Template 1: Manifesto Initiative Template

This template seeks a high-level summary of the Budget 2018 manifesto initiatives.

Your Vote Analyst will complete their assessment in the grey fields. Supporting information must be provided to your Vote Analyst. Please use the descriptions provided as a guide for what information is expected in each of the boxes below.

Contact your Vote Analyst in the first instance with any queries.

Section 1: Overview and Context

<table>
<thead>
<tr>
<th>Vote</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Minister</td>
<td>Hon Dr David Clark</td>
</tr>
<tr>
<td>Initiative title</td>
<td>Free doctor’s visits for all under 14s</td>
</tr>
<tr>
<td>Initiative description</td>
<td>This funding will provide free visits to a General Practitioner, after-hours visits and prescriptions for children under the age of 14 (approximately 56,000 New Zealanders).</td>
</tr>
<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.

This is one of a set of three Budget 2018 initiatives addressing financial barriers to accessing primary care. Specifically, this initiative ensures that cost is not a barrier for children aged 13 years old to visit a general practitioner. This also ensures that any follow-up GP visits resulting from a year 9 health check (the school based health services initiative) are free too.

This initiative seeks $4.9m p.a. to completely subsidise general practice visits, after-hours visits and prescriptions for children under the age of 14. We estimate that there are currently 58,311 New Zealanders aged 13 years old.

The initiative builds on the existing Zero Fees for Under 13s initiative which offers the same subsidies (daytime GP consultations, after hours GP consultations and prescription fees) to children aged 6 to 12 years old. The impacts of this initiative are expected to be very similar to those of Zero Fees for Under 13s which has been reviewed annually by the Ministry since implementation in 2015.

This initiative targets all 13 year olds, but is expected to particularly benefit families that experience financial barriers to accessing to primary care. This initiative is expected to have similar impacts to those observed since the implementation of the Zero Fees for Under 13s initiative in 2015. Since the Zero Fees for Under 13s initiative, 6 – 12 year olds:

- present at ED 3.4% less frequently overall,
- triage level 4 and 5 (non-urgent and non-life threatening) ED presentations have decreased significantly,
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- there has been a slight reduction in the proportion of hospital admissions that are classified as ambulatory sensitive hospitalisations (ASH), which are admissions that potentially could have been prevented with earlier treatment outside of hospital.

<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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</thead>
<tbody>
<tr>
<td>Operating</td>
<td>-</td>
<td>$4.9m</td>
<td>$4.9m</td>
<td>$4.9m</td>
<td>$4.9m</td>
<td>$19.6m</td>
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<tr>
<td>Capital¹</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>

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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<thead>
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<tr>
<td>Capital</td>
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<table>
<thead>
<tr>
<th>Vote Analyst Recommendation</th>
<th>Three components required: See Vote Analyst Assessment Guidance.</th>
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</thead>
<tbody>
<tr>
<td>1. [Support in full/Partial support and Scale/Defer]</td>
<td></td>
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<tr>
<td>2. [Please provide a two sentence summary to explain your recommendation above].</td>
<td></td>
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<tr>
<td>3. [Provide a succinct overall assessment which outlines the key judgements which support your two sentence summary (above)].</td>
<td></td>
</tr>
<tr>
<td>This will be entered into CFISnet and used in the supporting comment next to initiative assessments in advice to Ministers</td>
<td></td>
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<tr>
<td>This will be used in the Treasury moderation process and package development stages.</td>
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</tbody>
</table>

### 1.2 CONTEXT

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A. Has the initiative been stated in Labour’s Fiscal Plan, Coalition agreement, or Confidence and Supply Agreement?</td>
<td>Y</td>
</tr>
<tr>
<td>B. Has the initiative been jointly developed with other agencies?</td>
<td>N</td>
</tr>
<tr>
<td>C. Have you attached the supporting Better Business Case, Regulatory Impact Assessment, etc. (if applicable)?</td>
<td>N</td>
</tr>
<tr>
<td>G. If required, please provide additional information to support your answers above.</td>
<td>This initiative is included in the coalition agreement between Labour and New Zealand First.</td>
</tr>
</tbody>
</table>
Section 2: Problem / Opportunity & Strategic Alignment

### 2.1 PROBLEM DEFINITION OR OPPORTUNITY

**A. Describe the problem or opportunity that this initiative seeks to address.**

Some people experience barriers to accessing primary care in New Zealand due to cost. Internationally, health systems that place an emphasis on primary care have lower per capita costs, better health outcomes, and lower rates of premature mortality across a range of conditions. Most New Zealanders have good access to general practice services, engaging with primary care when they need it. However, for some primary care has become increasingly unaffordable. Financial barriers to primary care can cause delays in accessing care, and lead to unnecessary adverse health outcomes and cost to the sector, through preventable illness, prolonged illness, and unexpected admission to hospital.

Barriers to access can include difficulty getting an appointment in a timely manner, difficulty arranging transport to a GP practice, difficulty affording a GP appointment, difficulty accessing the GP during opening hours or getting time off work for a GP visit etc. Barriers to access primary care are estimated to affect roughly 28.1% of all adults, and 20.3% of children according the New Zealand Health Survey 2016/17.

This initiative is one of a set of three Budget 2018 initiatives that seek to address financial barriers to accessing primary care. While financial barriers to access are not the main barrier to access to care for everyone, they exist in an estimated 9% of families with 13 year olds, and disproportionately affect Māori and Pacific peoples and lower socioeconomic groups.

This initiative specifically aims to ensure that cost is not a barrier for 13 year old children accessing primary care, reflecting the value that the government puts on providing all New Zealanders with a healthy start in life. It will provide less restricted access to primary care for most Year 9 students, assisting in the integration of the proposed Year 9 checks (and school based health services more generally), and primary care services in the community.

There is significant public sentiment that children’s health should be a priority that children especially, with no financial agency of their own, should not forgo medical treatment because of the cost of care.

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5 Ministry of Health, Annual Update of Key Results 2016/17. New Zealand Health Survey (Wellington: Ministry of Health, 2017).
Many mental health conditions have their origins in early childhood, with symptoms often beginning in adolescence. Early intervention provides the best opportunity to help young people build resilience and learn the skills they need to manage future life transitions. The Government has committed to every Year 9 student receiving a health check through school-based health services (SBHS). If health issues are picked up in these checks and families experience cost barriers to primary care, they may not have the means to obtain follow-up care. This initiative will strengthen referral pathways and aid in cooperation between SBHS and primary care.

B. What inputs will the preferred option buy and why?

This initiative will extend the Zero Fees for Under 13s initiative to include 13 year olds. This will include full subsidisation of general practice, after hours consultations, and prescription fees for all New Zealanders aged 13 years. The under 13s initiative has been shown to increase utilisation by 10% for 6 – 12 year olds, and reported unaffordability of GP care for 6 – 12 year olds has reduced from 8% to 3% according to the New Zealand Health survey. ASH rates have decreased slightly for all 6-12 year olds, as have ED admissions, especially low acuity admissions, and purchased prescription items had risen by 20%. Similar results are expected if this initiative extended to include 13 year olds.

This initiative affects 58,311 New Zealanders aged 13 years old. The cohort currently faces average fees of $23.70 (as at end of June 2017). Utilisation is assumed to increase at the same rate as the under 13s increasing 16.2%.

**Subsidised general practice consultations**

Daytime coverage will cost approximately $3.2 million p.a. New funding for 13 year olds will be offered to general practices through the current capitation model. The rate will also compensate practices for the predicted increase in demand. The rate will be subject to negotiations through the Primary Health Services Agreement Amendment Protocol (PSAAP see section 3.4A), and will not be finalised until the conclusion of this process.

ACC, who fund injury-related general practice consultations, will match the expansion of free visits to 13 year olds. Funding to achieve this is bundled with the funding to match the reduction in GP fees by $10, and is sought in that template.

**Subsidised after-hours care**

$1.0 million p.a., is needed for after-hours practices consultations. In line with the current Zero Fees for Under 13s policy, after-hours care will be fully government funded.

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funded for 13 year olds. This is to further reduce barriers to accessing care, such as restricted opening hours of general practice.

Subsidised prescriptions
$0.7 million p.a. is required to fully subsidise the current $5 charge for prescriptions for all 13 year olds. In 2016/17 37,000 children under 14 had an unfilled prescription due to cost. Resulting increases in prescription uptake will likely improve adherence to prescribed treatment, increasing the effectiveness of GP services.

Total funding sought is an estimated $4.9 million, however the rates will not be finalised until the conclusion of the PSAAP negotiations.

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

The Government’s coalition commits to “Free doctor’s visits for all under 14s”.

The current Zero Fees for under 13s scheme includes full subsidisation of general practice and after-hours consultations, as well as prescription fees. Parents of these under 13s will have become accustomed to the full range of services that this initiative provides. Extending the current scheme avoids inconsistency of services which can negatively impact consumer’s perception of the system, cause confusion, and add further complexity to an already complex health system.

For these reasons the Ministry considered, but did not recommend progressing, some but not all of the subsidies available to 0-12 year olds, such as:

- the subsidy of daytime GP fees only,
- the provision of daytime GP subsidies and prescription fees only,
- and the provision of daytime GP subsidies and after-hour GP visits only.

VOTE ANALYST COMMENT

Has the problem or opportunity been clarified and does it support the prioritisation of this manifesto initiative?

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### 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. | The Government has made a commitment to implement this initiative through its coalition agreement.  
The coalition agreement stated that doctor’s visits would be free for all under 14s. The date of its implementation has not been specified publicly. As mentioned above, we recommend this includes after-hours consultations and prescriptions as fragmenting the point of service pricing of these services can negatively impact consumer’s perception of the system, cause confusion, and add to the complexity of the health system.  
**Phasing is possible with this initiative, but not recommended.** The Ministry could offer the subsidy first to particular practices or PHOs e.g. those with high needs populations, or those with the best capacity to meet increased demand. However, phasing does not meet the Government’s commitment for the subsidy to be accessible to all 13 year olds. |
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<tr>
<td>B. Outline how the costs compare to those outlined in Labour’s Fiscal Plan (if applicable)?</td>
<td>Not applicable (not included in fiscal plan)</td>
</tr>
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</table>
| C. Describe the implications on service delivery and risks/trade-offs for each of the scaled, phased or deferred scenarios section 3.4.A. | **PSAAP Negotiations**  
The final cost of the initiative will depend on agreement between DHBs, and PHO representatives during PHO Service Agreement Amendment Protocol (PSAAP) negotiations, which will commence in February 2018. This negotiation will also include the Government’s other primary care commitments, which means insufficient funding for those initiatives could undermine this initiative.  
This is a yearly process where PHOs and DHBs negotiate amendments to the PHO Services Agreement - the agreement that determines the scope of service and the remuneration of PHOs providing those services - is governed by the PHO Services Agreement Amendment Protocol (PSAAP). PHOs then have back-to-back agreements with practices*. It is up to practices whether they opt in to this initiative, which means the payment proposed must be competitive.  
*General Practices are independent businesses and as such have the regular rights of independent business. The new initiative would be an optional provision within the contract with practices choosing to opt-in, or continue delivering on the current agreement. The Ministry’s legal advice is that compelling practices to provide certain services (beyond their health and safety requirements) would be met with legal challenge, and put a large strain on the relationships between practices and health authorities. |
VOTE ANALYST COMMENT

Have credible choices and implications been set out? Is it clear how costings differ from Labour's Fiscal Plan?
Section 3: Value for Money and Impacts

3.1 EXPECTED IMPACTS

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

Please find evidence for these impacts in section 3.2 below

The logic underpinning the intervention is as follows (more detailed logic to be attached):

Offer free visits → reduced number of people experiencing cost barriers to access, or unmet need for primary care due to cost → long term reduced demand on the system including avoidable hospitalisations and ED services → improved health and equity for target population → wider social benefits from more days in education.

It should be noted that addressing financial barriers to access is just one way to increase the use of GP services. Others ways might include extending hours for families who have greater opportunity costs for taking time off work, improving public transport options to and from the GP or providing more culturally appropriate services. In 2010/11 approximately 20 percent of parents of children under 15 reported unmet need for primary health care, and 9 percent of those with 13 and 14 year olds reported unmet need due to cost.

Population: 58,311 13 year olds who (or whose parents) experience financial barriers to accessing primary care.

Impacts

As outlined in the Cost Benefit Analysis Template, the lifetime NPV is $9m. The costs and benefits underlying this are:

Costs

Cost to subsidise co-payments (GP, afterhours and Pharmacy), and capitation adjustments for expected demand increase

Health benefits:

- Reduced ED attendances (NPV - $1 million) – The Zero Fees for Under 13s programme reduced ED visits for the eligible population by 3.4%.
- Reduced health costs for acute hospital admissions (NPV $4 million) – More timely prevention of acute illness (e.g. flu vaccine) enabled by better access to GP care will also result in fewer acute admissions overall.
- Reduction in avoidable hospital admissions (NPV $2 million) – Ambulatory Sensitive Hospitalisations (ASH) are a measure of the effectiveness of the health system, including primary care services. An improvement in ASH rate indicates the prevention admissions to hospital for conditions that could have been treated at some stage before the admission, such as in a community setting. With more GP visits, GPs will
be better able to treat conditions before they develop and require hospital treatment.

Wider societal benefits include:

Private Savings resulting from reduced private healthcare spending (NPV $49 million)
The amount that the target cohort (or more likely, their parents) saves from reduced out of pocket costs per GP consultation is predicted to be positive (i.e. use won’t increase as much as extent as cost decreases).

Expected impacts not modelled in CBAX spreadsheet

Reduced mortality – numerous studies have indicated that mortality can be reduced through better primary care access, including through provision of lower-cost care.

Mortality hasn’t been modelled in the CBAX spreadsheet due to uncertainty regarding who in particular the mortality reductions affect (mortality reductions aren’t specific to children), and unclear mechanisms around the nature and timing of the effect.

Increased ability to participate in education, by supporting Year 9 checks and school based health services
Free GP consultations for 13 year olds will reduce barriers for referrals for potential conditions identified in most Year 9 health checks or school based health services. Ongoing treatment can be more easily and cheaper co-ordinated between community GP and school health practitioners.

Improving inequalities in access to health services and health outcomes.
Since the beginning of the Zero Fees for Under 13s initiative:

- low acuity Emergency department presentations decreased at a greater rate for Maori than the wider population,
- The proportion of acute admissions defined as Ambulatory Sensitive Hospitalisations decreased slightly more for Maori and Pacific peoples,
- The gap between the number of GP visits per annum for Maori and for non-Maori New Zealanders decreased.

This represents a small step towards more equitable outcomes and more equitable use of health services overall. The Ministry of Health expects to see similar results from this initiative.

Counterfactual

If the initiative does not go ahead, there is risk that health need identified through the Year 9 health check will go unmet. Most students in Year 9 will be over 12 years old at the time of their health check, meaning most referrals to general practice for follow up care will not be subsidised.
Early adolescence is a time of transition, and has particular vulnerability for later mental health. Ensuring continuity of care is an important part of ensuring early intervention.

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.

Cohort size:
58,311 people who are enrolled with a PHO, population growth based on Statistics NZ numbers of 13 year olds.

Demand
The increase in demand of GP visits has been approximated according to price elasticity of demand estimates for primary care from the experience of the recent implementation of the Zero Fees for Under 13s primary care initiative. Upon receiving free care, demand rose by 16.2% for 6-12 year olds.

Uptake
Uptake is modelled on the Zero Fees for Under 13s primary care initiative 2015 - 2017. As of 2017 there are only 5 practices (of over 1000) who don’t provide free services to either children 6 and under, and/ or free services to 6 – 12 year olds.

Unmet Demand
A small increase in demand is assumed to be able to be met using a combination of extending opening hours and efficiency gains (such as the adoption of online patient portals, improving patient triage). Waiting time increases are estimated to be temporary once workforce capacity responds.

Demand for secondary care services
A phenomenon of increased primary care utilisation increasing secondary care utilisation was observed in the Oregon Health Insurance Experiment. This effect is assumed to be unlikely to eventuate in the New Zealand context, or at worst would only be temporary as under-served patients are referred to secondary services for long standing health issues, as there are currently minimal barriers to access to treatment at the secondary level.
This assumption is based on the experience of the Zero Fees for Under 13s initiative, which saw no initial or longer term rise in ED or other secondary presentations. A rise in secondary services has not been modelled in the attached CBAx spreadsheet.

**Reduced health costs for acute hospital admissions**

More timely prevention of acute illness (e.g. flu vaccine) enabled by better access to GP care will also result in fewer acute admissions overall. Assumes that the vulnerable portion of this population will decrease acute admissions from 0.7% to 1% as a result of more frequent and timely utilisation of GP services. Acute admissions are assumed to cost the same as the average cost of an inpatient hospital admission. Assumed a 25% likelihood of this occurring due to low quality of evidence.

<table>
<thead>
<tr>
<th>B. What evidence supports the assumptions and impacts?</th>
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</table>

The evidence underpinning the budget 2018 initiatives “Cutting General Practitioner fees by $10 a visit” and “Extending the Very Low Cost Access rate for General Practitioner visits to Community Services Card holders”, describe the general population benefits of primary care. Evidence for these is presented in the “Cutting General Practitioner fees by $10 a visit” template. The Ministry of Health is using the results from the Zero Fees for Under 13s initiative as the basis on which to estimate the benefits of this initiative.

Monitoring of the under 13s initiative has shown that utilisation increased by 16.2% for 6 – 12 year olds, and reported unaffordability of GP care for 6 – 12 year olds has reduced to 3 percent from 8% in 2014/15. Nine percent of 13-14 year olds parents reported not going to the GP at least once because of the cost of the consultation in 2016/17.

ASH rates have decreased slightly for all 6-12 year olds as a proportion of total acute admissions. Before the initiative 22% of all acute admissions for 6-12 year olds were for ASH, after the initiative 21% of all admissions were ASH. With only very slight variation of acute admissions year on year, this is considered to be a 4.5% reduction in ASH rates.

ED admissions are down 3.4% for 6-12 year olds, particularly low acuity admissions (which decreased by approximately 10%).

Purchased prescription items had risen by around 20% since the implementation of the initiative. Although this couldn’t be considered an outcome, or an impact itself, this could be interpreted as increased compliance with medical advice.

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9 Ministry of Health, 2017 "HR20171427 "ZERO FEES FOR UNDER 13S – 12 MONTHS UPDATE FOR 2016/17”

10 Ministry of Health, Annual Update of Key Results 2016/17: New Zealand Health Survey (Wellington: Ministry of Health, 2017).
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VOTE ANALYST COMMENT

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.

<table>
<thead>
<tr>
<th>Values</th>
<th>Discount rate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6% real (default)</td>
<td>3% real (sensitivity)</td>
</tr>
<tr>
<td>Net Present Value (NPV)</td>
<td>$1m</td>
<td>$3m</td>
</tr>
<tr>
<td>Benefit Cost Ratio (BCR)</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>ROI – Societal total</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>ROI - Government</td>
<td>0.4</td>
<td>0.4</td>
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</tbody>
</table>

SBHS, and the year 9 health check, could identify unmet need. Extending free consultations and prescriptions to 13 year olds increases the likelihood of having these needs met through ongoing care in general practice. The impact of free consultations in primary care is expected to be increased through the provision of the health check and SBHS, as it provides another mechanism to identify need, and have it identified earlier.

VOTE ANALYST COMMENT

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? | This initiative will be implemented by agreeing a new payment on top of existing capitation that is based on the number of enrolled 13 year olds in each practice. The payment will be made alongside existing capitation on a monthly basis, and using existing payment mechanisms. The new payment will be agreed through the PHO Services Agreement Amendment Protocol (PSAAP) meetings, alongside the Government’s other primary care priorities. PSAAP negotiations are business as usual and won’t require extra expenditure or capacity. One of the key challenges of the three initiatives to subsidise general practice consultations is the ability of practices to meet increased demand. A shared concern of the initiatives proposed, aimed at reducing financial barriers to accessing primary care is the sector’s ability to meet demand. Based on economic literature, we have estimated a 2% increase in demand for every 10% decrease in cost of services.11 Of the three initiatives, this initiative has the smallest target population, and will result in the smallest increase in demand. As 13 year olds represent 1.2% of the total enrolled population, and less than 1% of total yearly GP consultations, it is not anticipated that this particular initiative will result in significant volume pressures for GPs. A discussion on managing demand pressures can be found in this section of the initiatives “Cutting General Practitioner fees by $10 a visit”. |
| B. Description of engagement with other agencies impacted by this initiative (if applicable). | The Ministry has discussed the initiative with primary healthcare representatives. This includes receiving advice and discussing operational issues in relation to this and other initiatives. Ongoing engagement with the health sector will continue. |
| C. How does this initiative relate to current activity undertaken by your agency and/or by others across the State Sector? | This is one of a set of three budget 2018 initiatives addressing financial barriers to accessing primary care. The other two initiatives address the targeting of subsidies to help relieve financial barriers to people with community service cards, and universally lowering co-payments for GP consultations by $10. Related current activity |

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11 O’Dea, D., Szeto, K., Dovey, S., & Tilyard, M., 1993 "The effects of changes in user charges on visits to New Zealand GPs" In Paper for the NZ Association of Economists conference. Christchurch: Lincoln University.


In 2015, the Ministry of Health began providing full subsidies of GP consultations for children under the age of 13. This includes access to after-hours care and eliminates prescription fees. The proposed initiative is an extension of this service.

This initiative also relates to the expansion of SBHS. The health check provided to all Year 9 students may identify health need, and this initiative ensures that students will be able to have that need addressed through primary care if necessary.

<table>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>PSAAP negotiation risk (financial only, maybe specifications but not likely)</td>
<td>As this initiative will be negotiated through the PSAAP process, the exact cost and coverage is uncertain, and will depend on the number of practices who consider this initiative to be agreeable financially or otherwise. Based on previous interactions with the PSAAP process, we expect that the price negotiated for this initiative could vary by a slight margin. This particular initiative is relatively cheap compared to the other initiatives in the Primary Care package. A significant variance in price for this initiative will likely make a negligible difference to the overall package.</td>
<td></td>
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<td></td>
<td>PHOs are also subject to consumer expectation that this initiative is implemented widely. Presenting a convincing case of projected costs, and fair compensation will increase buy-in. i.e. Competent analysis will mitigate risk.</td>
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</tbody>
</table>
4.2 LEGISLATIVE AND REGULATORY IMPLICATIONS

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

No regulatory systems need to be amended to implement this initiative.

VOTE ANALYST COMMENT

[Provide an assessment of the regulatory impacts of this proposal in consultation with the Regulatory Quality team.]

4.3 PERFORMANCE MONITORING AND EVALUATION

A. Performance measures/indicators.

The overarching framework for evaluation for the primary care initiatives addressing financial barriers to care, is described in this section of the initiative “Cutting General Practitioner fees by $10 a visit”.

The evaluation of this initiative differs slightly by:

- limiting the number of Long Term Conditions recorded, or eliminating tracking for these entirely as they make up such a low proportion of the burden of disease in these age groups,

- and potentially establishing a comparison group of 14-18 year olds. As there’s very little difference socially or physiologically between a 13 year old and a 14 year old, a comparison between adjacent ages would mainly capture the differences attributable to primary care policy, making this a good comparison group.

The overarching framework is reproduced verbatim below:

For any given gender, DHB region, age, and ethnicity (European/other, Asian, Pacific, or Māori) we will measure:

Impact on uptake of primary care services:

- Utilisation of GP consultations – received quarterly from PHOs,
- Utilisation of primary care nurse consultations – received quarterly from PHOs,
- Reported GP fees – NZ Health Survey yearly, weekly from Primary Care Patient Experience survey.

Impact on Secondary Health Service use:

- Admissions to the emergency department (as well as the lower acuity triage 4, and 5 admissions) – received weekly,
- Ambulatory Sensitive Hospitalisations (absolute, or as part a proportion of all acute hospitalisations) – received quarterly as a System Level Measure,
### 4.3 PERFORMANCE MONITORING AND EVALUATION

- General Acute Admissions - received quarterly as a System Level Measure.

**Impact on Long Term Conditions**
- Where Long Term Conditions are recorded and can be attributed to individuals and groups, the Ministry of Health will do so e.g. Virtual Diabetes Register, cardio-vascular disease risk assessments, cancer registry, prevalence of the conditions tracked by the NZ Health Tracker.

**Impact on patient experience (proxy for quality of care):**
- Perceived affordability of primary care services – received yearly from New Zealand Health Survey, weekly from Primary Care Patient Experience survey,
- Inability to get a primary care appointment in 24 hours - received yearly from New Zealand Health Survey, weekly from Primary Care Patient Experience survey,
- Patient rated quality of visit, e.g. overall experience, GP good at explaining conditions and treatments, GP involves you in decisions about - received yearly from New Zealand Health Survey, weekly from Primary Care Patient Experience survey.

We will consider creating a measure, or small set of measures, regarding perceived value of primary care services. This could help explain cultural, age, and income related trends in primary care utilisation (e.g. Maori have relatively high ED and A&I rates, but low GP consultation rates even when accounting for income, could this be because of a cultural “under-valuation” of GP services?).

People’s health at the time of GP visits can be an important factor in understanding the value of a marginal increase of GP utilisation at an individual level. Should individual utilisation and relevant clinical data be made available, the Ministry of Health will investigate a practical measurement for general health.

**Workforce and consumer evaluation of implementation (conditional on departmental funding):**

Should funding allow: In-the-field interviews with staff and consumers could be used to assess success of implementation, identify pressures and barriers to optimal implementation, assess workforce experience of care provision, and to qualitatively test the theory of intervention against empirical findings. This will be completed in two tranches – one tranche of qualitative analysis completed six months after implementation, and the other tranche completed after 18 months.

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

The overarching framework for evaluation for the primary care initiatives addressing financial barriers to care will apply to this bid and is described in this section of the initiative “Cutting General Practitioner fees by $10 a visit”. This section has been reproduced verbatim below:

How would agencies ensure that there are effective feedback loops in place to inform continuous improvement?

This will be achieved through quarterly reporting. Reports will be shared with PHOs.
### 4.3 PERFORMANCE MONITORING AND EVALUATION

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>Is funding being sought for evaluation?</td>
<td>Funding will be provided within departmental expenditure, and will be allocated in accordance with the Ministry of Health prioritisation processes.</td>
</tr>
<tr>
<td>C. Describe the method proposed to evaluate the impact of the initiative [if appropriate].</td>
<td>The overarching framework for evaluation for the primary care initiatives addressing financial barriers to care, is described in this section of the initiative “Cutting General Practitioner fees by $10 a visit”. This section has been reproduced verbatim below: A theory based evaluation is proposed to understand the key factors, monitor the outcomes, and measure the impact of the initiative. Theoretical assumptions based on previous national experiences and on international literature need to be tested. Ideally, the evaluation will involve stakeholders throughout the process from design to results, and include a post implementation and process review (leveraging the expertise of sector personnel), outcomes monitoring, and impact assessment. External consultation will be conditional on available departmental expenditure. The evaluation will apply a range of mixed research methods, including administrative data analysis, pre and post implementation comparisons, cost benefit analysis, and (should funding allow) stakeholder interviews, to deliver evidence for decision making. An attempt will be made to establish counterfactual groups, including propensity score matching. Potential risk in the evaluation includes: confidentiality associated with medical data, quality of data, lack of information on the health service provider capacity status, and insufficient internal evaluation capacity (resource) in leading/managing evaluation contracts and projects.</td>
</tr>
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</table>

### 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?