people with different utilisations or frequency of consultation.

Impact on people under 65 years will also be monitored for any adverse consequences, for example increased waiting time, unmet need and other consequences which emerge over the course of performance monitoring and evaluation (A) and (B).

VOTE ANALYST COMMENT

Please provide a brief comment on the proposed performance monitoring and evaluation. **A key aspect will be how success can be measured and the impact on the Government’s objectives.**

Is there a clear and quality plan for how the success of the initiative will be measured and at which points or milestones?