

Service Coverage Schedule

2015/16

Version 1.1 (for print) (16 June 2015)

This copy of the Service Coverage Schedule is released subject to endorsement by the Minister of Health in accordance with Crown Funding Agreement requirements.

This document is also subject to ongoing updates

This document is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability (NZPHD) Act 2000.

Updates in Version 1.1

- Admin update numbering chapter 3
- correction of emergency transport – aligned with transport wording in maternity section
- added reference to national transport destination policies in 4.4 ambulance schedule
- corrected primary care schedule for free services for children under 13 years
- clarified oral health schedule for fluoridation and adolescent coordination service.

Previous updates (since draft version 1.2 (8 January 2015))

- includes updates on Immunisation services and on primary care and pharmaceutical services for under 13s
- updated blood services

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1 Purpose and principles of service coverage information

The purpose of including service coverage information within, but not limiting it to, the Crown Funding Agreement (CFA) is to allow the Minister of Health (the Minister) to explicitly agree to the level of service coverage for which the Ministry of Health (the Ministry) and district health boards (DHBs) are held accountable.

The Minister is ultimately accountable to Parliament and to the taxpayer for the use of public funds to fund the health service cover for the people of New Zealand. The Minister has the final decision rights over service coverage.

This Service Coverage Schedule (SCS) is released subject to endorsement by the Minister in accordance with the CFA requirement. The SCS is updated annually.

1.1 Definitions of terms used

Throughout the Service Coverage Schedule, the following terms are used with the meanings set out below:

- ‘responsible funder’ is the party/parties that determine the service mix
- ‘funding’ refers to the exchange of dollars for delivery of health and disability support services
- ‘service mix’ is the specific quantity and type of services that are used to meet the service coverage
- ‘Ministry funded’ refers to services funded by the National Health Board business unit of the Ministry.

1.2 Responsibility for ensuring delivery of service coverage expectations

Responsibility for service coverage is spread across DHBs and the Ministry and is determined by the party responsible for establishing service mix.

DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high needs groups. This responsibility applies whether services are funded directly by the DHBs or by the Ministry.

Where funding responsibility for services has not been devolved to DHBs, the Ministry is accountable for making service mix decisions and for ensuring delivery of service coverage, in collaboration with DHBs.

Gaps in service coverage can be related to issues of either funding or service delivery or both. The Ministry and DHBs should work together to ensure resolution of service coverage gaps.

It is the responsibility of funders to decide whether additional levels or standards are or can be funded or provided from the available funding.

1.3 Service coverage information

Service coverage information describes how Government policy is to be translated into the required minimum level and standard of services to be made available to the public. In most instances, the range of services to be funded will be described, but not the way they should be funded.

1.3.1 Service coverage information

Service coverage information should include the:

- range of health and disability support services
- coverage of and/or terms of access to those services
- user charges (if any)
- standards for safety and quality
- particular process requirements indicated by the Minister (such as implementation of booking systems and Second National Mental Health Strategy and Blueprint).

1.3.2 Circumstances where more service coverage information detail is required

More detail of the range of services, including their terms of access, quality and safety standards and/or method of funding, is required in the following circumstances:

- when close government interest exists and action is being taken, for example, because of:
 - significant reprioritisation, transition or policy development
 - funder or system performance shortfall
 - requirements to undertake the provision of a service in a particular manner
 - DHBs asking to have the service specified in more detail
- when there are other related developments such as:
 - changes in legislation
 - specific safety requirements to protect the health of the public or consumers
 - user charges or levels of subsidy for services.

2 Key principles underlying the funding of services

2.1 Eligibility criteria applying to publicly funded services

The Ministry and the DHBs will fund services for eligible people according to the obligations set out in this document. A full description of the eligibility criteria applying to funded health and disability services is set out in the Health and Disability Services Eligibility Direction 2011 (Eligibility Direction) issued by the Minister. The Eligibility Direction is available publicly on the Ministry website¹ along with a range of other supporting material and tools, including an electronic guide to eligibility.

All sections of the SCS, unless specified otherwise, apply to eligible people only.

Additional purchasing criteria (such as those applying to acute treatment for ineligible people) may be found in individual CFAs.

2.2 Availability of publicly funded health and disability support services

The obligations of responsible funders outlined in this document represent population-level expectations, and generally do not confer individual entitlements to services. Levels of access to services are determined clinically, and are based on principles of levels of need and ability to benefit.

The availability of publicly funded health and disability support services and the level of services to be funded (service mix) will be determined in line with the requirements outlined below. These requirements ensure that rationing decisions are made to enable the maximum benefit from the funding available.

- Access to services will be determined on a fair and reasonable basis, and subject to generally accepted clinical protocols.
- Priority for access will be granted on the basis of need, ability to benefit and/or an improved opportunity for independence for those with a disability. The responsible funder will, where appropriate, target delivery of services to those groups with poor health status and those who are most likely to benefit.
- The responsible funder will ensure people have reasonable access to services as close as possible to where they live, taking into account the geographic location of where they live and the nature of the service to which access is required.
- When determining the availability of funded services, the responsible funder will consider and accommodate the needs of people in remote areas in the most practical, efficient and clinically safe way.

¹ www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services

- If a patient chooses to supplement the volumes of consumables prescribed and funded by the DHB, it is up to the patient to fund the additional consumables that they wish to have. There is no provision for part funding by the patient for their preferred consumable product.

2.3 Funding

Funding for services will not duplicate the services that are already funded by DHBs, the Ministry, the Accident Compensation Corporation (ACC), other accident insurers or other government agencies.

Publicly funded inpatient services, as well as day patient, services and any community-referred services provided in the hospital setting, are provided to eligible people free of charge. This includes all the services and supplies associated with the hospital treatment.

Services for which co-payments have been agreed are dental, orthotic and pharmaceutical services (refer to the individual schedules for the details). Providers of services which are permitted to charge co-payments must inform the client of the co-payment prior to commencing the service.

No co-payment will be sought from service users for supplies and equipment unless permitted under current Crown Funding Agreement and Service Coverage Schedule for the Provision of Equipment and Modifications and other Services and Supplies (T1 Community Health, Transitional and Support Services).

If a DHB wishes to fund services that are explicitly identified as excluded from the national minimum service coverage, the DHB must request a formal exemption from service coverage requirements from the Ministry.

2.4 Prioritising the funding of services and managing service risk

2.4.1 Deciding priority for publicly funded services

The Ministry and DHBs have a set budget provided by the Government from which they fund the services that are deemed to meet the minimum needs of New Zealanders.

There is a system for deciding on priority for publicly funded services that endeavours to balance values and principles, equity, effectiveness, value for money, and *whānau ora* against the pressure of infinite demand for more and better services. Funders should be guided by the principles outlined in *Evaluation of the District Health Board – Ministry of Health Prioritisation Framework*² (Ministry of Health 2004) and the related information in the Operational Policy Framework (OPF).

The Ministry and DHBs will comply with their funding obligations as described in this document by prioritising within and between services, and within and between population groups, within the constraints of statutory requirements such as the Mental Health (Compulsory Assessment and Treatment) Act 1992.

² <http://nhc.health.govt.nz/publications/nhc-publications-pre-2011/evaluation-district-health-board-ministry-health>

2.4.2 Requests for specific variation to the national minimum service coverage requirements

If the obligations are unsustainable, the responsible funder will identify the areas where reprioritisation is necessary.

A DHB or the Ministry can request a specific variation to the national minimum service coverage requirements. Such a request will be considered as part of the Annual Plan and/or CFA process. Variations or exemptions must be publicly transparent and shall be recorded in the accountability documentation with a clear reasoning for their existence and a time-bound review, resolution or improvement path.

2.4.3 Service coverage gaps must be reflected in DHB Annual Plans

All service coverage gaps affecting the DHB's population should be acknowledged in the DHB's Annual Plans. Supporting material for each service coverage gap should include either a workout plan for managing resolution of the gap identified within the period of the Annual Plan, or background material supporting an exception to service coverage for the period of the Annual Plan.

Where the gap is to be managed within the period of the Annual Plan, the DHB will be required to report on progress towards resolution of the gap through the service coverage measure in the DHB's performance measures.

New policy expectations that are agreed during the course of the year and that impact on service coverage will be implemented through a variation to the CFA.

2.4.4 The Ministry and DHBs have the responsibility to manage service risks

Strategies used to manage service risks include:

- working with clinicians and consumers (specifically Māori and Pacific peoples and users of mental health services) to develop best practice guidelines
- developing criteria governing the use of extremely high-cost treatments
- working with other government agencies to ensure coordination of services to identify and address policy and service risks
- collaborating with other DHBs and the Ministry nationally and, where appropriate, regionally, to ensure coordinated planning, funding and delivery of publicly funded health services and to collectively manage risks to public health
- collaborating with other DHBs to ensure the coordinated planning, funding and delivery of mental health services and services for Māori.

2.5 The Government's health priorities for Māori

*He Korowai Oranga: Māori Health Strategy*³ supports the Ministry of Health and DHBs to reduce health disparities and achieve health equity required by the New Zealand Public Health and Disability Act 2000. DHBs should consider He Korowai Oranga in their planning, and in meeting their statutory objectives and functions for Māori health.

He Korowai Oranga places an emphasis on the importance of leadership in achieving health equity and working in partnership with Māori for the future.

He Korowai Oranga sets the overarching framework to achieve the best health outcomes for Māori. Pae Ora - healthy futures is the Government's vision for Māori health that provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life. Pae Ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high quality, effective services. Pae ora includes three interconnected elements: Mauri Ora - healthy individuals, Whānau Ora - healthy families and Wai Ora - healthy environments.

The elements, directions, key threads and pathways of He Korowai Oranga are the health system's guide to improving Māori health and realising Pae Ora - healthy futures. The four pathways tell us how to implement He Korowai Oranga and include:

- supporting whānau, hapū, iwi and community development
- supporting Māori participation at all levels of the health and disability sector
- ensuring effective health service delivery
- working across sectors.

The Ministry and DHBs will ensure that mainstream services are effective for Māori and work to improve access for Māori, particularly for primary health care services. DHBs will allocate resources to reduce health disparities and achieve equity for Māori. DHBs will continue to identify and account for Māori health funding. This will involve identifying the expenditure targeted at reducing health disparities and achieving equity for Māori, which includes identifying funding for: Māori providers, Māori workforce and provider development, Māori targeted services across mainstream services, and resource allocation for intersectoral initiatives to improve Māori health.

Building Māori health providers' capacity and capability is also an important strategy for improving Māori health status. The Ministry and DHBs will continue to support accelerated development of the Māori health workforce at all levels of the health sector.

³ <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga>

2.6 Services to meet the needs of Pacific peoples

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 sets out the Ministry's priority outcomes and actions that will contribute to achieving better health outcomes and reduce health inequalities for Pacific peoples.

To ensure systems and services are effective for Pacific peoples, DHBs with significant Pacific populations will engage Pacific communities in DHB development and planning processes in order to allocate resources to reduce inequalities and improve health outcomes for Pacific peoples.

The Ministry and DHBs will ensure that all services are responsive to and effective for Pacific peoples, taking account of the health status as well as the linguistic, cultural and social characteristics of Pacific communities.

The Ministry and DHBs will progress towards addressing the broad determinants of health through intersectoral collaboration and the coordination of health services for Pacific peoples. A priority of the intersectoral collaboration is to improve access to all services, particularly primary health care services, for Pacific peoples

Funders will build the capacity and capability of Pacific providers' and support the growth and development of the Pacific health workforce at all levels of the health sector using Pacific expertise through supporting and co-designing responsive initiatives with Pacific expertise.

Funders will support the Health Workforce New Zealand strategy to respond to the changing needs of the health system and contribute to the development of the Pacific health workforce at all levels of the health sector.

2.7 Health emergency coverage

DHBs are responsible for being prepared to respond to health emergencies within their region, and for supporting other DHBs when there is a local emergency.

DHBs must ensure that essential health services – such as ambulance, primary health care, hospital services, mental health, disability support, aged residential care and public health services – will continue to be delivered during health emergencies, civil defence emergencies, large casualty-causing incidents, major weather events, infrastructure failures and natural disasters.

DHBs are required to maintain adequate stocks of reserve supplies of antibiotics as agreed with the Ministry of Health.

3 Specific services with transitional issues in 2015/16 and out years

Public health

3.1 Public health services

Core public health services are defined in an overarching, tier one service specification (issued in February 2014). The tier one specification was previously supported by 13 issues-based tier two service specifications.

The supporting 13 tier two service specifications were revised during 2014, and consolidated into five new, functions-based tier two service specifications that will be available for use in 2015/16. It is expected that 2015/16 will be an interim period during which providers will begin to transition to the new suite of revised tier two public health service specifications. During 2015/16 there may also be further updates of some of the associated tier three specifications.

3.2 Tobacco control

'Better help for smokers to quit' is one of the Government's six health targets aimed at encouraging and then supporting people to stop smoking. Stop smoking services are critical in assisting smokers to quit and are one of the core components of the overall tobacco control programme. DHBs are focusing the efforts of the health sector to better meet the needs of smokers to quit. The Ministry will continue to fund the majority of specialised cessation services; in main, those provided by the Quit Group (the national telephone stop smoking service) and Aukati Kaipapa providers (intensive face to face stop smoking services targeted at Māori).

In association with some PHOs, DHBs are taking an increased role in planning, coordinating and funding stop smoking activities in their districts to meet the needs of their populations. This is important, given the Government has an overarching aspirational goal of working towards a Smokefree Aotearoa by 2025, which will increase demand for support to quit services. Coordinated effort across the health sector will be required to meet this demand.

Child and youth

Health services for Children and young people are summarised at the start of chapter 4.

3.3 Gateway (Health and Education) Assessment Programme

The Gateway Assessment Programme is a comprehensive health and education assessment programme for children and young people engaged⁴ with Child, Youth and Family (CYF), a business group within the Ministry of Social Development. The Ministry of Health, Ministry of Education and CYF have collaborated on policy to support the programme, and report at ministerial level on joint outcomes.

The overall objective is to enhance the child or young person's physical, mental, educational and social wellbeing by identifying unmet need and referring them to services to address these needs.

CYF contracts with all DHBs for this service, and the Gateway Assessment Programme is described in Appendix 3.

3.4 Youth health services

The continued implementation of school-based health services in decile 1 to 3 secondary schools, teen parent units and alternative education facilities is a priority and a key element of improving access to health care for young people. The Ministry expects that school-based health services will be an integral part of DHB youth health plans.

While most youth access general practice services, barriers such as cost, assured confidentiality, opening hours and access to services are significant issues. DHBs will work with primary health organisations (PHOs) and primary health care networks to make general practice youth friendly and responsive to the particular needs of young people (see Schedule Primary health care services).

Since the release of the *Evaluation of Youth One Stop Shops* (Ministry of Health 2009a), the Ministry of Health and DHBs have been working with the Youth One Stop Shop (YOSS) network to address service improvement issues such as YOSS governance, workforce development and quality issues. To support a sustainable source of youth-friendly health and social services, DHBs will engage with youth service providers, including YOSS, in the locality planning process and facilitate relationships in the primary health care network to initiate and enable interagency collaborative and long-term strategic planning for youth services.

⁴ Children and young people entering care, in care, or being referred for a care and protection family group conference.

3.5 Immunisation programme

In addition to the Year 8 immunisation information, Year 7 immunisation information is also recorded on the National Immunisation Register. For DHBs choosing to use the School Based Vaccination System (SBVS), which is owned and operated by the DHBs under the same privacy and governance frameworks that apply to the National Immunisation Register, please note that since December 2012, IT support for the SBVS programme has been the responsibility of the individual DHBs.

To ensure that the school-based programme is delivered in a consistent, safe and effective manner, the DHBs will plan and deliver their school-based programme as outlined in the Ministry's 2008 school-based standards and in the Immunisation Handbook (Ministry of Health 2014).

In the event of a disease outbreak situation, the Ministry, from time-to-time, may ask DHBs to deliver immunisation programmes through schools.

By June 2016, a minimum of 90 percent of those aged 5 years will be fully immunised.

The DHB will introduce strategies to increase coverage rates of HPV vaccination in girls to 65 percent coverage for dose three by the end of December 2015.

3.6 Children's Action Plan

The Vulnerable Children Act 2014 (the Act) forms a significant part of comprehensive measures to protect and improve the wellbeing of vulnerable children and strengthen our child protection system. The Act provides a framework for professionals from different sectors (eg. health, education and social sectors) to work better together to help children. By breaking down barriers to information sharing and cross-sector working, and brokering more targeted service provision, children will get better coordinated access to services they need, and improved social and health outcomes. Children's Teams are a key part of how the Children's Action Plan will be delivered locally. In 2014/15 Children's teams were trialled in two DHB regions, in 2015/16 Children's teams will operate in 10 regions. See Appendix 4.

Other services

3.7 Physiotherapy services to ACC clients

On 15 November 2009 ACC stopped funding free treatment to people needing physiotherapy after accidents, and reduced the amount paid to providers. On 16 November 2009, private providers began charging patients a co-payment. Until further notice DHBs with an ACC physiotherapy contract are not to institute co-payments for physiotherapy services to ACC clients.

3.8 Maternity services

From the 2015/16 year the Ministry expects DHBs will provide pregnancy and parenting education services to a minimum of 30 per cent of pregnant women of each population group, defined as: Māori, Pacific Peoples, Asian and Other.

3.9 Diagnostic services

A programme to reduce waiting times for diagnostic services commenced in 2011/12. DHBs are required to report waiting time information on a number of key diagnostic modalities – colonoscopy, coronary angiography, computed tomography (CT) and magnetic resonance imaging (MRI). A monitoring and reporting framework supports collection and management of performance data. There was an initial developmental period, and from 2014/15 diagnostics has continued as a priority area. Waiting time indicators are agreed annually with performance monitored formally on a quarterly basis (data will continue to be provided monthly). There will be continued focus on providing support to clinical groups to lead the necessary service improvements.

Improving equity

DHBs will work to improve the equity of access to diagnostic services. DHBs will have in place, and maintain, effective systems to support them to make decisions around the priority, order and urgency of people's access to diagnostic services.

National patient flow system

DHBs will support and contribute to the development of the National Patient Flow system, designed to capture information on end-to-end patient pathways, including diagnostic services. DHBs will collaborate with the national work programme through a phased approach, and integrate local systems as required.

3.10 Oral health service coverage – hospital dental services

The Oral Health Clinical Leadership Network has reviewed the provision of hospital dental services and provided a report to the Ministry highlighting significant inconsistency of access to hospital dental services between DHBs (*Improving Oral Health Services of High Needs and Vulnerable Populations*). The Network developed a service eligibility matrix to clarify which patients should have priority of access to hospital dental services. The service eligibility matrix provides a tool for DHBs to benchmark their service against, and may assist them to enter into regional arrangements to improve consistency of access to services. This information was circulated to all DHBs in October 2013.

The Ministry and the Oral Health Clinical Leadership Network would like to see the service eligibility matrix, or a variation of it, embedded within sector planning and accountability arrangements and will work with DHBs during 2014/15 to facilitate this. The Ministry may seek additional information from DHBs about hospital dental service provision so that consistency of access to services can be measured.

3.11 Organ transplantations

The payment formerly made to a DHB when organs are retrieved from a deceased donor in a DHB intensive care unit (ICU) for use in transplantation, has been discontinued as these operational costs are included in casemix.

Transplant coordination services

Organ Donation New Zealand provides a range of services, both to support the process of organ donation and to educate staff about deceased donation. Its coordination activities will be expanded in coming years, following the Budget 2012 announcement of increased funding for

deceased organ donation, to include some support for ICU staff time for activities relating to organ donation in ICUs.

3.12 Pharmaceutical service coverage

From 1 July 2012, under the Community Pharmacy Services Agreement, a new service and funding model is being implemented over three years, but this will not alter pharmaceutical service coverage.

From 1 July 2015 the prescription rule for free prescriptions for subsidised medicines for children under six years is being extended to young people under 13 years old. Also the age between which a service user can be charged a maximum co-payment of \$10 per prescription item is now between 13 and 17 years of age.

3.13 Disability Support Services new model programmes

The DSS Group has developed a new model for supporting disabled people that is currently being demonstrated in the eastern and western Bay of Plenty. The elements of the new model are:

- the local area coordinator, who works with disabled people and their families to provide information and support them to plan and connect to their communities
- a new funding allocation process and tool, which the DSS Group is testing to provide people with a personal budget (rather than services) that they can use to purchase most types of support (within purchasing guidelines) through individualised funding
- a demonstration in the Waikato and Auckland called Choice in Community Living. Under Choice in Community Living, people will be supported to move from residential services, where they live in a home owned or rented by their support provider, to a home of their own. The demonstrations are being evaluated before deciding whether to move the model into other areas of the country.

3.14 Fracture liaison service

DHBs must deliver high-quality secondary preventative care for fragility fracture sufferers (through identification, investigation and intervention) to prevent future fractures.

3.15 Suicide prevention

DHBs are expected to coordinate suicide prevention activities. This includes implementing a district suicide prevention plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention and, when necessary, implementing a suicide postvention plan and a coordinated response to suicide clusters/contagion. Activities will support implementation of the *New Zealand Suicide Prevention Strategy 2006–2016* (Associate Minister of Health 2006), the *New Zealand Suicide Prevention Action Plan 2013–2016* (Ministry of Health 2013a) and any other guidance/toolkits provided by the Ministry.

3.16 Exclusion of Cardiac interventions from SCS

The Minister has agreed with the National Health Committee's recommendation that from 1 July 2014 the following cardiac interventions are excluded from the national minimum service coverage requirements: renal artery denervation for patients with refractory hypertension; percutaneous interventions for mitral regurgitation; percutaneous left atrial appendage occlusion for the treatment of atrial fibrillation.

4 Individual service coverage schedules

General operational service delivery mechanisms

Service specifications are the operational service delivery mechanism for service coverage. Where service specifications are nationally agreed, consistency of service is maintained through the National Service Framework (NSF).

The NSF service specifications and related information are published on the NSF Library website.⁵

Not all services funded by the Ministry of Health have their service specifications available on the NSF Library. In particular, Disability Support Services Service Specifications are available on the Ministry's website.⁶

Services are funded and delivered according to nationwide service specifications as stated, unless variations and exceptions are explicitly agreed through DHB CFAs.

In addition, responsible funders have agreements with their service providers that describe the range of services to be funded, the outcomes desired and the quality requirements of those services.

Services and programmes impacting on or related to several schedules are described in appendices one to four.

⁵ www.nsf.health.govt.nz/apps/nsfl.nsf/menumh/Service+Specifications

⁶ www.health.govt.nz/our-work/disability-services/contracting-disability-support-services/contracts-and-service-specifications

Summary schedule: health and support services for children and young people

This summary schedule collates the range of key health and support services for children and young people that are described in detail throughout this document.

Health and support services for children and young people are delivered in a variety of settings across a DHB's district to provide for needs of its local population. The types of services funded recognise individual circumstances, cultural preferences and service configurations available within the DHB's district. The service delivery ranges across the spectrum of health promotion and prevention, primary care, community and hospital services.

Although the national picture of health is positive, there are substantial variations in outcomes for different populations, particularly for Māori and Pacific peoples. For example, rates of some illnesses (such as rheumatic fever and skin infections) are much higher among Māori and Pacific peoples. As the New Zealand population is becoming more diverse, the health system recognises the need to be flexible to meet changing needs for and expectations of services.

The Government's Better Public Services goal envisages that people will be able to access services when they need them and that those services meet the needs of different population groups. One of the key ways to deliver better public health services is through integrated care. This involves careful coordination of patient care between different service providers and professions, often away from hospital, in patients' homes and communities. An example is maternity and child health services working alongside or with families and whānau, and other social services where necessary, to provide a seamless, consistent, network of coordinated care for pregnant women and for children.⁷

Transition to adult care

DHBs are responsible for ensuring that eligible young people aged from 14 to 24 years who require assessment or ongoing treatment for a medical or surgical condition, or are in transition to adult services (especially those with long-term conditions or disability or who require palliative care) must be able to access developmentally appropriate services. Pathways for transition to adult care will be developed and implemented for those children who require them. Core components of such a service include:

- identification of eligible children and young people
- development of an agreed care pathway for each clinical group of young people
- identification and/or development of a clinical service for young people to transition into
- transition plans agreed between the services and the child or young person with or without their family
- monitoring of the effectiveness and acceptability of the pathway.

Criteria for publicly funded treatment

Refer to the Eligibility Direction⁸ for detail on the eligibility of children for publicly funded health services (also see section 2.1).

⁷ For the funding chart on the services for children from 0–6 years, see www.health.govt.nz/our-work/life-stages/child-health/new-zealands-maternity-and-child-health-services-preconception-6-years.

⁸ www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services

The following services provide universal access for children. Refer to the respective sections below and the nationwide service specifications for more detail: well child/ tamariki ora, immunisation, newborn screening, child and adolescent oral health services

Access to health services for children and young people will meet the availability requirements set out in section 2.2.

DHB funded

DHB funded child and youth health services are provided for children and young people from birth up to the age of 18 years, although it may be appropriate in some circumstances for this age to be extended to up to 25 years. DHB-funded services include a range of community and primary health care services, inpatient and community-based mental health services, hospital core paediatric services, support services and disability services for children and young people. Note: Services for young children may be delivered through their parent or guardian (eg, parenting services for children with behavioural problems).

Ministry funded

The Ministry funds additional programmes and services for children and young people, sometimes in conjunction with other government agencies. These additional programmes are listed below under 'Other programmes for children and young people'.

Accommodation of children and young people as inpatients

The appropriate placement of a child or young person should be decided by clinical staff in discussion with the child or young person and their parents/guardians in the context of their developmental stage, clinical needs and availability of appropriately trained staff. In general, children should not be placed on adult wards (and vice versa), as this is developmentally inappropriate and is likely to be psychologically unsafe. If for any reason a child cannot be accommodated in an appropriate ward, the child must have paediatric-trained staff (medical and nursing) caring for him or her, should be physically separated from adults in the ward and should be relocated to a suitable location as soon as possible.

Article 37(c) of the United Nations Convention on the Rights of the Child (UNCROC) states that "Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances."⁹

Specific mandatory requirements for some health services are detailed in the nationwide service specifications published on the NSF Library website.¹⁰ The tier one service specifications for specialist medical and surgical services, and services for children and young people summarise the generic requirements for a range of services for children and young people.

⁹ New Zealand ratified the United Nations Convention on the Rights of the Child in 1993. The full convention is available here: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>

¹⁰ www.nsf.health.govt.nz/apps/nsfl.nsf/pagesmh/468

Range of services

Key services for children and young people are summarised below. More detailed information relating to each service is provided in the corresponding schedule in this document, or in specific service specifications, as follows.

Schedule 4.3: Disability support services

The DSS schedule details the supports provided to children and young people with disabilities and their families, whānau, aiga and carers. Generally people must be assessed by a Ministry-contracted Needs Assessment and Service Coordination (NASC) service or, where eligible, through a National Intellectual Disability Care Agency (NIDCA). Some children and their families may access child development services or assessment, treatment and rehabilitation services via health referrals, and as a result may access services without going through the NASC process.

Schedule 4.6: Immunisation services

All children are eligible to receive vaccinations listed on the National Immunisation Schedule.

Immunisation services include, but are not limited to, the following publicly funded immunisations:

- newborn and early childhood immunisation programme mainly delivered through general practice
- school-based immunisation programme
- influenza immunisation programme
- outreach immunisation services
- targeted immunisations programmes for some groups of children at high risk of certain diseases due to other medical conditions or high risk of exposure, including vaccination against tuberculosis, influenza and hepatitis A and hepatitis B, and the pre-post splenectomy/functional asplenia programme.

Schedule 4.7: Long-term support services

DHBs support the development of an 'integrated continuum of care' for children and young people with chronic health conditions and with long-term support needs. This requires that appropriate and effective clinical and support services are in place, which link with each other and are designed around the needs of the clients, their families, whānau, aiga and carers. Examples of such services are support packages for families caring for medically fragile children that take account of the whole family's needs, including the needs of siblings, and Ministry - funded child development services.

Schedule 4.8: Maternity services

Maternity services are provided to women and their families throughout pregnancy and childbirth and for the first six weeks of a baby's life.

Schedule 4.9: Mental health and addiction services continuum

For the strategy on child mental health, see Section 5 of the Mental Health and Addiction Service Development Plan (Ministry of Health 2012b).

Mental health and addiction services for children and young people are available up to and including the age of 19 years, and adult services are available from age 18 years – this overlap is managed according to the clinical and developmental needs of the consumer. Some flexibility will be allowed to manage the transition between child and youth services and adult services through to 25 years in order to best meet the needs of the young person. Perinatal and maternal mental health services are also included.

Children and young people have access to the same range of services as the adult population. However, those services are provided in a manner and setting that are safe and developmentally appropriate; ideally, services for children and young people should be separate from services for adults unless a different arrangement is in the best interests of any particular child or young person.

Schedule 4.10: Oral health services

Preventive, educative and treatment dental and oral health services are available for all preschool and primary school aged children and a specified range of dental services for adolescents under the age of 18 years.

Schedule 4.11: Palliative care

Guidance for Integrated Paediatric Palliative Care Services in New Zealand (Ministry of Health 2012) provides guidance for delivery of palliative care service to children and young people.

Schedule 4.12: Pharmaceutical Services

Prescriptions for subsidised medicines are free for children under 13 years of age.

Schedule 4.13: Primary health care services

Assessment, diagnosis and treatment of acute and long-term conditions by primary health care services are available for children and young people. All infants should be enrolled with primary health care, Well Child / Tamariki Ora and oral health services, and be placed on the National Immunisation Register, before they are two weeks of age. All young people should have access to primary health care that is responsive to the specific needs of youth.

Children and young people (under 18 years old), regardless of their citizenship or immigration status, are eligible for publicly funded Well Child / Tamariki Ora services, immunisation services, and primary prevention, promotion and protection services from birth.

Primary health care services for children and young people funded by the DHB or Ministry include, but are not limited to:

- Well Child / Tamariki Ora services such as hearing and vision tests, and Well Child checks which include the B4 School Check service
- essential primary health care services specified in the current PHO–DHB service agreement
- health assessment and treatment services to support at-risk children and adolescents and their families – for example, children and young people in the care of the State – and the Family/Whānau Support Service
- preschool and school health services such as: school based health services in decile 1, 2 and 3 secondary schools, teen parent units and alternative education facilities
- sexual and reproductive health services
- primary mental health promotion, education, diagnosis and treatment.

Cost

Long-term support services and disability support services are provided at no charge for children under 16 years old or until they qualify for a supported living payment. Children with disabilities may have their own Community Services Card, giving them access to subsidised health services.

PHOs provide access to essential primary health care services at low or reduced cost to their enrolled populations according to fees that they notify to the DHB in accordance with the Fees Framework – level policy and charges to services users included in the current PHO–DHB service agreement.

Children up to 13 years of age are eligible for free general practitioner (GP) visits and after-hours visits.

Schedule 4.14: Provision of equipment, modifications and other supplies and services

The Ministry and DHBs fund equipment, modifications and other supplies and services for disabled people to promote their independence, maintain and improve levels of mobility, enable them to remain in or return to their home, and support and maintain their access to education, vocational training and employment.

Schedule 4.15: Public health services and prevention services

Public health services primarily focus on populations or specific groups of people in specific settings, such as students in a school setting, not individuals. However this boundary is blurred, and interventions arising out of a public health programme, such as throat swabbing for rheumatic fever, may still be undertaken by public health nurses if this is the most effective and efficient model of care.

Prevention services are those that aim to stop people becoming ill. For example, the National Immunisation Register contributes to the prevention of key childhood illness by supporting health professionals to share information so that the right immunisations can be delivered to the right children at the right time.

Screening in child and youth health

There are a number of screening programmes and opportunistic screening interventions offered to children and young people. Organised screening programmes include newborn screening for metabolic disease, hearing loss screening, vision and hearing screening, and strengths and difficulties screening at four years of age.

Schedule 4.16: Specialist medical and surgical services

Specialist medical and surgical services for children or young people are usually provided in, or from, a hospital following a medical emergency or an accident, or after referral from an approved specialist or primary health care referrer, or another DHB. Where medical services are delivered in a hospital setting, they are traditionally provided for children and young people up to 14 years of age, but this is not a firm cut-off, and the upper limit may be extended on clinical grounds up to age 24 if appropriate safeguards are in place.

Other programmes for children and young people

Vulnerable Children – Children’s Action Plan (see Appendix 4)

Children’s Teams are a key part of how the Children’s Action Plan will be delivered locally. Children’s Teams work to ensure vulnerable children are kept safe before they come to harm so they thrive, achieve and belong¹¹. There is an expectation that DHBs will be active participants in the implementation and operation of local Children’s Teams in their regions.

Children’s Teams represent a new and different way of working. Putting children at the centre of everything we do means that providers from across the health, education and social sectors need to work through how best to work together to achieve better results for vulnerable children and their family/whānau.

DHBs will support the Ministry’s contribution to the implementation of local Children’s Teams in the following ways

- Service delivery and coordination that meets the needs of vulnerable children and their family/whānau:
- participate in local Children’s Team governance
- collaborate with other agencies to plan, test and monitor assessment processes to support early response systems, assessment processes and service coordination for vulnerable children
- develop effective referral pathways to/from Children’s Teams and primary and secondary health services.

Specific programmes for vulnerable children (see Schedule 4.16)

DHBs deliver violence intervention programmes in acute and community health services, in particular: mental health, alcohol and drug; child health (including school and home visiting services and tertiary paediatric services); maternity; sexual health; and emergency department.

Interagency programmes – Gateway Assessments (see Appendix 3)

The Gateway Assessment Programme is a comprehensive health and education assessment programme for children and young people engaged¹² with Child, Youth and Family (CYF), a business group within the Ministry of Social Development. The Ministry of Health, Ministry of Education and CYF have collaborated on policy to support the programme, and report at ministerial level on joint outcomes.

The overall objective is to enhance the child or young person’s physical, mental, educational and social wellbeing by identifying unmet need and referring them to services to address these needs.

CYF contracts with all DHBs for the service.

Youth services (see paragraph 3.4 and Schedule 4.13)

DHBs will engage with youth service providers (including YOSS), other primary health care and community health providers, and other social services agencies, to ensure youth services are

¹¹ Implementation of Children’s Teams is well underway with 10 teams operational by 30 June 2015: Rotorua, Whangarei, Horowhenua/Otaki, Marlborough, Hamilton City, Clendon/Manurewa/Papakura, Whakatane, Gisborne, Whanganui and Christchurch.

¹² Children and young people entering care, in care, or being referred for a care and protection family group conference.

provided in a planned and sustainable way. DHBs should support a range of sustainable youth-friendly health and social services, including:

- youth specific services as appropriate for the locality, which could include youth wellness hubs/networks, school-based health services or YOSS
- general practice that is responsive to youth.

4.1 Blood services

Range of services

DHBs will ensure the provision of blood, blood products and blood services include, but are not limited to:

- blood components and plasma-derived products for health services for people
- administration and transfusion
- informed consent, including provision of systems to document that the potential recipient has been informed of the benefits and potential risks associated with administration of the blood component or plasma-derived products
- monitoring the use of blood components and plasma-derived products
- reporting untoward events and adverse outcomes associated with transfusion to the New Zealand Blood Service (NZBS) Haemovigilance office.

The National Haemophilia Management Group (NHMG) is responsible for the management oversight of the coordinated services for people with haemophilia. Each DHB will ensure that recombinant Factor VIII and/or Factor IX products ('synthetic blood products') are able to be accessed for haemophilia treatment according to NHMG guidelines on the use of recombinant products in New Zealand.

Access

Doctors decide on the use of blood components and plasma-derived products in emergencies, and for the treatment of specific conditions like haemophilia and primary immune deficiency. In circumstances where a proposed treatment approach represents a significant move away from usual practice in terms of volume of product, clinical liaison with an NZBS transfusion medicine specialist is recommended.

Cost

Blood components or plasma-derived products are provided at no charge to all people requiring these products in New Zealand. NZBS has a list of national charges (which is reviewed each year) to DHBs for blood services and products. As set out in supply agreements between DHBs and NZBS, DHBs must pay NZBS for services and stock ordered, on invoice by NZBS.

Time

There is no waiting period for blood components or plasma-derived products in normal circumstances.

Other information

This service is accessible only because New Zealanders volunteer to donate blood, from which blood components and plasma-derived products are manufactured. All people who meet the NZBS's eligibility criteria are encouraged to donate blood.

4.2 Diagnostic, therapeutic and support services – personal health

This is a transitional schedule awaiting policy review; DHBs will be notified of any formal changes, including timeframes for implementation of those changes. Diagnostic, therapeutic and support services are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They do not include services described in other sections (eg, specialist medical and surgical services, DSS). Diagnostic, therapeutic and support services are provided by personnel who are not doctors (eg, dieticians, physiotherapists, laboratory technicians, medical radiation technologists and nurses).

The Ministry is working closely with DHBs to develop consistent national access criteria and standards for community services, and to remove discrepancies between what is available for people eligible for DSS and people who are not eligible for DSS but have an assessed need for support that may not be available within health services.

Range of services

Diagnostic, therapeutic and support services funded by the DHB include, but are not limited to:

- allergy testing
- assistance with daily living, including home help, personal care and meals on wheels
- audiology
- community nursing – both general and specialist services
- community oxygen therapy
- continence education and consumable services
- diagnostic imaging services (eg, X-rays, ultrasound scans), specifically including diagnostic mammography for symptomatic women
- diagnostic mammography for asymptomatic women regardless of age who have any of the following:
 - a previous breast cancer
 - a mother or sister with pre-menopausal breast cancer or bilateral breast cancer
 - a breast histology demonstrating an at-risk lesion (eg, atypical hyperplasia)
- positron emission tomography (PET) scans in line with national clinical indications
- dietary and nutritional counselling
- electro-diagnostic imaging (eg, electrocardiograms (ECGs) and electroencephalograms (EEGs))
- laboratory tests and services, including collecting, transporting and analysing specimens, and reporting results
- mortuary services
- occupational therapy
- physiotherapy
- podiatry services
- pre-implantation genetic diagnosis (PGD)
- speech language therapy
- social work
- stomal therapy services

- smoking cessation services.

In relation to the above services, each DHB funds all required materials, resources and health professional services as follows.

Mortuary services

DHBs must ensure the ongoing availability of services and facilities to appropriately support the provision of coronial and medical post-mortems.

In relation to laboratory services, if changes to service provision models are made, DHBs must ensure that the availability of forensic pathology services to support coronial post-mortems is maintained.

Smoking cessation services

The Ministry of Health currently funds the majority of smoking cessation services (eg, Quitline and Aukati KaiPaipa services). Note that some DHBs also fund local cessation services. This service may be provided by non-registered health care workers such as community workers.

Services related to diagnostic, therapeutic and support services covered in other schedules

- Support services associated with the long-term needs of people who meet the DSS definition of 'person with a disability' are addressed under Schedule 4.3: Disability support services.
- Support services associated with 'health and support services for older people' access criteria are addressed under Schedule 4.5 Health and support services for older people.
- Pharmaceuticals associated with diagnostic, therapeutic and support services are addressed under Schedule 4.12 Pharmaceutical services.
- Medical equipment and supplies associated with diagnostic, therapeutic and support services are addressed under Schedule 4.14 Provision of equipment, modifications and other supplies and services.
- Specific diagnostic modalities (CT, MRI, coronary angiography, colonoscopy) associated with the staged programme to reduce waiting times for diagnostic services are addressed under Schedule 3.9 Diagnostic Services.

Access

The referring health professional will make an initial decision about whether the service may be needed. With some services (eg, continence services), the client may self-refer for assessment.

Where a person using personal health services has been referred, for some diagnostic services, and most therapeutic and support services, the provider of the service to which the person has been referred will assess the person's need, and make the final decision about whether the service should be provided, and how urgently it is required. DHBs are expected to consider positron emission tomography (PET) scans on an exception basis for clinical indications outside of national clinical indications. Smoking cessation services may also be accessed directly by people who smoke.

Criteria for publicly funded treatment

The referring health professional determines which services will be requested according to their clinical judgement.

For some diagnostic service, and most therapeutic and support services, where a person using personal health services has been referred, the provider of the service to which the person has been referred will assess the person's need against predetermined eligibility and risk criteria contained in the service specifications.

Exclusions

Access criteria for some services vary around the country.

4.3 Disability support services

The New Zealand Disability Strategy (Minister for Disability Issues 2001) provides a framework that guides government departments towards a fully inclusive society for disabled people. It influences the way the Ministry develops and provides support for disabled people. To reflect the New Zealand Disability Strategy in its daily work, the Ministry's Disability Support Services Group, in consultation with consumers, developed a vision:

Disabled people can live in their home and take part in their community in the same way that other New Zealanders do.

Ministry-funded disability support services are services or products that, within available funding, assist disabled people to carry out their daily lives. This DSS service coverage schedule details the supports provided (where necessary) to disabled people and their families, whānau, aiga and carers.

Within Vote Health's agreed definition of disability,¹³ the Ministry is responsible for planning and funding DSS for people who have physical, sensory or intellectual disabilities, or a combination of these, and are generally aged under 65 years. A person's disability must be likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is needed.

There are three exceptions to this general rule.

- The Ministry funds environmental support services¹⁴ for people of all ages.
- The Ministry will continue to fund its clients, even if they are over 64 years, until they are assessed as requiring aged residential care, at which time the DHBs will take over funding responsibility.¹⁵
- DHBs fund services for people aged between 50 and 65 years who have been clinically assessed by a DHB and/or needs assessor as having health and support needs because of long-term conditions more commonly experienced by older people.

Services provided under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 are also funded by the Ministry.

Range of services

The Ministry funds a range of DSS. Generally, to access these services, people must be assessed by a Ministry-contracted Needs Assessment and Service Coordination (NASC) service or, where eligible, through a National Intellectual Disability Care Agency (NIDCA). Access to environmental support services, including equipment and modification services, is via a specialised assessment or an appropriate health professional. DSS may include, but are not limited to, the following features:

¹³ In Vote Health, disability support services support a person who has a physical, psychiatric, intellectual, sensory or age-related disability, or a combination of these, where the disability is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is needed.

¹⁴ Environmental support services include the provision of equipment and modifications (housing and vehicles), services and support for people with vision and/or hearing impairments, specified specialist assessment and training services, and specified subsidies and supports.

¹⁵ This was agreed as applying when responsibility for disability support services for people aged over 65 years was devolved to district health boards on 1 October 2003.

| Description of services | Service specifications / guideline documents |
|--|---|
| Inform people and their families, whānau or carers about available services and advise on access to services | Disability Information and Advisory Service Specification |
| <p>Assessment of individual needs</p> <p>Facilitated needs assessment through NASC organisations or for those eligible for high and complex services (civil population), through the NIDCA</p> <p>Offenders with intellectual disabilities are subject to the court-ordered timelines and procedures for determining access to services, which the NIDCA will carry out</p> <p>Service coordination¹⁶ to develop a package of services to meet an individual's prioritised assessed need, within available funding</p> | <p>NASC Service Specifications</p> <p>National Intellectual Disability Care Agency Service Specification</p> <p>Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines</p> <p>Operational Manual for Needs Assessment and Service Coordination Managers</p> |
| Individualised funding to enable eligible clients with disability-related needs to independently manage their support needs and budget | Individualised Funding Guidance Good Practice and Service Specifications |
| <p>Assistance with daily personal care activities (eg, dressing, bathing, eating and toileting)</p> <p>Assistance with household activities (eg, meal preparation, laundry, cleaning)</p> | Home and Community Support Services Service Specification |
| Carer support services (eg, carer support subsidy, respite care, carer training) | <p>Respite Care Service Specification</p> <p>Service specification for carer training</p> <p>Carer support guidelines for Ministry clients</p> |
| Day activities, primarily to assist people who have been reintegrated into community living under deinstitutionalisation agreements | Community Day Programmes Service Specification |
| <p>Rehabilitation and habilitation services, including:</p> <ul style="list-style-type: none"> • DHB-provided assessment, treatment and rehabilitation (AT&R) services • community-based rehabilitation services • child development services | <p>AT&R Service Specifications (assessment and planning service components)</p> <p>Child Development Service Specification (assessment and planning service components)</p> |
| Supported living | Supported Living Guidelines and Service Specifications |
| Residential support services (eg, community residential services and community residential placements in aged care facilities for younger people) | <p>Community residential support services specifications for people with physical or intellectual disability</p> <p>Community residential service within aged care facilities for younger people with lifelong disabilities specifications</p> |
| Autism Spectrum Disorder specific services | <p>NZ Autism Spectrum Disorder Guidelines</p> <p>Service specifications for Autism Spectrum Disorder specific services</p> |
| Behaviour Support Services | Behaviour Support Services service specification |
| Services for people with intellectual disabilities under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 | <p>Regional Intellectual Disability Supported Accommodation Service (RIDSAS) Service Specifications</p> <p>Regional Intellectual Disability Secure Care Service (RIDSS), Hospital-level Service Specifications</p> <p>National Intellectual Disability Secure Care Service (NIDSS, hospital high-level forensic assessment and secure beds) Specification</p> |

¹⁶ Service coordination assists the person with a disability to have their needs met from all appropriate supports that are available in the community, including, but not limited to, liaising with other government agencies such as Housing New Zealand and the Ministry of Education. In some cases, Ministry funding may be a component of the total support package. The Ministry will ensure that there are auditable boundaries between needs assessment, service coordination and other DSS.

| Description of services | Service specifications / guideline documents |
|---|---|
| <p>Funded Family Care – funding available to eligible adults with high and complex needs who are able to employ specific family members (excluding spouses) for assistance with:</p> <ul style="list-style-type: none"> • daily personal care activities (eg, dressing, bathing, eating and toileting) • household activities (eg, meal preparation, laundry, cleaning) | <p>Relevant notice under section 88 of the NZPHD Act 2000</p> <p>Home and Community Support Services Service Specification</p> <p>Funded Family Care Operational Policy</p> |

DSS-related services covered in other schedules

- For medical equipment and supplies, provision of equipment, modifications and other supplies and services, hearing and vision services, specialised assessment services, specialised assessor training and other support, see Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Disabled people should have access to the same range of health services as the rest of the general population, in a manner and setting that are safe and appropriate. This level of access includes people in residential care settings. Refer to the following service coverage schedules:

- 4.9 Mental health and addiction services continuum
- 4.11 Palliative care
- 4.12 Pharmaceutical services
- 4.13 Primary health care services
- 4.15 Public health services and prevention services (particularly injury/falls prevention)
- 4.16 Specialist medical and surgical services
- 4.17 Travel and accommodation services.

Access

The Ministry funds NASC. People wishing to receive DSS for the first time will have a needs assessment facilitated by a Ministry-contracted needs assessor. If needs change, a full reassessment may be undertaken. A person may be referred or self-refer to the needs assessment service.¹⁷ Where a person is being referred by another person, the referrer needs to make that referral, where possible, with the permission of the person being referred.

The Ministry funds NASC through NIDCA for access to high and complex services for eligible individuals. Access to high and complex services is required for people with intellectual disabilities who are subject to compulsory care orders under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. For other individuals defined as ‘civil’, referrals are made by mainstream NASC services. Eligibility and service access is determined according to the NIDCA eligibility criteria.

For people with intellectual disabilities who are convicted of imprisonable offences and are subject to compulsory care orders made by the court under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 or the Criminal Procedure (Mentally Impaired Persons) Act 2003, access is determined by court order.

¹⁷ A list of NASC organisations is available from www.health.govt.nz/our-work/disability-services/about-disability-support-services/needs-assessment-and-service-coordination-service

Provision of equipment, modifications and other specific environmental support services must be accessed through equipment and modification services assessors or appropriate health professionals.

Some people may access child development services or Assessment, Treatment and Rehabilitation (AT&R) services via health referrals and, in this way, may access services without going through the NASC process.

Any person with a disability or member of the community can self-refer to disability information and advisory services.

Criteria for publicly funded treatment

Needs assessment and service coordination

A needs assessor facilitates the assessment of the support needs of disabled people and their family, whānau, aiga or carers. The needs assessor does not facilitate an assessment of the total needs of a disabled person as they do not assess, for example, mental health or a person's financial situation. The needs assessor does complete a comprehensive assessment of disability needs, which can/does identify other areas where a person may require additional support. Based on this assessment, the needs assessor will, with the person's permission, refer them to appropriate support services.

After a needs assessment has been completed, a service coordinator:

- explores all options for achieving desired outcomes with the person who requires support
- may assist the disabled person to access support from other services
- may allocate DSS funding, within available funding and using prioritisation and resource allocation tools
- ensures services are in place and that agreed outcomes are being achieved.

Note: The needs assessor and the coordinator could be the same person.

Access to equipment and modification services is through specialised assessment and recommendation. The Ministry's contracted providers for the administration of the provision of equipment, modifications and other supplies and services make decisions based on Ministry access and eligibility criteria.

Exclusions

The Ministry of Health's Disability Support Services Group does not fund support services for conditions or situations covered by other funders, including those where people:

- have conditions covered under the Accident Compensation Act 2001, require support due to their injury and do not have a co-existing disability that meets DSS eligibility criteria
- require support due to a mental health problem and/or addiction and/or damage from alcohol or other drug abuse, and do not have a co-existing disability that meets DSS eligibility criteria
- require support due to a disabling chronic health condition and do not have a co-existing disability that meets DSS eligibility criteria (some may be funded under Schedule 4.7 Long-term support services for people with chronic health conditions)
- require support due to behavioural difficulties and do not have a co-existing disability that meets DSS eligibility criteria

- present with long-term support needs at age 65 or over except for provision of equipment, modifications and other environmental support services
- are aged 50 to 64 years and have been clinically assessed as having health and support needs because of long-term conditions more commonly experienced by older people
- have short-term support needs (less than six months)
- need personal health (clinical) and palliative care services.

Cost

NASC services, contracted services, environmental support services and most assessments for equipment and modifications are provided at no charge.

DSS are provided at no charge for children under 16 years old, or until they qualify for an invalid's benefit.

Personal care services, which are delivered mostly in a person's home (eg, assistance with dressing, bathing, eating), are provided at no charge.

Household management services (eg, meal preparation) are provided at no charge to Community Services Card holders. Note that children with disabilities may have their own personal Community Services Card which gives them access to subsidised health services, but this will not give the family access to funded household management services. For the family to get such access, where household management services are assessed as necessary, the child's parents or informal carers will need a Community Services Card as well. If a person does not hold a Community Services Card, they may be charged for these services.

Carer support services for informal carers are not income and asset tested. The carer support subsidy is designed to assist informal carers with some of the costs of securing short-term relief care services. Carers may have to contribute towards the costs of short-term relief care when those costs are higher than the subsidy.

A number of arrangements apply to specific equipment and modifications services. Refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

If Ministry-funded clients are in residential care, are beneficiaries under section 3(1) of the Social Security Act 1964 and are not subject to income and asset testing under Part 4 of that Act, they may be required to contribute some of the cost of care. These people will pay an amount no greater than the equivalent single person's benefit less any personal allowance permitted by the Ministry of Social Development. They do not have to pay any of the personal allowance portions of the benefit toward the costs of care.

Time

In a crisis, where a person's safety is at risk, they should receive, or be assessed for, DSS within 24 hours.

If a person urgently requires assessment for DSS but is not in a crisis situation, a needs assessor or health professional should contact them within two working days.

If a person is assessed to urgently require DSS but is not in a crisis situation, they should receive services within two weeks subject to availability of funding.

If the need for DSS is not urgent, a person will receive services as soon as possible. Timing of services will depend on the person's need relative to that of others, their ability to benefit

and become more independent as a result of the services provided, and the availability of funding.

For offenders with intellectual disabilities subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, timelines are determined by that Act.

Additional quality requirements

Compliance with certain standards

The Ministry and DHBs will ensure that all providers of relevant DSS are required by their service agreements to comply with the following standards and guidelines in addition to the quality and other relevant requirements within the service agreement or standard contract documentation:

- **needs assessment and service coordination** documents:
 - Standards for Needs Assessment, 1994
 - Guidelines for Service Coordination, 1995
 - Needs Assessment Standards, 1999, and Service Coordination Standards, 1999; Standards for NASCs, 1999
 - Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines, February 2002
 - National Health and Disability Sector Standards (HDSS) (only specific parts of the HDSS are relevant to NASC providers. All Ministry-funded NASC providers are required to be compliant with the criteria identified by letters A and B in the HDSS)
- **community residential:** relevant¹⁸ standards approved under the Health and Disability Services (Safety) Act 2001, as set out in the Health and Disability Services Standards (NZS 8134:2008).

¹⁸ Not all standards or criteria within NZS 8134 are relevant to all services.

4.4 Emergency ambulance services

Emergency ambulance services are to be provided in accordance with the joint Emergency Ambulance Service Specifications of the Ministry of Health and Accident Compensation Corporation.

For the purposes of this schedule, a 'medical emergency' is defined as:

An ambulance response to a call received and triaged by an ambulance communications centre as indicating that a person has a condition that requires urgent medical attention. The call indicates the person is triaged as requiring urgent medical attention (not caused by trauma). Emergency ambulance response does not include patient/client transfer services.

Range of services

Emergency ambulance services funded by the Ministry include, but are not limited to:

- provision of land, water and air emergency ambulance services to respond to people requiring assistance as a result of a medical emergency
- emergency assessment, treatment and transportation (where necessary and appropriate) of medical patients to appropriate medical facilities, including resuscitation and stabilisation before and during transport
- transport from public hospital emergency departments to a higher-level hospital, after arriving at the first hospital within three hours by ambulance¹⁹
- provision of a comprehensive 24-hour communications system, including a 111 answering facility and triage service to determine the most appropriate response, or access to same through a Service Level Agreement, and a two-way connection to Healthline for calls from that service that are promoted to an emergency response or calls to the 111 service for which an emergency response is not appropriate
- capacity to respond to potential and actual major incidents.

The following are guiding principles for retrievals/ treatment/ transport in/from the community:

- Treatment delivered is necessary, appropriate and of the required quality
- Treatment is delivered by the staff with the appropriate skill level and support
- Transport to treatment is undertaken only when necessary and appropriate and is related to patient need.
- Transport to treatment for patients should be in accordance with nationally or agreed destination policies.

Note: For all individuals accepted as accident claimants by ACC, emergency transport for treatment within 24 hours of injury (or being found or diagnosed) is funded by ACC.

DHB funded

DHBs fund inter-hospital transfers except those funded by the Ministry under the emergency ambulance services agreements. In relation to inter-hospital transfers, the DHB of domicile pays.

¹⁹ The exception to this is for the Order of St John in the Northern Region.

Refer to the 4.8 Maternity services schedule for maternity related transport.

Access

24-hour, seven-day a week access is provided to all people, for all settings, requiring emergency ambulance services whether by road, water or air.

Criteria for publicly funded treatment

The provider determines the mode of transport (where appropriate) and type of response (crew configuration) through protocols and procedures (including consideration of severity of an injury or illness, the risks of sudden severe complications, and the availability of local medical resources).

Exclusions

No public funding from Vote Health is made available for the following services: emergency ambulance services for individuals accepted as accident claimants by ACC (these are funded by ACC), and private hire response by ambulance of less than 'emergency' status.

Cost

In a medical emergency (eg, a heart attack) there may be a patient part-charge for ambulance transport to a hospital or place of definitive care, irrespective of the distance travelled. Contracts cap the part-charge amount and providers cannot increase this amount without prior agreement with the Ministry.

Time

All calls or requests for emergency services will be dealt with immediately to determine the most appropriate response. The Ministry monitors the performance of providers of emergency ambulance services, including a range of appropriate response times (from call to arrival at the patient). Information for this monitoring is indicated in the joint Ministry–ACC Emergency Ambulance Service Specifications and sourced directly from emergency ambulance service providers.

Additional quality requirements

All emergency air and road ambulance service providers covered by contracts, service agreements or funding arrangements with the Ministry are to be members of Ambulance New Zealand and are required to be certified as compliant with NZS 8156 (Ambulance and Paramedical Services Standard). Emergency air ambulance providers are also required to meet the Ambulance New Zealand Air Ambulance/Air Search and Rescue Service Standard (AA/ASAR Standard).

It is expected that DHBs will include both these quality standards in their agreements with providers for transfer services by ambulance, including inter-hospital transfers.

DHBs will participate in an emergency care coordination team where one exists.

4.5 Health and support services for older people

The focus for older people's health and support services is on developing an integrated 'continuum of care' to support older people to maintain and, where feasible, improve their health and wellbeing so that they can participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life.

Integrated care is about careful coordination of a person's care between different service providers and professions. Greater system integration, including clinical and support services, across the health and community sectors aligns organisations and health care professionals to improve outcomes for older people and provide a better experience. System integration is a way of achieving more timely and efficient person-focused services that are more cost-effective, reduce duplication of effort (eg, in collecting patient information) and achieve economies of scale.

The continuum of care for older people covers the whole range of health and support services for older people, including health promotion and primary care, secondary and specialist care, home- and community-based care, residential care, palliative care and end-of-life care. Within the continuum, responsive health and support services recognise the need for age-appropriate services, the importance of strong links across services and the sector, cultural and ethnic diversity, and the need for flexible and client-centred approaches.

Health and support services for older people will be delivered in a variety of settings across DHBs to provide for needs of the local population. The types of services will recognise individual circumstances, cultural preferences and service configurations available within a DHB's district.

The Government's priorities for aged care, which will have implications for the health of older people, include:

- a focus on improving older people's underlying health and wellbeing – particularly in the areas of mental health (dementia) and preventing disease and injury
- building better systems – including using standardised assessment and care planning tools and aggregated data for monitoring and audit to improve quality across home care and aged residential care
- providing new and expanded services – concentrating on dementia, and primary and community care improvements to avoid hospital admissions
- supporting family and whānau – in particular, through providing and enabling access to respite care, day programmes and social supports
- engaging in the next steps of the aged residential care review
- providing services closer to home – in particular, chronic disease management, services for the frail elderly, and support for the Whānau Ora initiative
- collaborating regionally to maximise clinical and financial resources
- strong clinical leadership.

Range of services

Services funded by DHBs will include, but will not be limited to:

- information, advice and education for older people and their families, whānau and carers about, but not limited to, available services, access to services, health promotion and self-management, and needs assessment of older people,²⁰ including assessment of carer needs
- interRAI Community Health Assessment and functional supplement or Home Care Assessment, which must be completed to determine need for aged residential care
- implementation and roll-out of interRAI into aged residential care
- service coordination²¹
- support to live at home, including personal care (eg, assistance with dressing, bathing, eating and toileting), household management (eg, assistance with meal preparation, laundry and cleaning) and, where appropriate, restorative and rehabilitative approaches to support older people to regain independence and remain part of their community
- support for informal carers including carer support subsidy and respite care (eg, carer training, residential respite, dementia respite care and day programmes for older people, in-home respite care)
- specialist health of older people services providing support to residential and home-based support services for older people as well as to acute hospital, primary health care and NASC services
- an organised stroke service
- AT&R services
- long-term residential care
- rest home
- hospital
- dementia
- specialised hospital (psycho-geriatric).

Older people should also have access to the same range of health services as the general population, in a manner and setting that are safe and age appropriate. Refer in particular to the following service coverage schedules:

- 4.2 Diagnostic, therapeutic and support services – personal health
- 4.9 Mental health and addiction services continuum'
- 4.11 Palliative care
- 4.12 Pharmaceutical services
- 4.13 Primary health care services
- 4.15 Public health services and prevention services (particularly injury/falls prevention)
- 4.16 Specialist medical and surgical services
- 4.17 Travel and accommodation services.

²⁰ Comprehensive clinical assessment through interRAI Contact Assessment, Community Health Assessment or Home Care Assessments to address risk factors, if present, and to allow for the early detection, intervention and management of conditions for clients at all levels of complexity.

²¹ Service coordination assists the older person to have their needs met from all appropriate supports available in the community. This may include liaising with other government agencies such as Ministry of Social Development and Housing New Zealand. Service coordination may include goal setting.

Additional services funded by the DHB

The DHB may fund other services to support a continuum of care for older people, including:

- separate needs assessment for carers, particularly where comprehensive clinical assessments (interRAI) signal that carers are under pressure
- intermediate or transitional care (eg, planned early discharge with home support, slow stream rehabilitation, convalescent care, short-term residential care).

Services funded by the Ministry

Ministry-funded services include environmental support services – refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Access

Access to support services funded by DHBs is determined through the NASC process. Older people can be referred from any source to have their needs assessed, and can self-refer. If an older person's needs change, then a full reassessment of their needs will be made. Access to support for informal carers (such as respite care and short-term relief through the carer support subsidy) is also determined through the NASC process. Access to equipment, modifications and other supplies and services is through specialist assessment and recommendations. Refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Criteria for publicly funded support services

The service coordination process identifies the specific services that will be provided to meet the assessed needs and goals of the older person and, where appropriate, their family, whānau and carers. Service coordination decisions take account of individual circumstances including current supports available (informal and formal) and support needs that can be met by other services. Decision-making may also use prioritisation and resource allocation tools.

Providers of equipment, modifications and other supplies and services make decisions based on Ministry of Health access and eligibility criteria. Refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Cost

Needs assessment and service coordination services are provided at no charge.

Personal care services, delivered primarily in a person's home (eg, assistance with dressing, bathing, eating and toileting) are provided at no charge.

Household management services (eg, assistance with meal preparation, laundry and cleaning) are income tested. If a person has a Community Services Card, household management services are provided at no charge. If a person does not have a Community Services Card, the person may be fully or partly charged for these services.

Support services for informal carers are not income or asset tested. The carer support subsidy, administered by the Ministry of Health and DHBs, is designed to assist informal carers with some of the costs of securing short-term relief care services. Carers may have to contribute towards the costs of short-term relief care when the costs of that care are higher than the subsidy.

DHBs can decide a limit on the cost of providing support services that enable an older person to remain in their own home. If the DHB does place such a limit:

- the limit must be at least the average cost to the DHB of relevant residential care (ie, the aged residential care (ARC) price for the relevant level of care less the average contribution of residents towards the cost of their residential care). The limit can be higher than that minimum. A limit must not be based on what the individual would pay based on their individual income and asset testing.
- any limit must allow for exceptions where the DHB judges expenditure above the limit is justified eg, for short-term care or where limiting care would increase the risk of a couple both going into residential care
- DHBs can include the cost of support services other than home support if they are ongoing and provided regularly
- DHBs may allow arrangements for the older person to purchase services that are beyond the DHB limit.

Aged residential care services (contracted care services)²²

People who have been needs assessed as requiring aged residential care indefinitely may apply to the Ministry of Social Development for a financial means assessment (income and asset test) to be completed under Part 4 of the Social Security Act 1964.

If a person's assets are under the asset threshold, then the Ministry of Social Development, through the financial means assessment, will determine how much the older person must contribute towards the cost of services up to the gazetted maximum contribution per week in their local region. If the cost of contracted care services exceeds the gazetted maximum contribution, the DHB will pay the difference between the maximum contribution and the cost of the contracted care services paid to the provider.

If a person has not had a needs assessment or has not been income and asset tested under Part 4 of the Social Security Act 1964, the person will pay the full cost of the services.

People aged 50 to 64 years who are assessed as requiring aged residential care indefinitely and who are single with no dependent children are income tested only (ie, not asset tested).

Exempt persons²³ (as defined in regulation 5 of the Social Security (Long-term Residential Care) Regulations 2005) will not be income and asset tested. The DHB will pay the cost of

²² Contracted care services are defined in the Social Security Act 1964 as 'services that are provided by a contracted care provider' (ie, a provider that has a service agreement or accepts payment under a section 88 notice) 'to an eligible person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely' and 'the services necessary to meet the person's assessed long-term residential care needs' (s 136).

²³ An 'exempt person' is defined in regulation 5 as a resident who:

- received long-stay geriatric care in a geriatric hospital before 1 July 1993, or
- was receiving long-stay care in one of the following hospitals prior to their closure – Kimberley Hospital (Levin), Templeton Hospital (Christchurch), Mangere Hospital (Manukau City) or Braemar Hospital (Nelson), or
- has intellectual disabilities and was receiving long-stay care in a psychiatric hospital prior to closure of the hospital, or
- under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is subject to a compulsory treatment order made under s 30; or, is declared a restricted patient under s 55; or, is a special patient under s 50 or s 52 of the Act, or
- is subject to a compulsory care order, or
- under the Health Act 1956 is removed to any hospital or rest home under s 79, or
- is committed to any hospital or rest home under s 126, or
- was receiving continuing hospital care in a rest home or hospital before 1 July 1993.

the contracted care services provided, but the exempt person will contribute the amount of any benefit they receive, less the amount of the personal allowance.

Elderly victims of crime (as defined in regulation 6 of the Social Security (Long-term Residential Care) Regulations 2005) will not be income and asset tested. The DHB must pay the full cost of contracted care services above the ACC level of payment of the services. The payments by the DHB are without prejudice to the Ministry or the Crown recovering from ACC the whole or part of those payments.

Time

The Social Security Act 1964 allows for an eligible person to apply at any time to a DHB for a needs assessment (s 137(2)). A DHB that receives such a request must arrange for a needs assessment to be conducted as soon as practicable (s 137(4)).

- In a crisis, where a person's safety is at risk, the person should receive, or be assessed for, support services within 24 hours.
- If a person urgently requires assessment for support services but is not in a crisis situation, needs assessors or health professionals should contact the person within two working days.
- If a person is assessed as urgently requiring support services but is not in a crisis situation, the person should receive services within two weeks subject to availability of funding.
- If the need for support services is not urgent, people will receive services as soon as possible. Timing of services will depend on the older person's need relative to that of others, their ability to benefit and become more independent as a result of the services provided, and the availability of funding.

Additional quality requirements

Residential care

Residential care services for rest home care (for three or more people) or hospital-level care (for two or more people) must be provided in facilities certified under the Health and Disability Services (Safety) Act 2001.

Residential care providers must comply with quality requirements under:

- their Age-Related Residential Care Services Agreement
- Part 4 of the Social Security Act 1964
- relevant²⁴ standards approved under the Health and Disability Services (Safety) Act 2001, as set out in the Health and Disability Services Standards (NZS 8134:2008).

Home-based support services

DHBs should have appropriate processes in place to receive and respond to complaints from older people or their families regarding the supports they receive. Older people should also be made aware of how they can complain if they wish to. Home support providers must comply with:

- quality requirements in their home support service contracts
- Home and Community Support Sector Standard (NZS 8158:2012).

²⁴ Not all standards or criteria within NZS 8134:2008 are relevant to all services.

4.6 Immunisation services

The Pharmaceutical Schedule lists immunisations provided free to eligible populations. The National Immunisation Schedule defines how the vaccine programme is delivered. There is a mix of universal programmes (everyone of a particular age is eligible) and targeted programmes (only people with certain conditions are eligible).

Range of services

Vaccines funded by DHBs are listed on the Pharmaceutical Schedule-National Immunisation Schedule. The following immunisations funded by DHBs include, but are not limited to:

1. Newborn and early childhood immunisation programme mainly delivered through general practice. Vaccines cover diphtheria, tetanus, whooping cough (DTaP), polio, hepatitis B, Haemophilus influenzae type b (Hib), pneumococcal infection (PCV), rotavirus, and measles mumps and rubella (MMR).
 - 6 weeks immunisations
 - 3 months immunisations
 - 5 months immunisations
 - 15 months immunisations
 - 4 years immunisations
2. School-based immunisation programme
 - Year 7 school immunisation programme: DTaP
 - Year 8 school immunisation programme: human papillomavirus (HPV) for girls
3. Influenza immunisation programme
 - Adults over 65 years
 - Children under the age of 5 years with significant respiratory illness
 - Children or adults with an eligible condition
 - Pregnant women
4. Other adult programmes
 - Tetanus-diphtheria booster for pregnant women and adults at age 45 and 65 years
5. Targeted immunisation programme
 - Pre-post splenectomy/functional asplenia programme
 - Additional vaccines are funded for some groups of children and adults at high risk of certain diseases due to other medical conditions or high risk of exposure, including vaccination against hepatitis A, hepatitis B, Hib, human papillomavirus, influenza, pertussis, meningococcal infection, pneumococcal infection, tuberculosis and varicella.
6. Outreach immunisation services
 - Children aged under 6 years who have missed vaccination events specified in the Childhood Immunisation Schedule
7. Outbreak control
 - Localised outbreaks
 - National outbreaks

Ministry-funded coordination of immunisation services

- **Immunisation Coordination Service** (the Service) provides up-to-date, evidence-based information to assist vaccinators, non-vaccinators and the general public in their decision-making in regard to immunisation services and the immunisation of children, young people and adults. The Service establishes and maintains effective working relationships with all service providers who have an interest in immunisation activity, to reduce duplication, enhance effectiveness of services and achieve the maximum benefit within allocated resources. The Service promotes immunisation and is designed to support and work with existing networks to provide immunisation information, education, support and advice to vaccinators, non-vaccinators and the general public.
- **Immunisation Advisory Centre (IMAC)** supports delivery of immunisation programmes through providing the Ministry and local service providers with clinical and technical advice. IMAC provides training for health professionals, national immunisation coordination and advocacy to implement best practice and improve immunisation coverage.
- **National Immunisation Register** enables authorised health professionals to quickly and easily find out what vaccines a child has been given and to make sure immunisations are given at the appropriate time. Each DHB ensures that information from the National Immunisation Register forms part of its planning, targeting and monitoring of immunisation services, outreach immunisation services, primary health care and other complementary services.

Access

Publicly funded vaccines are available through general practices, school-based programmes, work environments from occupational health nurses, family planning clinics (for HPV immunisations), marae and outreach providers, as well as through hospital services where cold chain compliance allows.

Criteria for publicly funded treatment

All children (under 18 years) are eligible for publicly funded immunisations, regardless of their citizenship or immigration status. For people aged over 18 years the Health and Disability Services Eligibility Direction 2011 issued by the Minister of Health sets out the eligibility criteria for publicly funded health and disability services in New Zealand.

Exclusions

There is currently no funding provided for the administration of adult type tetanus-diphtheria vaccine (Td) boosters given at 45 and 65 years of age, although the vaccine is free.

Cost

Only vaccines given according to the Pharmaceutical Schedule- National Immunisation Schedule are available free of charge, unless there is a specific funded programme in response to a recognised need.

Time

Immunisation services are age specific and required at the age prescribed in the National Immunisation Schedule (refer to Immunisation Handbook 2014). On-time immunisation coverage is an important milestone and is required to prevent disease outbreaks.

Additional quality requirements

The DHB will maintain minimum immunisation coverage of 95 percent for two-year-olds (previously a health target), and reach and maintain minimum immunisation coverage of 95 percent for 8-month-olds (Better Public Services target).

By June 2016, a minimum of 90 percent of those aged 5 years will be fully immunised.

The DHB will introduce strategies to increase coverage rates of HPV vaccination in girls to 65 percent coverage for dose three by the end of December 2015.

4.7 Long-term support services for people with chronic health conditions

This schedule covers services for people who are under the age of 65 years, have one or more chronic health conditions that is/are expected to continue for six months or more, and have an assessed need for long-term support services.

The service includes 'medically fragile children' (children with high health needs and/or multiple impairments whose health status has not yet stabilised and for whom a physical, sensory and/or intellectual disability with associated ongoing support needs has not been identified).

The aim of long-term support services is to support the development of an 'integrated continuum of care' for this client group. This requires that appropriate and effective clinical and support services are in place, which link with each other and are responsive to the needs of the clients, their families, whānau, aiga and carers.²⁵

Note: Other support services for the following groups are covered in these schedules:

- older people (people aged 65 years and over and people aged between 50 and 64 years who are assessed as 'close in interest'²⁶ to older people) – see Schedule 4.5 Health and support services for older people
- people with long-term support needs due to a mental illness or addiction – see Schedule 4.9 Mental health and addiction services continuum; however, the non-mental health needs of these clients may be subject to this long-term support services schedule
- people requiring palliative care – see Schedule 4.11 Palliative care
- people whose need for support is due to a physical, sensory or intellectual disability (or a combination of these) and who are generally aged under 65 years – see Schedule 4.3 Disability support services.

Range of services

Long-term support services for people with chronic health conditions funded by DHBs will include, but are not limited to:

- assessment of individual needs through NASC organisations or care/service coordination centres
- service coordination to develop a customised package of services to meet individual assessed need that can be provided within available funding and incorporating prioritisation tools – this service includes strong linkages with education and employment services
- assistance with daily personal care activities (eg, dressing, bathing, eating and toileting)
- assistance with household activities (eg, meal preparation, laundry, cleaning)
- carer support services (eg, carer support subsidy, respite care)

²⁵ On 1 July 2011, the Government gave DHBs the responsibility for planning and funding long-term support services for people who have chronic health conditions and are under the age of 65 years. This allocation was accompanied by transfer of existing funding and contracts that had been managed by the Ministry since November 2006 as the Long-term Supports – Chronic Health Conditions (LTS-CHC, formerly known as the Interim Funding Pool) programme.

²⁶ People aged between 50 and 65 years who have been clinically assessed by a DHB and/or a needs assessor as having health and support needs because of long-term conditions more commonly experienced by older people.

- intermediate care (eg, slow-stream rehabilitation) provided as medium-term residential care or in the community
- short- and long-term residential care (community, rest home, hospital, dementia, specialised hospital)
- flexible support packages for families caring for medically fragile children that take account of the whole family's needs, including siblings
- advanced personal care for people who require invasive personal cares that cannot be provided through home-based support services.

Within the range of support services described in the nationwide Community Health, Transitional and Support Services Service Specifications, there are specific service specifications for people with chronic health conditions:

- home support services (personal care and household support) for people with chronic health conditions
- community residential services within aged care facilities for people with chronic health conditions
- community residential support services for people with chronic health conditions.

Medical equipment and supplies for long-term support are described in Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Any person with a long-term condition can access disability information and advisory services.

Access

Access to long-term support services (excluding environmental support services, child development services, medically fragile children's service, and disability information and advisory services) is through a needs assessment facilitated by a DHB-funded needs assessment service. If needs change, a full reassessment will be undertaken. A person may be referred or self-refer to the needs assessment service.

Exclusions

DHBs do not fund long-term support services for people who meet the access criteria for: Ministry-funded DSS or environmental support services; or supports for which other agencies have responsibility such as ACC, Ministry of Education or Ministry of Social Development.

Cost

The following services are provided at no charge:

- needs assessment
- personal care services, which are delivered mostly in a person's home (eg, assistance with dressing, bathing, eating)
- household management services (eg, meal preparation) for Community Services Card holders only (note that children with long-term conditions may have their own personal Community Services Card, which gives them access to subsidised health services, but this will not give the family access to funded household management services)
- long-term support services for children under 16 years old, or until they qualify for a supported living payment.

Cost contributions

People receiving carer support services will not be income and asset tested for these services, but may have to contribute towards the cost of these services if the cost exceeds the carer support subsidy.

If people are in short- or long-term residential care for long-term conditions not associated with ageing, are beneficiaries under section 3(1) of the Social Security Act 1964 and are not subject to income under Part 4 of that Act, they may be required to contribute some of the cost of care. These people will pay an amount no greater than the equivalent single person's benefit less any personal allowance permitted by the Ministry of Social Development. They do not have to pay any of the personal allowance portion of the benefit toward the costs of care.

Funding by multiple funders for services may be put into place for service users, for example with DHB mental health and addiction services, Ministry of Health disability support services, and ACC.

Time

- In a **crisis**, where a person's safety is at risk, the person should receive, or be assessed for, long-term support services within 24 hours.
- If a person **urgently** requires assessment for long-term support services but is not in a crisis situation, a needs assessor or health professional should contact the person within two working days.
- If a person is assessed to **urgently** require long-term support services but is not in a crisis situation, the person should receive services within two weeks subject to availability of funding.
- If the need for long-term support services is **not urgent**, the person will receive services as soon as possible. Timing of services will depend on the person's need relative to that of others, their ability to benefit and become more independent as a result of the services provided and the availability of funding.

Additional quality requirements

In addition to the quality and other requirements within the service agreement and/or service specification, the following requirements apply.

- All NASC organisations are required to meet the standards and criteria to be identified in the Health and Disability Sector Standards.
- Home-based support providers must comply with the Health and Disability Sector Standards NZS8134:2008 mandated under the Health and Disability Services (Safety) Act 2001.

4.8 Maternity services

Maternity services are provided to women and their families throughout pregnancy, childbirth and for the first six weeks of a baby's life. These services are provided in the home and a range of maternity facilities by a range of health professionals, including midwives, GPs and obstetricians.

Maternity Service Specifications and the Primary Maternity Services Notice 2007, pursuant to section 88 of the New Zealand Public Health and Disability Act 2000, are the operational service delivery mechanism for service coverage.

Range of services

Maternity health services funded by the DHB and/or the Ministry will include, but are not limited to, the services below:

Ministry funded

The Ministry funds lead maternity care (including homebirth lead maternity care) and related primary maternity services as specified under the Primary Maternity Services Notice 2007, pursuant to section 88 of the NZPHD Act 2000.

DHB funded

Maternity services are to be provided as specified in the following service specifications:

- DHB Funded Maternity Services (tier one)
- DHB Funded Primary Maternity Services (tier two)
- Secondary and Tertiary Maternity Services and Facilities (tier two)
- DHB Funded Primary Maternity Facility (tier two), including in urban areas or rural communities with a catchment of 200 pregnancies where the facility is 30 minutes from a secondary service, and with a catchment of 100 pregnancies where the facility is 60 minutes from a secondary service
- Pregnancy and Parenting Information and Education services.

Maternity-related services covered in other schedules

- Medical equipment and supplies associated with maternity services are addressed under Schedule 4.14 Provision of equipment, modifications and other supplies and services.
- Pharmaceuticals associated with maternity services are addressed under Schedule 4.12 Pharmaceutical services.
- Ambulance services associated with maternity services are addressed under Schedule 4.4 Emergency ambulance services.
- Laboratory services and community referred professional services (eg, allied health) are addressed under Schedule 4.2 Diagnostic, therapeutic and support services – personal health.
- Neonatal services associated with maternity services are addressed under Schedule 4.16 Specialist medical and surgical services.

Access

All pregnant women and their babies must have access to maternity services. Women can choose to give birth at any primary maternity facility that has a contract with a DHB and where their chosen lead maternity carer (LMC) holds an access agreement.

The LMC selected by the woman retains primary responsibility for the woman's care, unless there is a transfer of clinical responsibility to a specialist as described in the *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* (Ministry of Health 2012a).²⁷

DHBs will provide pregnancy and parenting education services to a minimum of 30 per cent of pregnant women of each population group, defined as: Māori, Pacific Peoples, Asian and Other.

Decision-making criteria for publicly funded treatment

The Referral Guidelines provide guidance to LMCs and other primary providers along with secondary services and specialists in regard to clinical need for secondary/specialist maternity services.

Exclusions

As per the service specifications and the Primary Maternity Services Notice 2007, pursuant to section 88 of the NZPHD Act 2000, no public funding is to be made available for non-clinically indicated elective caesarean sections.

Cost

All maternity inpatient and outpatient services received from GPs, midwives and hospitals are provided at no charge. DHBs will not charge for any maternity services provided in a public facility. DHBs will ensure that all women have access to specialist services at no charge including specialist obstetric, lactation, anaesthetic, paediatric and radiology services (including primary referred ultrasound services).

Ineligible spouses or partners of eligible people are to be provided the same access to subsidised maternity-related services as eligible women.

Public funding of preventive treatment and all care during pregnancy, birth and postnatally that is designed to limit risk of mother-to-child HIV transmission is required to be made available to HIV-infected women who are currently not eligible to receive publicly funded health care. This includes postnatal hospital visits for the child for the purpose of disease exclusion, that is, to provide medication to prevent transmission and determine the HIV status of the child.

In maternity cases the woman will not be charged a part-charge for emergency ambulance transport from home or a community primary maternity facility to a secondary or tertiary maternity service where the ambulance transfer is requested by a health professional.

Transport of women and/or babies from one DHB-run facility to another is provided at no charge to the women, where the transport is required on clinical grounds. This transport is funded by the DHB of domicile.

²⁷ www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines

Time

Maternity services, including emergency transportation services, are to be available when they are needed.

Additional quality requirements

In addition to the quality and other requirements within the service agreement and/or service specification, the following requirements apply.

The DHB will establish and maintain a Maternity Quality and Safety Programme to continually improve the maternity services funded for its population; and will seek the views of women about those services. Maternity facilities will promote and support breastfeeding by achieving and maintaining Baby Friendly Hospital accreditation.

4.9 Mental health and addiction services continuum

Epidemiological studies indicate that one in five New Zealanders at any one time experience a mental illness or addiction (Oakley Browne et al 2006). Mental health and addiction problems experienced range from mild to severe. The service delivery continuum ranges across the spectrum of health promotion and prevention, primary, secondary and tertiary services. It embodies the concept of early intervention intended to mitigate against the severe impacts of mental illness. This service coverage schedule covers all mental health and addiction services funded through Vote Health with the exception of services provided by the Health Promotion Agency, the Health and Disability Commission (Mental Health Commissioner) and the Health Research Council. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 (Rising to the Challenge)* sets the direction for the delivery of mental health and addiction services.

Broader government policies have placed improvements in the health status of Māori and approaches to whānau ora as an overall priority. *Te Puāwaiwhero –The Second Maori Mental Health and Addiction National Strategic Framework 2008-2015*²⁸ (Ministry of Health 2008) provides the framework for the delivery of mental health and addiction services for Māori. It is expected that all mental health and addiction services will be responsive to the needs of Māori, that services will be designed to facilitate earlier access to mental health and addiction services by Māori, and that choice will be promoted by facilitating development of Kaupapa Māori services.

Responsive mental health services will recognise New Zealanders' growing ethnic diversity, and consider their cultural and ethnic needs as well as their clinical needs. (Concepts to be taken into account include spirituality, family and whānau, social inclusion, and different understandings of mental health, wellbeing and recovery.) Mental health services will not exclude eligible people on the basis of underlying disabilities or chronic health conditions where the one or more presenting issues relate to mental illness.

Specialist mental health and addiction services are funded for those people who are most severely affected by mental illness or addictions. In addition to the access expectations set out in *Rising to the Challenge*, it is expected that DHBs provide access to specialist services for a minimum of 3% of their population. A focus on early intervention strategies will mean specialist services may be delivered to people who are at risk of developing more severe mental illness or addiction.²⁹ A focus on early intervention strategies will mean specialist services may be delivered to people who are at risk of developing more severe mental illness or addiction.

To the extent that funding for specialist mental health and addiction services does not support coverage for all target populations, it is expected that DHBs will have criteria in place for prioritising the provision of services to people with the highest level of need. DHBs are expected to ensure the people of their district have access to regional and national mental health and addiction services.

²⁸ www.health.govt.nz/publication/te-puawaiwhero-second-maori-mental-health-and-addiction-national-strategic-framework-2008-2015

²⁹ Responsibility for planning and funding DSS for people with psychiatric disabilities devolved to DHBs in 2001 (CAB Min (01) 12/12). Residual Ministry-funded DSS for people with mental illnesses, personal health conditions and palliative care needs were devolved to DHBs on 1 October 2003 along with planning and funding of disability support services for people aged 65 years and older (CAB Min (03) 23/8).

Range of services

Services funded by the Ministry

- **Mental health promotion and prevention services:**
 - for the whole population: mental health and addictions public health education, prevention, promotion and de-stigmatisation
 - for eligible people: liaison and support for families, whānau, carers and the wider community.

Services for people with gambling problems

The following problem gambling services are funded by the Ministry of Health:

- screening and assessment
- brief interventions and other treatment including a range of psychosocial interventions
- services related to problem gambling for people with co-existing mental health or alcohol and other drug problems
- dedicated problem gambling services for priority populations involving consultation collaboration and liaison including with PHOs and other primary health care services.

Mental health and addiction services funded by DHBs

DHBs fund **primary mental health and addiction services** that provide a general primary care response to the needs of people of any age with mild to moderate mental illness, as part of the primary health care strategy.

DHBs fund services for **people in crisis, or at risk of or having an acute episode** (especially when their own or someone else's safety is at risk) including:

- acute services provided within an inpatient setting, such as a specialist psychiatric hospital ward or mental health facility
- where clinically appropriate (and an efficient use of resources), 24-hour acute intensive home-based treatment and/or alternatives to hospitalisation
- assessment and referral from hospital-based accident and emergency departments (these services may be delivered by visiting community mental health teams or by inpatient liaison teams)
- community-based crisis respite, including a treatment component (services that provide people, including carers, with a break, so crisis can be eased)
- consultation, liaison and collaboration, including with PHOs and other primary health care services, secondary and tertiary services, for people with both addictions and mental health disorders.

DHBs fund services to **support people to recover and develop resilience** – to enable people with experience of mental illness and addiction to participate in the everyday life of their communities and whānau – including:

- assessment and brief interventions
- a comprehensive range of treatments including, but not limited to, a range of psychotherapeutic and psychosocial options
- liaison and support with education, employment and housing for service users, including service user led recovery services and peer support

- consultation, liaison and collaboration with PHOs, other primary health care services and other social service agencies
- liaison, education and support for carers, family, whānau and significant others
- mental health and addictions education, prevention and mental health promotion, and early intervention skills.

DHBs fund the following services for **people with alcohol and other drug problems**:

- assessment
- brief and early intervention
- withdrawal management
- treatment including a range of psychosocial interventions³⁰
- day programmes and residential treatment
- alcohol and other drug services for people with co-existing mental health or pathological gambling problems
- opioid substitution treatment services
- rehabilitation
- peer support
- consultation, collaboration and liaison, including with PHOs, other primary health care services, secondary and tertiary services and other social service agencies.

DHBs fund services for people with mental health and/or addictions problems and/or damage from alcohol and other drug abuse and other causes needing **long term support**, including:

- services to assess a person's needs
- coordination services (service to ensure people get the services they need)
- Kaupapa Māori services
- social support services (eg, self-help groups)
- support for carers
- residential support (supports to live in the client's own home), including home support services
- residential care, including hospital rehabilitation
- rehabilitation
- information services
- treatment and ongoing illness management and clinical care
- planned respite
- consultation and liaison.

Note:

- Funding responsibility for long-term support services for people aged under 65 years with dementias and other disabling chronic health conditions, including damage from alcohol and other drug abuse and other causes, is inconsistent nationally and disputed in some regions. The Ministry is working with DHBs to clarify funding responsibility for these groups.

³⁰ Withdrawal management may be provided in a variety of environments according to assessed treatment needs.

- Mental health and addiction services will not exclude eligible people on the basis of underlying disabilities or chronic health conditions where the presenting issue is related to a mental health issue.
- The mental health and addiction treatment and support needs of this group will be funded by DHBs through mental health and addiction services.
- Mental health and addiction services will broker access to other services such as disability support services, health and support services for older people and long-term support services for people with chronic health conditions when clients receiving mental health and addiction services also present with needs that are not related to mental health and addiction and are likely to be eligible for services.³¹

DHB-funded services tailored to the needs of specific groups

In addition to the services described above, DHBs fund services tailored to the needs of specific groups, as follows.

Services for offenders in the criminal justice system and alleged offenders with mental illness and addictions

DHB-funded services include:

- assessment and treatment of people on remand or sentenced to prison
- inpatient treatment in secure settings
- a secure unit for people needing long-term care
- secure rehabilitation and residential facilities and services, including extended care
- monitoring and management of special patients and restricted patients as defined by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health (CAT) Act 1992)
- regionally based community forensic teams
- court liaison services and liaison with the Department of Corrections and Ministry of Justice
- consultation and liaison services to community services provided by the Department of Corrections and Ministry of Justice in each region
- community follow-up of people who may pose a risk to others by reason of mental disorder by either forensic or general mental health services
- services for people with mental illness or addictions who are unable to be managed by general mental health services because of a high and/or level of serious danger to others.

Services for children and young people

Services are available up to and including the age of 19 years, and adult services are available from 18 years; this overlap is managed according to the clinical and developmental needs of the consumer. Some flexibility will be allowed to manage the transition between child and youth services and adult services through to 25 years in order to best meet the needs of the young person.

Children and young people should have access to the same range of services as the adult population provided in a manner and setting that are safe and developmentally appropriate.

³¹ The Ministry will work with DHBs to address policy and operational barriers to working collaboratively across funders and services in the context of the work outlined above and in relation to the Ministry's Mental Health of Older People/Dementia Project.

Ideally, services for children and young people should be separate from services for adults unless a different arrangement is in the best interests of any particular child or youth.³² If for any reason a child cannot be accommodated in an appropriate ward, the child must be cared for by paediatric-trained staff (medical and nursing), should be physically separated from adults in the ward and should be relocated to a suitable location as soon as possible.

In addition to generic mental health and addiction services, specialist services funded specifically for children and young people include:

- inpatient care
- provision of specialist advice to crisis services
- specialist consultation and liaison services to other professionals working with children and young people who require mental health services – including Ministry of Education, Ministry of Social Development (Child, Youth and Family), youth justice, other health services in the primary care, secondary and tertiary sectors, and other agencies
- participation in interagency processes such as Strengthening Families, Family Group Conferences, and high and complex needs case management
- education, prevention and early intervention activities for children and young people, and for families, whānau, carers and others affected
- liaison, support and respite care for families, whānau, carers and others affected
- Youth Court liaison services and liaison with the Department of Corrections, the Ministry of Justice and the Ministry of Social Development (Child, Youth and Family).

Services should promote effective engagement with both the young person and their family and whānau (when appropriate).

Primary Mental Health Services

Primary mental health and addiction services provide interventions for people presenting with mild to moderate mental health and addiction problems. In addition to the general primary care response to the needs of people of any age, access to primary mental health interventions is funded for the following specific population groups:

1. The enrolled adult population focused on Maori, Pacific and/or low income. The expected outcome is increased access to psychological and psychosocial interventions for these at-risk groups.
2. Youth primary mental health services, available to all youth in the 12 to 19 year age group (regardless of PHO enrolment) who require such a service. The expected outcomes are to enable early identification of developing mental health and/or addiction issues and better access to timely and appropriate treatment and follow up.

Primary mental health interventions are based on a stepped care model with interventions matched to service user needs in terms of level of intensity.

Perinatal and maternal mental health

It is known that women with mental health problems – particularly women with a history of bipolar disorder, psychosis or postnatal/severe depression – are at risk of an escalation of symptoms during the pregnancy and postnatal period. Women who are identified as needing mental health services when pregnant or in the period after birth will be able to access

³² Incidents of age-mixing in mental health inpatient facilities should be reported to the Director of Mental Health at the Ministry of Health. For guidance on interpreting 'best interest' and adhering to United Nations Convention on the Rights of the Child contact the Director of Mental Health at mentalhealth@moh.govt.nz.

appropriate services to meet their needs and keep themselves and their babies safe. It is expected that all women will have access to perinatal and maternal mental health services, DHBs can either directly provide specialist services, through trained staff in generic adult mental health services or provide access to specialist services.

Older people (65 plus years)

Older people should have access to the same range of mental health and addiction services as other eligible people provided in a manner and setting that are safe and age appropriate. Older people with a mental illness and/or an addiction are also eligible for the range of specific health services for older people. Current adult specialist service users over 65 years will remain with their current specialist service provider unless their needs change. They will not be excluded from specialist services due to age.

Services funded specifically for older adults include:

- specialist services for older adults with serious mental health disorders, including serious behavioural and psychological symptoms of dementia (BPSD)
- specialist consultation and liaison services from other professionals working with older people who require mental health services – including the older persons services, community-based support and advocacy services, PHOs, other primary health care services and other social agencies.

Access

Referrals to secondary mental health and alcohol and other drug services for assessment may be made from any source. This includes self-referrals, which is to ensure that referral pathways do not form a barrier to access. Access to mental health and addiction services is determined on the basis of highest level of need identified by a health professional as defined by the Health Practitioners Competency Assurance Act 2003 or an addiction worker who is a member of a recognised professional body. While access to peer support services and family support services may not necessarily be determined by a health or addiction professional, need should nonetheless be a guiding principle in the access decision.

Criteria for publicly funded treatment

On referral (including self-referral), the criteria for assessment are based on the person having a suspected, developing or identifiable mental illness, and/or an addiction problem.

Following assessment, access criteria for ongoing service delivery are based on:

- clinical judgement about diagnostic classification
- the severity of the mental illness or addiction
- the likely impact of the mental illness and/or addiction on the person's ability to participate in activities of daily living, work, education and community life
- meeting any legal requirements
- the safety of the individual or the safety of others.

Exclusions

DHBs will fund (and may provide) services to address the mental health and addiction treatment needs of people with the primary needs identified below. However, they will not fund services

from Vote Health funding allocations for mental health and addiction treatment services where the service or support needs are solely oriented to:

- sexual abuse
- violence and anger
- intellectual disability (including post-head injury), with or without behavioural problems
- learning difficulties
- criminal activities (anti-social behaviours)
- parenting difficulties
- conduct disorder
- nicotine addiction
- relationship issues.

Note: Services may be funded for these people through other health funding streams or in some cases by other agencies.

Services for parenting difficulties and conduct disorder may be funded by Vote Health when delivered in collaboration with other funding agencies as an interagency funded venture. Where DHBs provide the following services, they will provide those services on a fee for service basis, reimbursing the mental health and addiction service funding allocation for the costs incurred for the:

- preparation by the mental health and addiction services of court reports ordered by Ministry of Justice, except for those under section 38(2)c of the Criminal Procedure (Mental Impaired Persons) Act 2003
- preparation of court-ordered reports or parole board reports
- assessments under section 65 of the Land Transport Act 1998
- assessments and reports under section 333 of the Children, Young Persons, and Their Families Act 1989.

The following services are not funded within Vote Health:

- mental health and addiction treatment services where they are the sole focus of the intervention
- counselling interventions that are unrelated to mental health and addictions
- psychological testing for educational requirements.

Cost

Services are provided free of charge for people who receive:

- mental health and/or addiction treatment services as an inpatient (including pharmaceuticals)
- mental health services (including pharmaceuticals) as a day patient or an outpatient, including as a patient of a community mental health team, and are receiving compulsory treatment under the Mental Health (CAT) Act 1992
- compulsory treatment under the Alcoholism and Drug Addiction Act 1966 (including pharmaceuticals).

With the exception of residential services (see below) and prescription charges for pharmaceuticals (notwithstanding the preceding statement), other mental health services funded by DHBs in the community are free.

Some residential services will require part payment by the resident. If people are in short- or long-term residential care not associated with ageing, are beneficiaries under section 3(1) of the Social Security Act 1964 and are not subject to income and asset testing under Part 4 of that Act, they will be required to contribute to the cost of care. These people will pay an amount no greater than the equivalent single person's benefit less any personal allowance permitted by the Ministry of Social Development. They do not have to pay any of the personal allowance portion of the benefit toward the costs of care.

Service providers (including mental health and addictions counsellors and private mental health and addictions residential services) who are not funded by the DHB may charge for their services.

Primary health care providers may require people to pay for mental health services on the same terms as other primary health care services, unless they are part of a specifically funded programme for primary mental health in which case there is no charge.

Problem gambling services funded by the Ministry of Health are provided free of charge.

Time

When assistance is required under the Mental Health (Compulsory Assessment and Treatment (CAT)) Act 1992, 90 percent of people presenting should be assessed within four hours. DHBs with isolated rural communities will ensure that effective arrangements are in place.

If a person is assessed as needing hospital care under the Mental Health (CAT) Act 1992, 90 percent should be admitted to a hospital within six hours of being assessed by a doctor or another health professional.

The DHB will ensure that crisis services to deal with critical or urgent mental health and/or addiction needs will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act 1992) as follows:

- telephone or other remote assistance will be available at all times with minimal delay
- where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided within four hours;³³ DHBs with isolated rural communities will ensure that effective arrangements are in place
- other services will be arranged when required, including acute inpatient admission and crisis respite.

People seen and assessed as needing services will receive those services as soon as possible. For some services (eg, opioid substitution programmes) there may be a wait before treatment can begin.

³³ Until a person is assessed, it will not be known whether they fall under the Mental Health (CAT) Act 1992.

4.10 Oral health services

Oral health services are provided to assist people in maintaining healthy teeth and oral tissues. Publicly funded oral health services are provided by DHB-approved, registered oral health professionals.

Range of services

The oral health services funded by DHBs will include, but are not limited to, the following.

- 1. Preventive, educative and treatment oral health services for all preschool and primary school-aged children.** These services consist of:
 - education on appropriate oral health practices
 - preventive services
 - restorative services.
- 2. Basic oral health services for adolescents up to their 18th birthday.** These services consist of:
 - examinations
 - radiographs
 - extractions
 - diagnosis and advice
 - restorations
 - prosthetics.
- 3. Emergency dental services for some Community Services Card holders.** DHBs provide these services where capacity and funding allow.
- 4. Hospital and community dental services.** Note that the Ministry and DHBs will continue to work to improve national equity of access in the context of an overall oral health work plan. DHBs will fund:
 - essential dental treatment for hospital inpatients
 - general and specialist dental services to all people requiring primary, secondary or tertiary services as a necessary part of other hospital treatment (eg, tooth extraction prior to radiation therapy)
 - general and specialist dental services that require inpatient, day patient or outpatient services not available from a dentist or other health professional in the community because of the person's special dental or medical condition, disability or need for special management facilities
 - outpatient general and specialist services that are not available from a dentist in private practice to all people requiring such services because of the person's special dental or health or disability problems, or the need for special management facilities for the person
 - basic dental services for low-income people unable to access private care, where capacity and funding of the DHB's hospital dental service allow.
- 5. Adolescent oral health coordination service.** This service facilitates access to and utilisation of DHB-funded dental services delivered mainly under the Service Agreement for the Provision of Oral Health Services for Adolescents and Special Dental Services for

Children and Adolescents (also known as the Combined Dental Agreement). It supports the provision of adolescent oral health services.

All services will promote dental public health, including water fluoridation.

Access

For those areas in which they are provided, emergency dental services for people on low incomes, such as Community Services Card holders, are available only to people who are not receiving income support for dental services. DHBs can assist in determining individual entitlement for these services.

Early enrolment in the school dental service is to be encouraged through the Well Child / Tamariki Ora programme. Primary health care providers, such as GPs, practice nurses and other Well Child providers, should provide information about enrolment and prevention in accordance with the national Well Child schedule.

Suitable arrangements must be available for providing dental care to children whose needs fall outside the scope of practice for dental therapy, but within the definition of basic dental services. Suitable arrangements must also be provided to ensure a seamless and effective transfer of care from the school dental service to the adolescent dental service.

Adolescents may be referred to dentists holding an agreement with the DHB to provide services by a dental therapist, or may enrol directly with a participating dentist.

Hospital dental services are accessed by referral from registered health professionals.

Criteria for publicly funded treatment

Dental therapists make assessments of need for children and adolescents within their scope of practice. Some therapists may also have the requisite training to allow them to undertake assessments for adults, within the terms of their scope of practice.

Dentists make assessments for all patients.

Cost

Services provided free of charge are:

- a designated range of preventive, educative and treatment oral health services for preschool, primary and intermediate school children. Funders should plan to ensure funding generally allows annual examinations, but allow for twice-yearly examination for children matching 'at risk' criteria
- basic dental care for all adolescents up to their 18th birthday
- orthodontic treatment for children and adolescents aged from 0 years up to their 18th birthday for the correction of severe congenital craniofacial abnormalities and malocclusions
- dental health services provided as part of inpatient and day patient services in hospitals.

The following services are provided with a charge.

- Community Services Card holders in some areas partly pay for dental services to relieve pain. In these areas, adult Community Services Card holders will be charged a maximum of \$35.78 (\$31.11 excluding GST) per visit.

- DHBs may charge co-payments for outpatient dental services (other than those described above). Charges for comparable services should not be greater than 70 percent of the applicable fee set out in the Combined Dental Agreement. Further information on charging is set out in the Hospital Dental Service Specification.

Note

- In any consecutive 12-month period, DHBS should ensure that any increases in the level of co-payments charged do not exceed the annual Forecast Funding Track (FFT) percentage adjustor currently applicable. The annual FFT percentage adjustor is advised annually to each DHB in its annual funding package. Service providers in each DHB may need to refer to the DHB's planning and funding function for details of the applicable FFT percentage adjustor.
- Any increase in user charges must be limited to the annual FFT percentage adjustor against the fees being charged by the service prior to this service specification becoming applicable.

Time

Urgent dental services (eg, pain relief, treatment of infections) will be available by the following working day or sooner if necessary.

The DHB contracts with providers of oral health services on the basis that oral health services recommended during a dental examination of a preschool, primary or intermediate school child will be provided within two months.

The frequency of dental examinations for preschool, primary and intermediate school children who are at risk will be determined according to individual need, but there should be no longer than 18 months between examinations.

Adolescents should receive at least an annual examination. Those requiring further treatment should receive services within two months of their assessment for treatment.

Elective hospital dental services should be provided according to the timeframes specified in the Elective Services National Access Criteria

Additional quality requirements

In addition to the quality and other requirements within the service agreement and/or service specification, the following requirements apply:

Qualified supervision and provision of oral health services

Providers are required to comply with current professional standards and codes of practice (see Dental Council of New Zealand) and in accordance with the Code of Ethics (where relevant). Services will comply with specific dental infection control procedures.

Where emergency dental services are provided to Community Services Card holders (see above), the services will be of a similar standard to the standard of services normally provided in a dental practice.

4.11 Palliative care

Palliative care is provided for people who are dying from active, progressive diseases or other conditions when curative or disease-modifying treatment has come to an end. Palliative care aims to:

- optimise a person's quality of life until death by addressing their physical, psychosocial, spiritual and cultural needs
- support a person's family, whānau and other caregivers where needed, through the illness and after death.

DHBs must ensure that all people can access palliative care services according to their need.

The Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand (Ministry of Health 2013) (the Framework) provides guidance to support more consistent access to and purchasing of palliative care services. The Framework is based on the concept that, for many people, the need for palliative care can be met by their existing primary care provider (eg, their general practitioner). The need for specialist palliative care services may be episodic or shared rather than required on an intensive basis. The Framework also promotes a collaborative and integrated approach to service delivery.

Guidance for Integrated Paediatric Palliative Care Services in New Zealand (Ministry of Health 2012) provides guidance for the delivery of palliative care service to children and young people.

Range of services

Palliative care services funded by DHBs include but are not limited to: assessment, care coordination, clinical care, and some support services.

Services are also available for family and whānau members of people receiving specialist palliative care, where palliative care services assess them as requiring grief and loss support services.

Palliative care services may provide additional services (eg, non-clinical patient and family support services such as biography writing and day activities). These additional services are usually provided by volunteers and/or funded through community fundraising.

Access

Access to palliative care services funded by DHBs is determined by health professionals who are responsible for making clinical decisions about when palliative care should be provided, on the basis of the level of need.

Criteria for publicly funded treatment

Palliative care services are available for people, including children and adolescents, who:

- have an active, progressive and advanced disease
- are reasonably expected to die within 12 months, but in exceptional circumstances this timeframe may be longer
- have episodic specialist palliative care needs.

Exclusions

No public funding is available to the services usually provided via hospice volunteers.

Cost

Palliative care provided by hospital services, domiciliary nursing and allied health services will be provided free of charge.

Publicly funded palliative care services provided by hospices will also be provided free of charge. additional palliative care services provided by hospices are generally provided free of charge.

There may be user charges for palliative care clients accessing primary health care services and pharmaceuticals, etc. (see service coverage requirements in Schedules 4.12 Pharmaceutical services and 4.13 Primary health care services).

Time

Palliative care telephone services will be available 24/7 and home visits may be available outside standard working hours.

4.12 Pharmaceutical services

Range of services

All DHBs must comply with the requirements of the Pharmaceutical Schedule. Pharmaceutical services funded by DHBs include all components of services listed in service specifications. These include, but are not limited to:

- provision and dispensing of medicines
- provision of therapeutic medical devices and supplies
- In accordance with the 1998 Health (Needles and Syringes) Regulations, in particular Section 9(1), the Ministry of Health expects that all DHBs fund a sharps disposal services for people using needles and syringes in the community, at no cost to the patient. Pharmacies and medical practitioners are responsible for the collection of sharps they dispense, and DHBs are responsible for their disposal.

Access

Practitioners who are able to prescribe pharmaceuticals are specified in Medicines Regulations. Pharmacists may dispense pharmaceuticals only upon presentation of a prescription from one of these practitioners, written in the appropriate format, as set out in the Medicines Act 1981, Misuse of Drugs Act 1975 and accompanying regulations.

Decision-making criteria for publicly funded treatment

- Prescriptions must be written and dispensed in accordance with current legislation and meet the requirements for subsidy and payment.
- The appropriateness of the prescribed pharmaceutical should be verified.
- The acquired medication history should be checked for consistency of treatment, interactions and evidence of non-compliance or misuse.

Exclusions

No public funding is made available for non-subsidised pharmaceuticals, except in some circumstances (see 'Cost' below).

Time

DHBs will contract for pharmaceutical dispensing services to be available for prescriptions presented to a pharmacy during normal business hours, as follows:

- 90 percent of the prescribed items will be dispensed within one hour of being presented
- 99 percent of the prescribed items will be dispensed before the end of the next business day of being presented³⁴
- 100 percent of the prescribed items will be dispensed within two business days of being presented.

³⁴ The requirements of 90 and 99 percent are national targets, and practice may vary across regions.

These dispensing waiting times will not apply if the pharmaceutical is not available in New Zealand at the time the prescription is presented.

DHBs will use best endeavours to ensure a level of access to after-hours pharmacy services that meets the reasonable needs of their populations.

Cost

The following groups may be charged a co-payment of \$5 or less for pharmaceutical services.

- Where the service user holds a valid Community Services Card or a valid High User Health Card, they will pay a maximum co-payment of \$5 per prescription item.
- Where the service user or their family holds a valid Pharmaceutical Subsidy Card, then the co-payment will be \$0.
- Where the service user is under 13 years of age, the co-payment will be \$0.
- Where the service user has been prescribed contraceptives (drugs and devices that help prevent pregnancy), they will pay a maximum co-payment of \$5 per item of contraceptive prescribed. This includes condoms if prescribed by a general practitioner.
- The service user will pay a maximum co-payment of \$5 per prescription item where they are eligible for publicly funded services (regardless of whether they are enrolled in a PHO or not) and the provider/prescriber: is employed by a DHB; or has an access or service agreement with the Ministry or a DHB or a PHO; or is an after-hours provider that has an access or service agreement with a DHB or a PHO; or is a provider providing a fully publicly funded service under a section 88 (NZPHD Act 2000) notice alone.

Eligible providers

Prescriptions from the following additional providers are eligible for \$5 co-payments on subsidised medicines if they meet the specified criteria:

- public hospital
- a midwife
- family planning clinic
- general practitioners (as long as they are part of a PHO)
- after-hours accident and medical services (as long as they have a DHB or a PHO contract)
- youth health clinics (as long as they have a DHB or a PHO contract)
- dentists (only if the prescription relates to a service being provided under a DHB contract)
- private specialists (only if the prescription relates to a service being provided under a DHB contract)
- other health professionals (as long as they have a DHB or a PHO contract)
- Health practitioners who write a prescription during normal business hours to a person who is not enrolled in the general practice, provided the person is eligible for publicly funded services and the general practice is part of a PHO
- hospices (as long as they have a DHB contract)
- providers making an ACC-related claim.

Additional prescription rules

Prescriptions for subsidised medicines are free for eligible people if:

- their prescription is written by an eligible provider/prescriber and they have a Prescription Subsidy Card
- they are under 13 years old, regardless of their provider's eligibility.

Prescriptions may incur a greater co-payment in the following circumstances:

- Where a service user is aged between 13 and 17 years and does not fall into one of the other co-payment categories, then they will pay a maximum co-payment of \$10 per prescription item.
- Where a service user is aged 18 years or over and does not fall into one of the other co-payment categories, then they will pay a maximum co-payment of \$15 per prescription item.
- Where a service user receives a prescription from a private specialist who is not contracted with a DHB for publicly funded services, a higher co-payment (up to \$15) may apply.

Product premiums

PHARMAC is responsible for setting subsidies for pharmaceuticals. If the price of the pharmaceutical charged by the supplier is more than the subsidy set by PHARMAC, the service user will pay this difference plus a mark-up charged by the pharmacy in addition to the co-payments listed above.

Other charges

- In addition to co-payments and product premiums, service users may be charged extra:
 - for other services provided to them in addition to the services funded under the Pharmacy Services Agreement; this includes fulfilling a request by a service user or prescriber that is in excess of the requirements of the Pharmaceutical Schedule or the Pharmacy Services Agreement
 - for pharmaceuticals provided in excess of the maximum quantity specified for the relevant pharmaceutical in the Pharmaceutical Schedule
 - for delivery of the pharmaceutical (eg, if it is delivered to a service user's home or business)
 - for the cost of unusual packaging
 - if the pharmaceutical is collected by the service user outside ordinary business hours of the pharmacy³⁵
 - where the information contained in a prescription form does not include all the information it should include and where the pharmacist has to obtain this missing information from a person or organisation other than the service user so that the pharmacist can forward the script to the DHB's payment agent to obtain payment for their services.
- For the avoidance of doubt, a service user may not be charged for:
 - compliance packaging if the pharmacy is providing age-related residential care pharmacy services to the service user
 - any additional amount by way of a pharmacy charge unless a relevant circumstance listed above has arisen
 - any charge that has the effect of spreading the cost of circumstances listed above across service users more generally

³⁵ Ordinary business hours are defined in the Pharmacy Agreement 2012 on the Nationwide Service Framework Library website (www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/165).

- any other pharmacy charge not expressly permitted by the Pharmacy Services Agreement.
- Where a pharmacy charge is applicable, it must be fair and reasonable, and the provider must inform the service user of the amount of and reason for the pharmacy charge, which may include providing reasonable supporting evidence if requested. The provider must also explain how this charge may be avoided or reduced.

Hospital pharmaceutical charges

- Service users will not have to pay for any pharmaceuticals needed by and dispensed to them while they are receiving treatment in a public hospital.
- Where a service user is prescribed a pharmaceutical by a staff member of a public hospital (or one of its contractors, eg, a private specialist) to be dispensed at a community pharmacy for use in the community (eg, discharge prescriptions for outpatients), then the patient charges listed above will apply.

Quality and audit

- DHBs will appoint suitably qualified auditors to undertake pharmacy quality audits against the Pharmacy Services Standards, and claiming audits against the Community Pharmacy Services Agreement.
- Audit of the Community Pharmacy Services Agreement will ensure monitoring of the provision of services by identifying good performance as well as areas of improvement, and the supply and management of pharmaceuticals
- Organisational quality standards are set out in the Health and Disability Services Pharmacy Services Standard NZS 8134.7:2010, Community Pharmacy Services Agreement, quality specifications and specific quality requirements set out in each service specification.

4.13 Primary health care services

Primary health care services are typically people's first and most frequent point of contact with the health system. These services aim to improve, maintain and restore people's health. They are offered in a local community setting and are usually provided by a primary health care team including general practitioners, registered nurses (including nurse practitioners, diabetes nurse specialists and nurse prescribers), pharmacists and other appropriately qualified health care professionals. Many primary health care services are contracted through or provided by primary health organisations.

Nationally consistent services are provided to the eligible and enrolled population of the PHO in accordance with the current DHB–PHO service agreement.

PHOs are expected to provide access to essential primary health care services at low or reduced cost to their enrolled populations in accordance with the Fees Framework – level policy and charges to services users included in the current PHO–DHB service agreement.

These reductions apply when the general practice claims a subsidy for each visit (general medical services, GMS) and where general practices are paid for each enrolled patient (capitation).

See also Schedule 4.15 Public health services and prevention services.

Range of services

The primary health care services funded by DHBs or the Ministry will include, but are not limited to:

- essential primary health care services specified in the current PHO–DHB service agreement
- Well Child / Tamariki Ora services to help children stay well (eg, hearing and vision tests, Well Child assessments)
- health assessment and treatment services (including oral health, sexual health and primary mental health) to support at-risk children and adolescents and their families (eg, children and young people in the care of the State (Child, Youth and Family, including those in Child, Youth and Family youth justice and care and protection facilities) and the Family/Whānau Support Service)
- school-based health services in decile 1, 2 and 3 secondary schools (including secondary school-aged students that attend other schools, such as composite schools), teen parent units and alternative education facilities. DHBs will implement school-based health services in new decile 1–3 secondary schools, teen parent units and alternative education facilities, or in secondary schools that become eligible by being reclassified from a higher decile into decile 1, 2 or 3. The services are to be provided as previously advised in the school-based health services CFA variation and in accordance with the tier three service specification 'Additional school-based health services', and with standards supplied by the Ministry which may be updated from time to time. Each DHB is responsible for identifying all eligible schools in its district, and for ensuring that the roll-out of school-based health services to all decile 3 secondary schools is completed by the end of 2015. Coverage requirements for these services are:
 - all decile 1–3 secondary schools, teen parent units and alternative education facilities with school-based health services

- all Year 9 students receiving home, education/employment, eating, activities, drugs, sexuality, suicide and depression and safety (HEEADSSS) assessments from nurses in decile 1–3 schools, teen parent units and alternative education facilities
- school-based health services reporting requirements as outlined in the operational policy framework (OPF) support for local interagency coordination initiatives, such as Strengthening Families
- sexual and reproductive health services including family planning services, provision of counselling and birth control information and assessment, diagnosis treatment and contact tracing of sexually transmitted infections
- primary mental health promotion, education, diagnosis and treatment.

Pharmaceuticals and devices associated with primary health care services are addressed in Schedule 4.12 Pharmaceutical services.

Diagnostic services associated with primary health care services are addressed in Schedule 4.2 Diagnostic, therapeutic and support services – personal health.

Access

Service users can access primary health care services directly – that is, they do not require a referral. PHOs are funded to provide ‘services to improve access’ (SIA), which may include outreach services, mobile clinics and follow-up services.

Some services are usually initiated by the health practitioner (eg, Well Child / Tamariki Ora examinations, sexual contact tracing).

Each PHO must ensure that casual users (not enrolled) have access to the same standard of care as the PHO’s enrolled population. General medical services may be provided in accordance with the current DHB–PHO service agreement.

Criteria for publicly funded treatment

Access to first-level and urgent care services is to be provided in accordance with the current DHB–PHO service agreement and Minister’s Eligibility Direction.

In most cases the health practitioner determines which services will be provided, and how urgently those services are required, according to their clinical judgement. Routine Well Child / Tamariki Ora services are to be provided according to the national Well Child schedule and service specification and Public Health Service Specifications.³⁶ Screening services are to be provided according to specific contracts (eg, DHB newborn hearing screening services), agreed national policies and guidelines (eg, cervical screening), or best evidence-based practice (eg, screening at-risk groups for diabetes and problem drinking).

Exclusions

No public health funding is available for:

- issuing of certificates (except for purposes of obtaining a government benefit)
- immunisations not on the New Zealand Immunisation Schedule.

³⁶ Previously known as the *Public Health Handbook*; refer to www.nsfh.health.govt.nz

Cost

General medical services provided through non-PHOs

For general medical services provided outside PHO agreements the government subsidises the cost of access for certain people. General practices are required to reduce any fee they would otherwise charge the patient by at least the amount of the subsidy.

Smear taking

Smear taking is available at no charge from a number of providers. Details of the locations of these providers must be available from the local DHB. Women may be charged a fee by their GP or other smear taker to take a cervical smear. As with other publicly funded health services, the testing, reporting and any necessary follow-up provided within secondary facilities, as a result of the smear, are free.

Well Child / Tamariki Ora services

Routine Well Child / Tamariki Ora care services, hearing and vision screening, and some support services for children who are at risk are provided at no charge.

Immunisations

All immunisation services listed in the Immunisation Schedule (contained in the *Immunisation Handbook*, Ministry of Health 2011) are provided at no charge.³⁷

Sexual health services

People will have access, at no charge, to at least one provider of sexually transmitted infection services; these service locations must be available from the local DHB.

Primary mental health promotion, education, diagnosis and treatment

Refer to Schedule 4.9 Mental health and addiction services continuum.

Other primary health care services

The following primary health care services will be provided free of charge to the consumer:

- services to support at-risk children and adolescents and their families (eg, the Family/ Whānau Support Service)
- support for local interagency coordination initiatives (eg, Strengthening Families).

Services for under 13 years of age as per the PHO agreement:

Zero-fee general practice visits during regular hours should be available to children up to 13 years of age. Access to free after-hours services for this age group (for general practice and pharmacy) will also be purchased by DHBs for care that could not be deferred until regular business hours. Access to free after-hours services is required for 95 percent of the population enrolled with a general practice within 60 minutes travel time. DHBs will ensure information in relation to practices providing free daytime access and free urgent after-hours arrangements is publicly available on their websites.

Time

Refer to the current DHB–PHO service agreement.

³⁷ Link to Immunisation handbook 2014: <http://www.health.govt.nz/publication/immunisation-handbook-2014>

4.14 Provision of equipment, modifications and other supplies and services

This schedule relates to both people accessing Ministry-funded disability support services³⁸ and those accessing DHB-funded health and support services for older people, people with a personal health need and people with chronic health conditions. Some of these services overlap those detailed in Schedule 4.3 Disability support services, Schedule 4.5 Health and support services for older people and Schedule 4.16 Specialist medical and surgical services.

Range of services

The Ministry and DHBs fund equipment, modifications³⁹ and other supplies and services for disabled people to:

- promote their independence
- maintain and improve levels of mobility
- enable them to remain in or return to their home
- support and maintain access to education, vocational training and employment.

On 1 October 2003, DHBs were devolved responsibility for some long-term equipment and supplies in addition to their existing responsibilities, specifically orthotics and prosthetics services. The Ministry has retained responsibility for funding other equipment and modifications for people of all ages with a physical, sensory, intellectual or age-related disability or a combination of these, whose needs last longer than six months and people aged under 65 years with disabling chronic health conditions who have high needs.⁴⁰

DHB funded

DHBs will fund equipment and supplies for all age groups, regardless of whether it is for a short- or long-term need. These equipment and supplies include, but are not limited to:

- orthotics services
- prosthetics services (note that in 2003 funding for prosthetic limb services was devolved from the DSS Group to Capital & Coast DHB as the lead DHB (CAB Min (03) 23/8). Capital & Coast DHB contracts with the Artificial Limb Board for the provision of this service.)
- contact lenses (Central Region)
- incontinence supplies (except where the supply of products is included in the bed day funding for the facility)
- equipment to help people manage medical conditions. (conditions include asthma, diabetes and sleep apnoea), including peak-flow meters, nebulisers and medicine dispensers for asthma, and monitoring equipment, oxygen equipment, syringes and needles for diabetes

³⁸ Within the Ministry's agreed definition of disability (see the first footnote in Schedule 4.3 Disability support services), the Ministry of Health's DSS Group is responsible for planning and funding disability support services for people who have physical, sensory or intellectual disabilities, or a combination of these, and are generally aged under 65 years.

³⁹ Environmental support services include the provision of equipment and modifications (housing and vehicles), services and supports for people with vision and/or hearing impairments, specified specialist assessment and training services and specified subsidies and supports.

⁴⁰ The Ministry's DSS equipment and modification services support a person who has a physical, intellectual, sensory or age-related disability, or a combination of these, where the disability is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is needed.

- equipment that allows some illnesses to be managed at home instead of in hospital, where appropriate. Examples include drug delivery devices and supplies for people with cancer, renal dialysis equipment and supplies, equipment and supplies that people may need after discharge from publicly funded hospital care such as dressings, drips, ostomy and urological supplies, along with the appropriate equipment, including wheelchairs, temporary ramps, walking sticks and crutches, and hospital beds and hoists used in providing follow-up care to publicly funded secondary and tertiary medical services.⁴¹

Ministry funded

The Ministry funds, or contributes to the cost of, equipment and modifications where a person meets specified criteria, the Ministry's Equipment and Modification Services Prioritisation Tool has determined that funding is available, and it has been identified that the equipment or modifications are essential for the person (or with assistance from support people) to do one or more of the following:

- get around more safely in their home
- remain in or return to their home
- communicate effectively
- study full time (tertiary level) or take part in vocational training
- work full time
- work as a volunteer
- be the main carer of a dependent person.

When a person meets the Ministry's definition of disability, their disability is likely to last longer than six months and they meet agreed criteria for services, and the outcome of the Ministry's Equipment and Modification Services Prioritisation Tool is that funding is available, the Ministry will fund, or contribute to the funding of, equipment and modification services including, but not limited to:

- communication devices – equipment and resources to support a person to communicate effectively and safely, and training in the use and application of this equipment
- seating and positioning – equipment to minimise the person's physical discomfort and deterioration and to support them to carry out daily activities as independently and safely as possible
- housing modifications – including rails, level access showers, and access modifications such as ramps
- mobility – equipment such as standing frames, walking aids and wheelchairs, as well as, in some cases, adaptations to vehicles and assistance with vehicle purchase
- vision – equipment that enables a person with a vision disability to interpret visual information
- equipment for daily living – including shower stools, commodes, specialised beds and hoists
- hearing – hearing aids and hearing assistive technology to support a person to live safely in their home (eg, visual/vibrating smoke detectors).

⁴¹ DHB provision of equipment is referred to in the Community Health, Transitional and Support Services – Allied Health Services (Non Inpatient) Service Specification, which states DHBs should provide equipment for short-term loan for people who do not need it in the long term – ie, up to three months – but should provide it for longer if necessary. Once it is clear that the person's need is not long term (ie, they do not have a disability that lasts longer than six months), short-term equipment should remain on issue to the person until they no longer require it. This could be an interim solution while the person is awaiting long-term loan equipment funded by the Ministry of Health.

Other equipment and services

Note: See 'Cost' below for eligibility by age and other factors.

The Ministry will contribute to the funding of:

- wigs and breast prostheses
- replacement artificial eyes
- hearing aids
- children's spectacles
- contact lenses (Northern, Midland and Southern regions)
- cochlear implant services (assessment, surgery, device, habilitation/rehabilitation, repairs for children's devices, replacement processors).

Access

DHB funded equipment and supplies

Based on assessment of need, decisions about a person's access to particular equipment or supplies are made by:

- the person's general practitioner, for items that are provided on prescription
- other health professionals, such as midwives, in some circumstances
- the specialist hospital service that is providing the person's course of treatment or an ongoing service
- appropriately skilled assessors for the provision of equipment, modifications and other supplies and services (eg, an occupational therapist or physiotherapist), to whom the person could self-refer or be referred to, and who will assess the need for access to equipment and supplies.

Ministry-funded equipment and modifications

Based on assessment of need, decisions about a person's access to particular equipment and modifications⁴² are made by an appropriately skilled assessor (eg, an occupational therapist, physiotherapist, audiologist or speech-language therapist), who will assess the person's needs related to their disability. The Ministry's contracted providers of equipment modification services will arrange access to equipment through an appropriate supplier, or housing modifications through appropriate contractor. The person may access an appropriately skilled assessor through:

- a referral arranged by the person's needs assessor or service coordinator
- self-referral
- referral by a DHB health professional, GP or family member.
- Ministry-funded hearing aids
- Based on specific eligibility criteria, a person with hearing loss can receive funding for hearing aids. Two funding schemes are provided.
- Hearing Aid Funding Scheme⁴³ – eligible children and adults can be provided with a hearing aid that is suitable to meet their hearing needs.
- Hearing Aid Subsidy Scheme⁴⁴ – adults who are not eligible for the Hearing Aid Funding Scheme can receive a subsidy towards the cost of hearing aid(s).

⁴² Funding availability is subject to the outcome of the Ministry's Equipment and Modification Services Prioritisation Tool

⁴³ www.health.govt.nz/publication/guide-getting-hearing-aids-hearing-aid-funding-scheme

Other equipment, supplies and services funded by the Ministry

Based on assessment of need, referrals or recommendations for a person to access particular equipment and other supplies and services are made by:

- GP or medical specialist for wigs and breast prostheses benefit
- registered medical specialists for artificial eyes
- audiologists for hearing aid(s) funding
- optometrist or ophthalmologist for children's spectacle subsidy
- optometrist or ophthalmologist for contact lens benefit (Northland, Midland and Southern regions)
- the Cochlear Implant Programme Assessment Team for cochlear implant services.

Note:

- Audiologists must be **full members** of the New Zealand Audiological Society to access hearing aid funding through the Ministry of Health on behalf of their clients.
- Audiometrists, audiology technicians and other personnel working in an audiology clinic are **unable** to access hearing aid funding from the Ministry of Health on behalf of their clients.

Criteria for publicly funded treatment

For items available on a general practitioner's prescription

The doctor may prescribe items listed in the Pharmaceutical Schedule that are appropriate for the treatment of the diagnosed condition, such as diabetes or asthma. The doctor decides, on the basis of their diagnosis, what medicines and equipment are appropriate for the treatment of the condition.

For items relating to non-urgent medical and surgical services

Access is based on the decision of the specialist hospital service about the person's suitability for treatment and ability to benefit. See Schedule 4.16 Specialist medical and surgical services.

For equipment and supplies funded by Ministry and/or DHBs

Access to equipment, modifications and other supplies and services for people with disabilities is through assessment from an appropriately skilled, approved or credentialed assessor.

Access to the service is based on eligibility criteria and prioritisation of need.

Exclusions

No services are specifically excluded from DHB funding. Rather, decisions about offering particular services or treatment on a publicly funded basis are made according to an assessment of each individual's specific clinical and social circumstances.

Funding from Vote: Health is not available for people who are eligible for direct funding from Veteran's Affairs New Zealand.

⁴⁴ www.health.govt.nz/publication/guide-getting-hearing-aids-hearing-aid-subsidy-scheme

Cost

DHB funded

Limits on charges

People may not be required to pay a deposit for short-term items such as crutches, or to pay for the long-term use of some of the items listed under 'Range of services' above, if any of the following conditions applies:

- paying will cause financial hardship
- the person receives residential care
- the items are disposable and will not generally be used again
- the person receives temporary additional support under section 61G of the Social Security Act 1964, or special benefit grandparented under section 23 of the Social Security (Working for Families) Amendment Act 2004
- the full cost of the service is covered by ACC.

People may be required to make a co-payment for items provided through pharmacies as per Schedule 4.12 Pharmaceutical services.

Deposits for short-term use of some items

People may have to pay a deposit for the short-term use of some items, such as crutches, used in providing follow-up care to specialist medical and surgical services. The charge will be a **maximum** of \$37.82 (\$32.89 excluding GST) per item. Any deposit will be refunded in full when the item is returned in acceptable condition.

Consumables

If a patient chooses to supplement the volumes of DHB-funded consumables that have been prescribed, it is up to the patient to purchase the additional consumables that they wish to have. There is no provision for DHBs to provide part funding for a patient's preferred consumable brand.

Ministry-funded specific benefit/subsidy regimes

The Ministry will subsidise the cost of the following items.

Wigs, hair pieces and head gear (eg, turbans) benefit

- For permanent alopecia, the Ministry will pay adults (18 years and over) up to \$2,330.66 (\$2,026.66 excluding GST) over a nine-year period.
- For permanent alopecia, the Ministry will pay children and young people (under 17 years of age.) up to \$1,226.66 (\$1,066.65 excluding GST) over a three-year period.
- For temporary hair loss, the Ministry will pay up to \$408.88 (\$355.55 excluding GST) over a one-year period.

Breast prostheses benefit

- Unilateral – the Ministry will pay up to \$613.33 (\$533.33 excluding GST) over a four-year period.

- Bilateral – the Ministry will pay up to \$1,226.66 (\$1,066.66 excluding GST) over a four-year period.

Artificial eyes

- The Ministry will pay the full cost of a replacement eye for a child under six up to once every two years. This funding cannot be accrued from one year to the next.
- The Ministry will pay full cost of a replacement eye for children and young people aged 6 to 17 years inclusive, up to once every three years. This funding cannot be accrued from one year to the next.
- The Ministry will subsidise the cost of artificial eyes up to the cost of \$150.00 (\$133.33 excluding GST) per eye for those 18 years of age and over. This payment may be accumulated if not used every year. The person may have to pay the difference if the items cost more than the amount paid by the Ministry.
- Provision of the first artificial eye is the responsibility of the DHB at which the procedure was performed and cannot be claimed for under the subsidy for artificial eyes.

Hearing Aid Subsidy Scheme

The Ministry will pay a subsidy of \$511.11 (\$444.44 excluding GST) towards the cost of a new hearing aid no more than once every six years for people other than those eligible for the Hearing Aid Funding Scheme as noted below. For people who require bilateral hearing aids, the amount is a maximum of \$1,022.22 (\$888.88 excluding GST) no more than once every six years. The subsidy can be used for replacement hearing aids after the six-year period if the person's needs have changed and their current hearing aids no longer meet their needs.

Hearing Aid Funding Scheme

1. **Hearing aids for children:** The Ministry provides funding for hearing aids and frequency modulation (FM) systems for preschoolers, and hearing aids for children and young people aged 20 years and under who are studying at school or tertiary level.
2. **Hearing aids for adults:** The Ministry will fund the cost of hearing aids for eligible adults who have:
 - had long-term hearing loss since childhood
 - had onset of sudden and severe hearing loss during adulthood
 - a dual disability (such as being deaf and blind, or having hearing loss and an intellectual disability).

The Ministry will fund hearing aids for eligible adults who have a Community Services Card and need hearing aids to:

- work full time (more than 30 hours per week)
- study at tertiary level or do vocational training leading to future employment (for adults aged over 21 years)
- do voluntary work (more than 20 hours per week)
- safely look after a dependent person full time.

Children's spectacles subsidy

The Ministry will pay up to a maximum of \$287.50 (\$250.00 excluding GST) per child per year toward the price of eye examinations (this does not cover examinations undertaken in DHB

services), frames, lenses and patches prescribed for children aged 15 years or under who are holders of High Use Health Cards, community services cards or whose families hold Community Services Cards. An additional \$51.11 (\$44.44 excluding GST) is available for children who need adult-sized frames.

Ministry-funded equipment and modification services

Equipment

The Ministry will not pay for equipment under \$50.00 (\$43.48 excluding GST) except when the:

- person is living in residential care
- person is unable to pay due to hardship and is receiving either a special benefit or temporary additional support from Work and Income
- person is under 16 years old
- item is available on the Ministry of Health's Equipment Lists, which are managed by the equipment and modification service providers.

Housing modifications, and vehicle modifications and/or purchase

For housing modifications costing more than \$8,076.00 (\$7,022.22 excluding GST) where the person is aged 16 years and over, or for funding towards the purchase of a vehicle, a person may be income and cash asset tested by Work and Income to determine their level of contribution, if any, towards the cost.

Housing modifications costing less than \$200.00 (\$173.91 excluding GST) are not funded by the Ministry.

There is an upper limit on the amount of funding of \$15,334.00 (\$13,333.33 excluding GST) that a person can get towards access modifications to allow them to get in/out of their home, including moving between floors. This upper limit includes modifications such as ramps, platform lifts and through-floor lifts, but does not include other types of housing modifications such as door widening and level access showers.

The maximum funding available for vehicle purchase for eligible adults is \$12,165.00 (\$10,577.78 excluding GST). This is subject to income and cash asset testing.

The maximum funding available for vehicle modifications for eligible people is \$12,165.00 (\$10,577.78 excluding GST). Income and cash asset testing is not required for vehicle modifications.

4.15 Public health services and prevention services

Public health has been defined as ‘the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society’ (Acheson 1988). Public health services act to protect people from health threats, prevent disease, improve health and promote better health for all New Zealanders. Public health services focus on populations or specific groups of people, such as children, not individuals. Prevention services are those that aim to stop people becoming ill or seek to improve outcomes through the early detection of health conditions.

Some disease prevention services for individuals, which need to be delivered on a population basis (eg, organised population-based cervical screening programme), are also considered part of public health services.

Range of Services

All public health service agreements and service schedules must be consistent with the requirements outlined in the Public Health Service Specifications. Specific mandatory requirements and regulations for some services (eg, for the provision of information, notification of public health risks, and minimum standards of service coverage) are detailed in some of the service specifications. The tier one Public Health Service Specification summarises the generic requirements for all public health services.

Service volumes are determined as part of contract negotiations and are considered in relation to local needs and priorities as well as national service planning processes.

During 2015/16, providers will begin to transition from the 13 ‘issues-based’ tier two specifications to the five new, ‘functions-based’ tier two specifications. The following service specifications describe the public health services funded directly by the Ministry:

- Public Health Services tier one (updated as at February 2014)
- 1. Health assessment and surveillance – tier two
- 2. Public health capacity development – tier two
- 3. Health promotion – tier two
- 4. Health protection – tier two
- 5. Preventive interventions – tier two.

These five new tier two specifications effectively replace the former tier two specifications:

- Physical Environment tier two
- Communicable Disease tier two
- Social Environments and Health Promoting Schools tier two
- Well Child Promotion tier two
- National Screening Unit Screening Programmes tier two
- Prevention of Alcohol and Other Drug Related Harm tier two
- Tobacco Control tier two
- Healthy Physical Activity and Nutrition tier two
- Sexual Health Promotion tier two

- Mental Health Promotion tier two
- Unintentional Injury Prevention tier two
- Preventing and Minimising Gambling Harm – Problem Gambling tier two
- Public Health Infrastructure tier two.

While the high level framework is now functions-based, the overall scope of public health services remains unchanged. Furthermore, providers may continue to configure their services in ways that reflect their own planning, organisational and service delivery requirements, so long as they meet the public health needs of their service users / communities.

During 2015 the Ministry may also complete the revision of some of the associated tier three public health service specifications.

Service planning and delivery

For most of the service categories outlined below, a ‘mix’ of complementary services are purchased from providers of services at national, regional and local levels.

Public health services can be categorised into the following three broad categories.

1. Public health promotion services

Some health promotion services are provided to benefit the whole population, such as national media campaigns, or the national Quitline service. Other health promotion services are provided for a particular community or group in the population according to need. The Ministry funds the following categories of public health promotion services:

- **social environments** – services to promote better social environments – for example, Health Promoting Schools and healthy city programmes
- **injury prevention** – programmes such as community injury prevention programmes and services to protect against non-communicable diseases like melanoma
- **Well Child /Tamariki Ora promotion** – services to promote the wellbeing of children – for example, the promotion of immunisation and oral health
- **mental health** promotion– services and programmes to promote better mental health, including programmes to reduce the stigma associated with mental illness, and programmes to prevent suicide
- **nutrition and physical activity** – programmes that promote healthy diets and physical exercise
- **sexual health** – sexual and reproductive health promotion programmes

2. Public health protection and regulatory services

Most public health protection and regulatory services are provided to protect and benefit the whole population. These services include:

- monitoring public health risks
- providing advice on public health protection and regulatory services
- investigating public health complaints
- taking action where necessary to protect public health.

The Ministry funds the following categories of public health prevention services:

- **environmental and border health** – services to protect and promote healthy communities and healthy environments – for example, sewerage, drinking-water and air-quality services
- **communicable diseases** – services to help prevent the spread of communicable diseases such as HIV/AIDS, tuberculosis (TB), hepatitis A (including needle and syringe exchange programme) and food-borne illness
- **alcohol and drug** – services to reduce alcohol- and/or drug-related harm
- **tobacco** – tobacco control programmes, including monitoring smokefree workplaces and restaurants, and public education programmes

Public health protection and regulatory services available from all public health units cover:

- contaminated land
- drinking-water quality
- recreational water quality
- sewage treatment and disposal
- waste management (liquid and solid waste)
- hazardous substances
- resource management
- environmental noise management
- ionising/non-ionising radiation
- air quality (indoor and outdoor)
- public health emergency planning and response
- burials and cremation
- early childhood centres
- imported disease control
- Alcohol regulatory roles
- tobacco control
- Psychoactive substances regulatory roles
- communicable disease control, including TB control and regulatory components of the prevention and control of sexually transmitted infections and HIV/AIDS and of food safety and quality
- border health and quarantine.

Note: Depending on the nature or circumstances of public health issues, the public health unit may not be the lead agency and /or may share legislative responsibilities with other regulatory agencies.

3. Prevention, detection and early intervention services

A range of specific prevention, detection and early intervention services is also purchased, including the following services: national screening programmes, immunisation, stop smoking and family violence prevention:

Breast screening

Breast screening services are provided through BreastScreen Aotearoa, a national breast screening programme for eligible asymptomatic women aged from 45 to 69 years. Services include:

- recruitment and retention services
- regional engagement and coordination, including with primary health care
- support to screening services in some regions
- screening mammography services, including mobile services
- assessment services for women requiring further investigation following initial screening
- connecting women requiring treatment support with appropriate providers
- national and regional BreastScreen Aotearoa promotion and education services
- monitoring and evaluation services.

Cervical screening

Cervical screening services are provided through the National Cervical Screening Programme (NCSP), a national cervical screening programme for eligible women aged from 20 to 70 years. Services include:

- invitation and recall services through primary health care
- support to services in some regions, including targeted free smears
- monitoring and evaluation services
- NCSP Register to support the clinical management of the women
- hospital and community-generated laboratory cervical cytology services – NCSP tests
- hospital and community-generated laboratory cervical histology services – NCSP tests
- hospital and community-generated laboratory human papilloma virus testing services – NCSP tests
- diagnostic and treatment services for women with cervical abnormalities (colposcopy)
- regional coordination services.

Newborn metabolic screening services

Newborn metabolic screening services are provided through the Newborn Metabolic Screening Programme, a national screening programme for over 20 metabolic disorders offered to all eligible newborns within New Zealand. Samples are taken by lead maternity carers and tested by LabPLUS, which is part of Auckland DHB.

The National Screening Unit (NSU) is responsible for the strategic direction, monitoring and evaluation of this screening programme.

Antenatal HIV screening services

HIV testing is offered to all pregnant women at their first antenatal visit. Testing is performed by community laboratories who also provide data to DHBs for local monitoring. The NSU provides consumer resources, education and training for referring practitioners.

Antenatal screening for Down syndrome and other conditions

All pregnant women should be offered antenatal screening for Down syndrome and other conditions.

Laboratory services for first trimester combined screening and second trimester serum screening will be nationally purchased.

Nuchal translucency scanning may have a part charge.

Newborn hearing screening services

Newborn hearing screening services are offered through the Universal Newborn Hearing Screening and Early Intervention Programme, a national newborn hearing screening and early intervention programme offered to all eligible newborns within New Zealand. Its services include:

- newborn hearing screening services
- monitoring services
- diagnostic audiology and ear, nose and throat services for babies with a 'refer' result
- early intervention and amplification services as required for babies with hearing loss.

Other services

Other prevention, detection and early intervention services are:

- **National Poisons Centre** – a poisons advisory service providing 24-hour emergency advice
- **vaccine distribution** – buying, storing and distributing vaccines (drugs to prevent infection and disease)
- **National Immunisation Register** – supporting the prevention of key childhood illnesses through sharing information among health professionals so that the right immunisations can be distributed to the right children at the right time.

Access

Information and advice on public health promotion and public health regulatory services is available from all public health units. These are often located at the nearest public hospital.

Health protection and regulatory services

Health protection and regulatory services are available from public health units as required. In some cases, another organisation is the lead agency.

Health promotion services

While some services are available to the whole population, other programmes are targeted to specific populations where greatest need has been identified.

Services for specific populations

Breast screening

Breast screening is provided two-yearly for asymptomatic women aged 45 to 69 years.

Women can access the programme in several ways:

- they can self-refer by telephoning 0800 270 200
- they may receive a direct invitation from their regional lead provider. This will only happen if their GP has provided their contact details to the provider, after seeking and receiving the woman's permission to do so
- their GP may enrol them (with the woman's consent)
- they may be assisted to enrol after attending a regionally planned and coordinated health promotion and recruitment initiative.

Cervical screening

Women aged 20 to 70 years are automatically enrolled in the National Cervical Screening Programme when they have a smear taken, unless they choose to withdraw from the programme. The National Cervical Screening Programme provides a record of a woman's cervical screening history, sends reminder letters to women enrolled in the programme if their cervical smear is overdue and provides information to smear takers regarding women overdue for their smear test or overdue for follow up.

DHBs have a three-yearly coverage target for women aged 25–69 years under the National Cervical Screening Programme. This target is 80 percent coverage for Māori, Pacific, Asian and European/Other ethnic groups and for total women.

Newborn metabolic screening

Participation in the screening programme is voluntary. Under section 88 of the NZPHD Act 2000, lead maternity carers are required to gain informed consent from mothers and send a sample to LabPLUS, which is part of Auckland DHB.

Antenatal HIV screening

Participation in the screening programme⁴⁵ is voluntary. Maternity care providers must offer antenatal HIV screening to all pregnant women and gain informed consent, but there are extended specific eligibility criteria for this screening.

Antenatal screening for Down syndrome and other conditions

Participation in screening is voluntary. Maternity care providers must offer all pregnant women appropriate antenatal screening for Down syndrome and other conditions and gain informed consent.

Newborn hearing screening

Participation in the screening programme is voluntary. Newborn hearing screeners must offer screening to all newborns and are required to gain informed consent from parents. Newborns may be screened in the hospital before discharge, as an outpatient or in the community.

Criteria for publicly funded treatment

For most of the health promotion and recruitment services, and some of the health protection services, a 'mix' of complementary national, regional and local services is purchased. For example, the range of services to reduce alcohol- and drug-related harm, purchased in a particular community, may include services to monitor and inform liquor licensing, public education services (eg, to reduce drink-driving and community action programmes). Some services may be most efficiently provided at a regional level. Both local and regional services are supported by national services such as training or media strategies. Most health protection and regulatory services are complemented by non-regulatory services, such as public education programmes that complement the enforcement of the Sale and Supply of Alcohol Act 2012.

The mix of services purchased will depend on the needs of the particular community as well as on what services are in accordance with the national strategy and complementary regional and national services in the particular service area.

⁴⁵ www.nsu.govt.nz/current-nsu-programmes/antenatal-hiv-screening.aspx

Public health protection and regulatory services are available from 12 DHB-based public health units (PHUs) across the country, which are funded to provide a 24-hour, seven-day-a-week response capacity on the issues listed in 'Range of services' above (note: the PHU is not always the lead agency).

Cost

Most public health services are funded from Vote Health with no direct cost to users. See also the Eligibility Direction and Tier One Public Health Service Specification for further details.

In order to safeguard the public's health, these services are expected to contribute to the investigation of suspected TB and treatment of active TB, regardless of the patient's usual eligibility for publicly funded services and ability to pay. For patients not usually eligible for publicly funded services, the services must still be provided and cost recovery must be attempted. Cost recovery may be directly from the person or from their insurance company. It is important to remember that treatment to protect the public health may not necessarily equate with the benefit of the infected individual; for example, treatment to render a person non-infectious may be for a period of two to four weeks to enable a non-eligible person to safely depart from New Zealand.

Two-yearly breast screening is provided at no charge for asymptomatic women aged 45 to 69 years through BreastScreen Aotearoa. Cervical screening diagnostic and treatment services (within public hospitals) and laboratory services (community and public hospital laboratories) are provided at no charge. However, women will be charged a fee by their GP or other smear taker to take a cervical smear. (See Schedule 4.13 Primary health care services for further details.)

The Newborn Metabolic Screening Programme screens for over 20 metabolic disorders in New Zealand. It is provided at no charge as it is fully publicly funded. Samples are sent to LabPLUS, which is part of Auckland DHB.

The blood test for antenatal HIV screening is provided at no charge. However, women may be charged an attendance fee by their GP. (See Schedule 4.8 Maternity services for further details).

For antenatal screening for Down syndrome and other conditions, the blood test is provided at no charge. Women may be charged a co-payment for ultrasound scans.

The newborn hearing screening test and audiology services are provided at no charge.

Time

Public health protection response capacity services are available 24 hours, seven days a week in order to respond to public health emergencies.

Information and advice on public health protection and regulatory services are available during normal business hours from public health units at:

- Northland DHB
- Auckland Regional Public Health Service (provider for Auckland, Waitemata and Counties Manukau DHBs)
- Waikato DHB
- Toi Te Ora Public Health (provider for Bay of Plenty and Lakes DHBs)

- Tairāwhiti DHB
- Taranaki DHB
- Hawke's Bay DHB
- MidCentral DHB (provider for MidCentral and Whanganui DHBs)
- Regional Public Health (provider for Capital & Coast, Hutt Valley and Wairarapa DHBs)
- Nelson Marlborough DHB
- Community and Public Health (provider for Canterbury, South Canterbury and West Coast DHBs)
- Public Health South (provider for Southern DHB).

Breast screening

BreastScreen Aotearoa provides breast screening for eligible women every two years. There are screening sites that can be accessed by women in urban centres. In rural and some urban areas, mobile services are available.

Cervical screening

Screening services such as laboratory and diagnostic services, the NCSP register, the promotion of screening, monitoring, audit and evaluation services are planned and funded by the Ministry on an ongoing basis. However, women need to access the actual taking of cervical smears by individual health practitioners through general practice or other smear taking services.

Newborn Metabolic Screening Programme

The programme screens for several metabolic disorders in New Zealand neonates. Screening is offered when the baby is 48 to 72 hours old.

Antenatal HIV screening

Screening is offered as part of an antenatal visit in the first trimester with the other first antenatal bloods. It may be offered later in pregnancy if not offered at this time.

Antenatal screening for Down syndrome and other conditions

Screening will be offered to pregnant women when they first present for maternity care.

Newborn hearing screening

Screening is offered within one month of the birth of the child.

Additional quality requirements

Public health services require coordinated planning and delivery of services at national, regional and local levels and a collaborative approach between DHBs, NGOs and the Ministry, to identify and fund services to address emergent public health issues. The Ministry and DHBs, as well as NGO providers, need to collaborate to ensure quality planning and provision.

Public health protection and regulatory services must meet the requirements of: public health legislation; the relevant sections of the Public Health services specifications tier one and tier two

(Health Protection); Ministry of Health manuals, guidelines, directions and advice; and the Provider Quality Specifications v1.1 attached to all new contracts.

Breast screening

BreastScreen Aotearoa providers must meet the requirements of the BreastScreen Aotearoa National Policy and Quality Standards.

National Cervical Screening Programme

NCSP providers must meet the requirements of the NCSP Policies and Standards.

Newborn Metabolic Screening Programme

LabPLUS must meet the requirements of the Newborn Metabolic Screening Programme National Policy and Quality Standards. The *Guidelines for Practitioners Providing Services within the Newborn Metabolic Screening Programme in New Zealand*⁴⁶ (NSU 2010) define the requirements for practitioners.

Antenatal HIV screening

DHBs must meet the requirements of the Universal Offer Antenatal HIV Screening Programme Policy and Quality Standards. The *Guidelines for Maternity Providers Offering Antenatal HIV Screening in New Zealand*⁴⁷ (NSU 2008) define the requirements for maternity providers.

Newborn hearing screening

Universal Newborn Hearing Screening providers must meet the requirements of the Universal Newborn Hearing Screening and Early Intervention Programme National Policy and Quality Standards. Newborn hearing screening must be completed by one month of age. Audiology assessment diagnosis must be completed by three months of age. Early intervention services must commence by six months of age.

⁴⁶ www.nsu.govt.nz/health-professionals/3819.aspx

⁴⁷ www.nsu.govt.nz/health-professionals/3806.aspx

4.16 Specialist medical and surgical services

DHBs fund specialist medical and surgical services. These specialist services are usually provided in or from a hospital following a medical emergency or an accident, or after referral from an approved specialist or primary health care referrer, or another DHB.

DHBs also fund a range of diagnostic, therapeutic and support services that are related to the specialist medical and surgical services described below. For more information, see Schedule 4.2 Diagnostic, therapeutic and support services – personal health.

Specific mandatory requirements for some services are detailed in the nationwide service specifications. The tier one service specifications for specialist medical and surgical services and for services for children and young people summarises the generic requirements for the range of services listed below.

Range of services

Specialist medical and surgical services funded by DHBs include, but are not limited to:

- anaesthesiology (including pain management services)
- assisted reproductive technology, including fertility preservation
- audiology
- cardiology
- cardiothoracic surgery
- clinical haematology, including services for haemophiliacs
- dermatology
- diabetes
- emergency services
- endocrinology
- gastroenterology
- general medicine
- general surgery
- gynaecology, including secondary-level infertility services, termination of pregnancy, sterilisation services
- genetics services
- immunology
- maxillofacial surgery
- medical and radiation oncology
- metabolic services (linked to genetics)
- neurology
- neurosurgery
- neonatology
- ophthalmology
- oral health services
- organ transplants

- otorhinolaryngology
- orthopaedics
- paediatric
- plastic and reconstructive surgery, including burns
- pulsed laser dye
- pulmonary medicine
- renal medicine
- respiratory medicine
- rheumatology
- sexual health services
- spinal cord services
- tolerisation
- urology
- vascular surgery.

For each of the services outlined above, the following service components and related services are also included in the funding:

- assessment, diagnosis and treatment
- specialist diagnostic services (eg, endoscopies and clinical post-mortems)
- nursing and other clinical support services
- discharge planning or onward referral to other services
- consultative services
- health education and promotion and disease prevention as part of a treatment programme
- meals, cleaning and other non-treatment services related to an inpatient stay
- pharmaceuticals associated with these services, as addressed in Schedule 4.12
Pharmaceutical services
- medical equipment and supplies associated with these services, as addressed in Schedule 4.14
Provision of equipment, modifications and other supplies and services
- other associated diagnostic, therapeutic and support services, as addressed in Schedule 4.2
Diagnostic, therapeutic and support services – personal health
- rehabilitation including community-based care and support, as addressed in Schedules 4.2
Diagnostic, therapeutic and support services – personal health, 4.3 Disability support
services and 4.5 Health and support services for older people
- communication with linked services, such as health and support services for older people,
DSS, ACC and primary health care providers.

Coordination of services

DHB funded

Adolescent and Young People Oncology/ Haematology Services Coordination Service applies to adolescents and young adults from the ages of 12 to 24 years inclusive. The Ministry will provide funding to the following six regional cancer centre DHBs to implement the Adolescent and Young People Service Specification: Auckland, Waikato, MidCentral, Capital & Coast, Canterbury and Southern.

Ministry funded

The Ministry will also fund services through a lead DHB such as national coordination of organ transplant services and donor coordination.

Services provided at tertiary hospital centres

While most of the specialist medical and surgical services described here are available through public hospitals, some more highly specialised, lower-volume services are provided only at the larger centres, usually referred to as 'tertiary' centres. The hospitals providing regional or national services are required to have systems in place to ensure that access is available according to the criteria set out in the relevant service specification.

Cancer treatment services

Cancer treatment services will be provided in line with existing service specifications and agreed standards.

- **Radiation oncology:** Auckland, Waikato, MidCentral, Capital & Coast, Canterbury and Southern DHBs are responsible for providing radiation oncology services. Southern DHB is responsible for providing the national stereotactic radiosurgery/therapy service.
- **Medical oncology** services should be administered under the direction/supervision of a medical oncologist. Haematology services should be administered under the direction/supervision of a haematologist.
- **Paediatric oncology:** Auckland and Canterbury DHBs are responsible for providing paediatric oncology services.

Special high cost treatments

DHBs are required to ensure funding is made available for follow-up treatment for services funded via the Special High Cost Treatment Pool as clinically required.

Simultaneous pancreas kidney transplants are now fully casemix funded and are therefore not accessible through the Special High Cost Treatment Pool.

Criteria for publicly funded treatment

Assisted reproductive technology and fertility preservation

Access to these services will be guided by the relevant clinical priority access criteria (CPAC) (under development). Further detail is provided in the Assisted Reproductive Technology Service Specification.

- Access to in vitro fertilisation (IVF) is for one full IVF/intracytoplasmic sperm injection (ICSI) treatment, including subsequent transfer of any thawed embryo or four AIH/DI (hyperstimulation, donor insemination) cycles. If the first cycle does not result in a live birth, the couple may access a second cycle provided they still meet the (CPAC) access threshold.
- Access to fertility preservation for the retrieval, freezing and long term storage of gametes (specifically sperm and eggs) is for people whose fertility will be permanently impaired by treatment for medical conditions, such as by cancer treatment.

Emergency and acute services

Approved referrers may refer people to hospital services based on their assessment of the urgency of the situation. Where people present for emergency treatment, triage and other guidelines will be used to determine appropriate levels and timeframes for treatment.

Electives

New Zealand's publicly funded health care system has a limit to the amount of elective treatment that taxpayer funding can support. Where demand for elective services cannot be met within existing capacity, the explicit requirement is that resources are allocated based on need and ability to benefit. Where a service is offered to patients, they wait no longer than four months.

The key principles underlying the elective system are:

- clarity – patients know whether or not they will receive publicly funded services
- timeliness – where services can be delivered within the available capacity, patients receive them in a timely manner
- fairness – ensuring that the resources available are directed to those most in need.

To manage elective services, DHBs must focus on improving access to elective surgery and reducing waiting times.

Improving access

DHBs will ensure that the hospital(s) provide the amount of elective operations, procedures and assessments agreed to in their Annual Plan. They will review the key operations performed to ensure the right level of service is delivered for the people in the region.

DHBs will demonstrate innovative strategies to improve elective capacity, or alternative delivery options aimed at increasing productivity and efficiency, particularly theatre efficiency, and workforce development. Innovation and efficiency should be within the DHB and across the primary–secondary interface.

Reducing waiting times

DHBs will comply with required standards on Elective Services Patient Flow Indicators, which demonstrate that the DHB is managing patients in accordance with the three principles (clarity, timeliness and fairness) and matching its commitments to capacity. DHBs will focus on meeting the commitments given to patients for specialist assessment and treatment and ensure patients wait no longer than four months.

Improving quality

There is to be ethical and equitable access to elective services. Patients with similar need are to have similar access to elective services, regardless of where they live. DHBs will have in place, and maintain, effective prioritisation systems as agreed with the Ministry of Health. Patients are to be prioritised using the appropriate assessment tools and processes. DHBs will ensure that patients are assessed and prioritised for surgery on a consistent basis, and that they then receive surgery according to the priority they were given.

Diagnostics

Diagnostics are a vital step in the pathway to access appropriate treatment. Very few diagnostic procedures have specific targets set for increases in delivery or service quality. Consequently the wait for diagnostics can result in significant delays to a patient's episode of care. Reducing waiting times for diagnostics will improve access and patient outcomes in a range of areas including cancer pathways, emergency department waiting times, and access to elective surgery. The programme to reduce waiting times for diagnostics is addressed in Section 3.8: Diagnostic services.

Termination of pregnancy

Termination of pregnancy services are provided for those women who meet the criteria provided by the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977.

Exclusions

Except where explicitly stated, no services are specifically excluded from DHB funding. Rather, decisions about offering particular services or treatment on a publicly funded basis are made according to an assessment of each individual's specific clinical and social circumstances. In particular, consideration is given to the likely benefits of the service for the individual, relative to the costs of that service, and to the potential benefits of directing those resources to a different service or another individual's treatment.

DHB-specific exclusions from nationwide service specifications are outlined in CFAs, on application to and agreement with the Ministry.

Excluded cardiac interventions

No public funding is made available for the following cardiac interventions excluded from the national minimum service coverage requirements:

- Renal artery denervation for patients with refractory hypertension
- Percutaneous interventions for mitral regurgitation
- Percutaneous left atrial appendage occlusion for the treatment of atrial fibrillation.

Cost

Publicly funded inpatient services, as well as day patient, outpatient and any community-referred services provided in the hospital setting, are provided to eligible people free of charge. This includes all the services and supplies associated with the hospital treatment.

To safeguard the public's health and to protect individuals who may have infectious diseases, these services are expected to contribute to the investigation and treatment of suspected cases of notifiable infectious diseases, regardless of the patient's usual eligibility for publicly funded services and ability to pay. If it is suspected that a patient has a notifiable infectious disease and may be infectious and so pose a risk to others, they have access to publicly funded diagnostic, treatment and follow-up services (for further details of the services, see the Ministry's website).⁴⁸ Where a patient is not eligible for publicly funded services, these services should be provided and cost recovery should not be attempted.

⁴⁸ www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services

Note: Treatment to protect public health may not necessarily equate to the benefit of the infected individual. For example, treatment to render a person non-infectious may be for a period of two to four weeks to enable a non-eligible person to safely depart from New Zealand.

See Schedules 4.2 Diagnostic, therapeutic and support services – personal health, 4.10 Oral health services, 4.12 Pharmaceutical services, 4.14 Provision of equipment, modifications and other supplies and services and 4.17 Travel and accommodation services, for details associated with each of these services.

Organs for transplant are provided to eligible people at no charge.

Time

Electives

People have direct and immediate access to hospital emergency department services and will move through those services to the most appropriate level for care and/or treatment. For elective services, booking system timeframes are as follows:

- timely and efficient access to specialist advice and assistance
- 100 percent of people accepted for assessment receive their first specialist assessment within four months
- 100 percent of people offered publicly funded treatment receive that treatment within four months of the offer to treat
- 100 percent of people placed in active review receive a review of their condition and eligibility status at least every six months.

Diagnostics waiting times

Waiting time measures have been agreed for a number of diagnostic modalities – colonoscopy, coronary angiography, computed tomography (CT) and magnetic resonance imaging (MRI). Performance monitoring against these waiting time measures will continue during 2015/16.

Radiation oncology waiting times

Facilities should be provided to ensure that patients who require radiation treatment can be treated within appropriate timeframes. The timeframes for treatment priorities are:

- urgent patients should be treated within 24 hours of referral
- curative category (radical primary radiotherapy) patients should be treated within two weeks of the radiation oncology assessment and decision to treat
- palliative and other radical patients should be treated within four weeks of radiation oncology assessment and decision to treat
- sequential chemotherapy and radiation treatment should start on a date scheduled according to the chemotherapy protocol requirements.

Medical oncology waiting times

Capacity should be provided to ensure that patients who require chemotherapy treatment can be assessed and treated in accordance with the timeframes outlined in the medical oncology prioritisation criteria. The timeframes for treatment priorities are:

- immediate category patients should be treated within 48 hours of decision to treat
- semi-urgent patients should be treated within two weeks of a decision to treat

- routine patients should be treated within four weeks of a decision to treat
- concurrent chemotherapy and radiation treatment should start within four weeks of the decision to treat.

Additional quality requirements

- All DHBs have been contracted through Vote Health since 2007 to deliver violence intervention programmes in acute and community health services, in particular: mental health, alcohol and drug, child health (including school and home visiting services and tertiary paediatric services), maternity, sexual health and emergency department.
- Funding is provided through public health service contracts to deliver violence intervention programmes aligned with the Ministry's *Family Violence Intervention Guidelines: Child and partner abuse* (Ministry of Health 2002) and *Family Violence Intervention Guidelines: Elder abuse and neglect* (Ministry of Health 2007). DHBs are expected to achieve audit scores of 70/100 for each of the child and partner abuse components of their violence intervention programme. Contract performance and accountability against national service specifications are managed by the Public Health Group, National Services Purchasing (NHB).

4.17 Travel and accommodation services

This schedule describes service coverage requirements that were implemented on 1 January 2006, when the new National Travel Assistance (NTA) Policy 2005 was introduced.

Range of services

All DHBs must provide assistance for patient travel and accommodation as specified in the National Travel Assistance Policy 2005. The *Guide to the National Travel Assistance (NTA) Policy 2005*⁴⁹ (Ministry of Health 2009b) sets out the minimum requirements; DHBs may have additional arrangements in recognition of local needs.

The aim of the policy is to provide targeted financial assistance towards the travel and accommodation costs for those for whom transportation is a significant barrier, as identified in the policy, to accessing specialist services. For patients who are eligible for NTA funding, the policy provides assistance for transport from the patient's home to the location of the patient's specialist health and/or disability service provider and for accommodation if the patient is required to stay closer to the specialist service or meet certain travel distance criteria. In addition, some assistance is available for transport and accommodation for eligible patients' supporters.

Access

Eligibility is based on combinations of factors such as age, financial need (Community Services Card), frequency of service use, and distance from services. The NTA Policy 2005 can only consider referrals from publicly funded health and disability specialists when people are referred to publicly funded specialist health and disability services.

To ensure their patients in need are informed, DHBs are required to advertise their policies at key points in their facilities, to provide access to NTA registration and claims forms and to train key staff for helping patients to fill in forms if needed.

The Ministry provides details of eligibility criteria, registration and claims forms and other information on its website.⁵⁰ To ensure national consistency, the Ministry (NTA payments team, Sector Operations Group) administers NTA registration and claims processing on behalf of DHBs. Eligible patients can register for NTA through their DHB health or disability specialist. Once registered, patients can obtain claims forms from their DHB or the Ministry's NTA payments team, or download them.⁵¹ Registration and claim forms need to be completed and forwarded to the Ministry's NTA payments team, with all the specified information attached.

Criteria for publicly funded treatment

NTA registrations are approved or declined by the Ministry's NTA payments team according to the eligibility criteria set out in the policy. Patients must usually meet all the criteria under at least one eligibility category (long distance travel, high frequency travel, frequent travel, Community Services Card holder and additional categories addressed in the NTA Policy). Assistance with

⁴⁹ www.health.govt.nz/system/files/documents/publications/nta-policy-guide-v2-1-aug-2009.pdf

⁵⁰ www.health.govt.nz/your-health/services-and-support/health-care-services/hospitals-and-specialist-services/travel-assistance

⁵¹ www.health.govt.nz/your-health/services-and-support/health-care-services/hospitals-and-specialist-services/travel-assistance/how-claim-travel-assistance

travel and accommodation costs for a support person of an eligible patient may be granted if the patient is a child or the specialist deems that a support person is necessary. Claims must be received within 12 months of the last date of treatment to be eligible for assistance.

Claims that are approved will usually be processed within 10 working days and paid to the nominated bank account or to the transport and/or accommodation provider.

Exclusion

Travel and accommodation services are not available under the current National Travel Assistance Policy for the following purposes, unless otherwise advised by the patient's DHB of domicile:

- access to primary health care services
- referral from a primary provider to a first specialist assessment (eg, GP referral)
- self-referrals (which includes emergency room visits)
- private referrals or treatments
- emergency transportation
- when travel assistance is funded by other parties (eg, ACC, Work and Income)
- patients returning to their residential home following an unplanned acute admission to a treatment facility that is not the closest one to their home while they were voluntarily travelling out of their DHB district (eg, on holiday or travelling for work)
- inter-hospital transfers – note: inter-hospital transfers discharged to their residential home from a treatment facility must meet the usual NTA criteria to qualify for NTA funding
- overseas travel
- transfers from home to airport or public transport terminals (or vice versa)
- travel between client accommodation (NTA paid) and the treatment centre or any about-town travel
- when the client is an inpatient, travel between a support person's accommodation (NTA paid) and the treatment centre or any about-town travel.

Cost

Travel and accommodation costs are reimbursed at the rates specified in the policy. These may include:

- 28 cents per kilometre for private mileage, which is always calculated from the patient's address.
- actual costs for air transport if clinically required (travel insurance excluded)
- actual costs of public transport
- assistance with accommodation costs if required and approved by a specialist, up to the maximum amount specified in the policy. This maximum is usually \$100 per night for motel accommodation, or \$25 per night for private accommodation
- some assistance with travel and accommodation costs for a support person.

The above reimbursement rates are subject to review and change with the approval of the 20 DHBs and the Minister of Health.

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Appendix 1: Special high cost treatment

1. Definitions

The following definitions apply to this appendix.

- **Senior Advisor** means the Ministry's Senior Advisor (Special High Cost Treatment).
- **Complex case** means a case that may require case management due to its rarity and high cost that is not adequately compensated for by weighted inlier equivalent separations (WIES) methodology, and where there is a significant financial risk that neither DHBs nor the Ministry can control.
- **Special High Cost Treatment** includes the following treatments:
 - medical treatments overseas
 - complex cases
 - treatments currently available generally only outside public hospitals.
- **Special High Cost Treatment Pool** means the central fund for special high cost treatment, which will be administered and managed by the Ministry.

2. Purpose of Special High Cost Treatment Pool

The purpose of the Special High Cost Treatment Pool is to:

- ensure equitable access for eligible people throughout New Zealand to special high cost treatments
- manage the financial risk for certain highly specialised procedures that pose a risk due to their unknown, high or fluctuating costs
- promote the use of cost-effective procedures in the public health care system.

3. Business rules for special high cost treatment

The Ministry will determine funding for Special High Cost Treatment individually, but intends to standardise such prices wherever possible. For unusual cases, the Ministry will establish funding on a case-by-case basis.

4. Access to the Special High Cost Treatment Pool

Access to the Special High Cost Treatment Pool will be determined by the Ministry. All applications for funding through the Special High Cost Treatment Pool will be subject to the eligibility criteria set out below.

5. General eligibility criteria for special high cost treatments

For special high cost treatment, the general eligibility criteria (which must normally all be satisfied) are listed below. Some types of special high cost treatment have additional specific

criteria, which are listed below under the appropriate subheadings. The general eligibility criteria are:

- the person for whom access to the pool is sought to fund treatment must be an eligible person
- the treatment must have proven efficacy through appropriate clinical trials, and preferably also have been established as effective through regular application
- failure to receive the treatment would be likely to result in serious irreversible deterioration in the patient's condition, or an inability to recover lost function, or significant impairment to normal development of a child
- failure to receive the treatment could deny an adult with a lifelong disability access to treatment which would lead to a marked improvement in their quality of life
- treatment would lead to reasonable prospects of survival and to an improved quality of life after treatment
- the treatment is well established and not an experimental form of treatment
- the treatment is cost-effective, which means that the:
 - expected long-term savings to the health care system outweigh the initial costs of the treatment, and/or
 - dollar costs for the expected benefit are acceptable when evaluated against other Ministry and DHB priorities.

6. Where all the criteria are not met

Consideration will be given to individual circumstances.

7. Additional criteria for medical treatment overseas

For the approval of special high cost treatment to be provided overseas, the appropriate treatment must also not be available in New Zealand.

Where medical treatment overseas requires multiple trips over a long period of time, or in the case of, for example, a transplant and the date of the procedure being funded is unknown, the Ministry of Health and DHB of domicile will share:

- accommodation costs for the duration of the period spent overseas
- treatment costs leading up to the actual procedure.

8. Additional criteria for complex cases

For complex cases, the Ministry may agree to an arrangement where the cost of the complex case is shared between the DHB and the Ministry. The Ministry's share of such cost will be met from the Special High Cost Treatment Pool. The Ministry will determine the extent to which the Ministry and DHB respectively contribute to the cost of the complex case and, in doing so, will take into account a number of factors, including (without limitation):

- the variability of the cost profile for the complex cases in question
- whether the DHB is in a position to balance the cost variation across other services provided by the DHB
- the extent to which severity/complexity is already covered in the DHB's appropriation.

9. Additional criteria for treatments available only outside public hospitals

A person will not be eligible for special high cost treatment unless the treatment is not currently available from any public hospital in New Zealand or under any existing contractual arrangement that the Ministry and a DHB may have entered into.

10. Application and approval process to use the Special High Cost Treatment Pool

The following application and approval process applies:

- All applications for funding must be made prior to the commencement of treatment. Retrospective funding will not be made available. The exception to this is urgent cases where DHBs must send completed applications for consideration by the Senior Advisor on the day that the person is identified as possibly meeting the criteria, except that where that day is not a working day, the application must be forwarded on the next working day. The Senior Advisor will communicate an indicative decision within 48 hours of receipt of the completed application.
- All applications for funding through the Special High Cost Treatments Pool will be received by the Senior Advisor, High Cost Treatment Pool, Sector Capability and Implementation Business Unit and will be considered on a case-by-case basis.
- The Ministry will only accept applications from DHB specialists with supporting documentation and recommendations for treatment.
- All applications must use the standard application form (which is available from the Sector Capability and Implementation Business Unit of the Ministry) and must be accompanied by supporting evidence and costing information. Forms must be sent to the Senior Advisor.
- The Ministry will ensure that the Senior Advisor acknowledges receipt of all applications in writing, and informs all applicants of the approval process (including the likely timeframe for approval) within seven days of receipt of an application. Applicants will be informed of the Senior Advisor's decision (or reasons for any delay in the decision-making process) in writing, within 21 days of receipt of application. In urgent cases, the Senior Advisor may give a verbal approval followed by written approval within the timeframe specified above.
- For urgent treatments, the DHB must negotiate with the Senior Advisor for approval of funding as soon as the case is identified as possibly being a special high cost treatment case and before any costs are incurred.
- All payments for approved treatments will be administered by the Ministry and paid by the Ministry through National Contracted Services – or directly to the contracted providers on receipt of one aggregated invoice.
- Any decision made on any application for funding from the Special High Cost Treatment Pool does not set a precedent for decisions on any future application or applications.

Appendix 2: Requirements in relation to accident claimants

1. ACC – public health acute services

The Accident Compensation Act 2001 is the principal Act under which ACC operates. While this Act came into force on 1 April 2002, the main impact on the purchasing of public health acute services⁵² occurred from 1 July 2002, when ACC began purchasing these services through the Minister of Health under a service agreement between the Minister for ACC and the Minister of Health. Services included in 'Public health acute services' (PHAS) are the services specified in the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002. These regulations came into force on 1 July 2002.

2. Purchase objectives – outputs to be delivered by each DHB providing services for ACC claimants

Each DHB will provide public health acute services under its Annual Plan and Crown Funding Agreement in relation to the treatment of an eligible person for a personal injury for which that eligible person has cover under the Accident Compensation Act 2001.

DHBs will provide for the same performance standards, in so far as they are relevant to the delivery of public health acute services to ACC claimants as to the delivery of those services to eligible people in general.

⁵² As defined in clause 4 of the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002:

1. For the purposes of the Act, public health acute services, in relation to treatment of a claimant for a personal injury for which he or she has cover, means any of the following personal health services:
 - (a) services provided as part of an acute admission:
 - (b) services provided as part of an emergency department presentation, and any subsequent services provided by the emergency department within 7 days after that presentation:
 - (c) outpatient services that are provided by a registered medical practitioner and associated with services described in paragraph (a) if those outpatient services are provided within 6 weeks after the day of discharge:
 - (d) outpatient services that are provided by a registered medical practitioner and associated with services described in paragraph (b) if those outpatient services are provided within 6 weeks after the day of treatment:
 - (e) services that are provided by a registered medical practitioner less than 7 days after the date on which the claimant is referred for those services by another registered medical practitioner, other than:
 - (i) services associated with services described in paragraph (a) or paragraph (b); and
 - (ii) referrals to a radiologist by a registered medical practitioner who is providing treatment for which a payment or contribution is to be made under section 73 of the Act or under clause 1 of Schedule 1 of the Act:
 - (f) services that are ancillary to any of the services described in paragraphs (a) to (e), including non-emergency travel and accommodation for the claimant and an escort or support person for the claimant, but excluding emergency transport:
 - (g) services that relate to the provision of treatment described in paragraphs (a) to (f), including, for example, the provision of consumables, diagnostic imaging, and equipment.
2. To avoid doubt, subclause 1 applies only to services that are purchased through the Minister of Health and provided by a publicly funded provider.

*Accident Services: A guide for DHB and ACC staff*⁵³ (ACC and Ministry of Health 2014) provides a guide for providers of public health acute services to assist in determining which agency is responsible for purchasing treatment rehabilitation and related services required by an injured person.

The information in the guide is intended to serve as a general guide to purchasing arrangements under the Accident Compensation Act 2001 and the public health acute services regulations. For legal or financial purposes, the Accident Compensation Act 2001 and contractual arrangements between funders and providers take precedence over the contents of the guide.

Where there is a dispute over whether a service is included or excluded from public health acute services, services to individuals will be maintained by whichever agency is currently providing the treatment until the issue is resolved.

3. Ownership objectives: access of ACC's representative

Each DHB will grant such access by ACC as is reasonable in the circumstances to any patient who is receiving public health acute services for a personal injury covered by the Accident Compensation Act 2001, and to their medical records. This includes access to any relevant health professional who is necessary for arranging post-discharge treatment, rehabilitation or other services.

4. Ownership objectives: dispute resolution

Each DHB will work together with ACC and other appropriate agencies to clarify and resolve interface issues relating to the provision of public health acute services.

The following principles are to be used to reach agreement on boundary issues on services:

- disputes should be resolved at the lowest possible level of management that is appropriate given the nature of the dispute concerned
- where responsibility for payment is disputed, services to individuals will be maintained by whichever agency is currently providing the treatment, until the issue is resolved.

ACC is responsible for paying (either directly or through the Crown) for services for patients if these are required as a result of personal injury covered under the Accident Compensation Act 2001. Otherwise it is an illness or disability and the responsibility for determining the funding rests with the DHB and/or the Ministry.

If ACC receives a request to pay for a service that ACC considers is part of the public health acute services or is illness-related and this issue cannot be resolved at a local level, the Ministry will work with ACC and the Ministry of Business Innovation and Employment to determine whether a particular service is considered part of the public health acute services or not. ACC can seek a judicial review of any decision or determination by the Ministry with respect to whether ACC funds a particular service.

Each DHB will continue to provide public health acute services to eligible people while any dispute as to responsibility for payment is being resolved.

⁵³ www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/guide/wpc120337.pdf

5. Ownership objectives: consultation

Each DHB is to consult with ACC on any material issue related to the purchase of 'public health acute services' (PHAS) under the PHAS Agreement that may affect ACC or ACC claimants.

6. Non-residents

Non-resident accident patients who require public health acute services are to be included in acute volumes, and are not to be charged directly by a hospital that is covered under the definition of 'publicly funded provider' in the Accident Compensation Act 2001.

7. Invoicing for non-Public Health Acute Services

DHBs must invoice ACC within 12 months from the date of service for non-acute services provided to ACC claimants. Claims such as treatment injury will be excluded from this 12-month timeframe where a cover decision by ACC prohibits the DHB from invoicing within the 12-month period. In such instances the DHB must invoice ACC within 12 months of the claim being accepted. Where this is not possible, ACC will consider cases on an individual basis.

8. Physiotherapy services to ACC clients

On 15 November 2009 ACC stopped funding free treatment to people needing physiotherapy after accidents and reduced the amount paid to providers.

On 16 November 2009 private providers began charging patients a co-payment. Until further notice DHBs with an ACC physiotherapy contract are not to institute co-payments for physiotherapy services to ACC clients.

Appendix 3: Gateway Assessment Programme

The Gateway Assessment Programme is a comprehensive health and education assessment programme for children and young people engaged⁵⁴ with Child, Youth and Family (CYF), a business group within the Ministry of Social Development. The Ministry of Health, Ministry of Education and CYF have collaborated on policy to support the programme, and report at ministerial level on joint outcomes.

The overall objective is to enhance the child or young person's physical, mental, educational and social wellbeing by identifying unmet need and referring them to services to address these needs.

CYF contracts with all DHBs for the service. DHBs are required to employ a Gateway Assessment Coordinator and will ensure the Gateway Assessment Coordinator and any other DHB staff involved in the Gateway Assessment Programme follow the specified process, as outlined in the service specification. The *Interagency Guide to Gateway Assessments*⁵⁵ (CYF 2011) provides the detail and tools needed to implement and provide the service.

The health assessment component is delivered by a registered health practitioner who is experienced in child and/or youth physical and/or mental health assessment.

Within the education sector, teachers, resource teachers learning and behaviour (RTLBs) or early childhood education providers provide a profile of the child or young person's educational engagement and achievement, which is an integral component of the Gateway Assessment.

CYF social workers provide the context and history of the care and protection issues of the child or young person. The Gateway Assessment Coordinator collates this information along with any information received from the Accident Compensation Corporation, Plunket, primary health care services and the New Zealand Health Information Service (as appropriate) and books the health assessment with the appropriate health practitioner.

Once the Gateway health assessment has been completed, the Gateway Assessment Coordinator combines the information, writes a health report and creates an Interagency Services Agreement that is forwarded on to the child or young person's CYF social worker. The CYF social worker discusses the recommendations in the report with the child or young person and their family and whānau, and the report contributes to the broader plan for the child or young person. The Gateway Assessment Coordinator reviews the Interagency Services Agreement three months after the health assessment with the CYF social worker and the relevant education sector representative.

⁵⁴ Children and young people entering care, in care, or being referred for a care and protection Family Group Conference.

⁵⁵ www.cyf.govt.nz/keeping-kids-safe/ways-we-work-with-families/gateway-health-and-education-assessments.html

Appendix 4 Vulnerable Children – Children’s Action Plan

This work programme contributes to the Government’s Better Public Services: Supporting vulnerable children, result 4: to reduce the number of assaults on children.

The White Paper for Vulnerable Children and the Children’s Action Plan were released in October 2012. On 1 July 2014 the Vulnerable Children Act 2014 and other associated legislation passed into law. The Act forms a significant part of comprehensive measures to protect and improve the wellbeing of vulnerable children and strengthen our child protection system.

The Vulnerable Children Act 2014 and the Children’s Action Plan rest on the belief that no single agency alone can protect vulnerable children. The chief executives of five government agencies (Ministries of Health, Education, Justice, Social Development and New Zealand Police) are jointly accountable for acting together to develop and implement a plan to protect our children from harm, working with families/whānau and communities.

The legislative changes provide a framework for professionals from the different sectors to work better together to help children. By breaking down barriers to information sharing and cross-sector working, and brokering more targeted service provision, children will get better coordinated access to services they need, and improved social and health outcomes.

Children’s Teams

Children’s Teams are a key part of how the Children’s Action Plan will be delivered locally. Children’s Teams work to ensure vulnerable children are kept safe before they come to harm so they thrive, achieve and belong⁵⁶. There is an expectation that DHB’s will be active participants in the implementation and operation of local Children’s Teams in their regions.

Children’s Teams represent a new and different way of working. Putting children at the centre of everything we do means that providers from across the health, education and social sectors need to work through how best to work together to achieve better results for vulnerable children and their family/whānau.

DHBs with a local Children’s Team will be required to ensure resources and health services are provided within baseline funding to support the local Children’s Team operations.

Each Children’s Team has a Local Governance Group (LGG). The LGG will provide overall sector leadership and ensure cross-community, Iwi and agency participation and decision-making to support effective management of resources for the local Children’s Team. Core members of the LGG will be local decision makers from Education, Health (local DHB representation), Social Development, Te Puni Kokiri, and the New Zealand Police. These core members should be at the right level to make decisions regarding systems, services and resources at the local level.

⁵⁶ Implementation of Children’s Teams is well underway with 10 teams operational by 30 June 2015: Rotorua, Whangarei, Horowhenua/Otaki, Marlborough, Hamilton City, Clendon/Manurewa/Papakura, Whakatane, Gisborne, Whanganui and Christchurch.

DHBs will support health's contribution to the implementation of local Children's Teams in the following ways

- Service delivery and coordination that meets the needs of vulnerable children and their family/whānau:
- participate in local Children's Team governance
- collaborate with other agencies to plan, test and monitor assessment processes to support early response systems, assessment processes and service coordination for vulnerable children
- develop effective referral pathways to/from Children's Teams and primary and secondary health services.

Appendix 5: Summary of changes to 2014/15 Service Coverage Schedule

The service coverage document has been reviewed and updated to reflect policy changes and to clarify some areas. Key changes are summarised below, along with a summary of specific service areas with transitional issues in 2014/15 and out years.

This list describes in summary form the changes made to each of the following sections of service coverage.

1 Purpose and principles of service coverage information

Minor clarification.

2 Key principles underlying the funding of services

Minor clarifications.

2.3 Funding

Clarified co-payments

2.4 Quality and Standards

Removed because duplication from OPF

3 Specific services with transitional issues in 2014/15 and out years

3 Specific services with transitional issues in 2014/15 and out years

3.1 Public health services

3.2 Tobacco control

Clarified wording

3.3 Gateway (Health and Education) Assessment Programme

3.4 Youth health services

3.5 School immunisation programme

3.6 Children's Action Plan

New section

3.7 Physiotherapy services to ACC clients

3.8 Maternity services

3.9 Diagnostic services

Updated for current year

3.10 Oral health service coverage – hospital dental services

3.11 Organ transplantations

3.12 Pharmaceutical service coverage

Added extension of free prescriptions to under 13 years of age.

3.13 Disability Support Services new model programmes

3.14 Fracture liaison service

3.15 Suicide prevention

3.16 Exclusion of Cardiac interventions from SCS

4 General operational service delivery mechanisms

Summary schedule: health and support services for children and young people

Added UNCROC requirement to Accommodation of children

4.1 Blood services

Update to clarify eligibility and alignment with agreements with NZBS

4.2 Diagnostic, therapeutic and support services – personal health

4.3 Disability support services Minor update

4.4 Emergency ambulance services

Clarified

4.5 Health and support services for older people

Added requirements for DHBs when they limit cost of providing support services to enable older people to remain living in their own home.

4.6 Immunisation services

Clarified and updated to align with national immunisation schedule

4.7 Long-term support services for people with chronic health conditions

4.8 Maternity services

Inclusion of requirement for pregnancy and parenting services to a minimum of 30% of pregnant women. Change to emergency transport for maternity cases free of part-charge.

4.9 Mental health and addiction services continuum

Clarification

4.10 Oral health services

Minor update

4.11 Palliative care

Clarified, included link to Resource and Capability Framework

4.12 Pharmaceutical services

Clarified and changed age for free prescriptions from 6 to 13 years. New clause on sharps disposal.

4.13 Primary health care services

Updated access from under 6 to under 13 years of age.

4.14 Provision of equipment, modifications and other supplies and services

Minor updates

4.15 Public health services and prevention services

Incorporated new core functions model. Updated antenatal HIV screening

4.16 Specialist medical and surgical services

Minor updates

4.17 Travel and accommodation services

Clarifications

References

Appendices

Appendix 1: Special high cost treatment

Clarification

Appendix 2: Requirements in relation to accident claimants

Minor update

Appendix 3: Gateway Assessment Programme

Appendix 4: Vulnerable Children- Children's Action plan

New

Appendix 5: Summary of changes to 2014/15 Service Coverage Schedule