Summary of proposal

1. As identified through the Fit for the Future programme of work there is significantly more need in primary care than is currently being met by available services.

2. The impact of unaddressed mental health and addictions issues are high for both individuals, families and the system— in terms of adverse impacts on health and quality of life, flow-on social impacts, increased healthcare utilisation and adverse economic impacts.

3. There is a workforce shortage (general practitioners) and so addressing the significant unmet need will require a complementary workforce.

4. Existing investment in primary mental health and addictions is low relative to need, is inequitable in its distribution around the country, has taken place in the absence of a coherent strategy and there has been no evaluation since early on as to the cost-effectiveness of the various different approaches around the country.

5. The working hypothesis from the Ministry of Health is that increased support through primary and community care will enable those with complex needs outside of the secondary care system to experience improved outcomes and will help to rebalance demand pressures across the continuum of care.

Solution proposed

1. The solution proposed is for a suite of services, based on best available evidence of ‘what works’, that will enhance the ability of primary and community care to re-orientate towards achieving positive outcomes across health and social need.

2. The proposed future spectrum of services makes better use of the existing workforce across primary, secondary and community services and supplements these with an expanded workforce including some entirely new roles.

3. A two stage implementation is proposed with the first stage being the focus of this proposal. Stage one is focused on establishing eight development sites across the country, focused on high need groups, where a set of national service standards and specifications, data measurement protocols and cost-effectiveness considerations can be established before wider roll out in stage two. (see phase one summary table below.)

Impacts

1. Make better use of existing resources and use enhanced investment to decrease unmet need and substantially increase access to effective interventions.

2. Positive outcomes: physical health and mental health, social functioning, wider family impacts, decrease unnecessary healthcare utilisation, improve productivity across primary and secondary care.

3. General practices better meet the healthcare needs of the wider populations they serve through freed up GP time for other functions.

4. Through testing the range of evidence based responses in a range of locations and with a range of populations, flexible responses can be developed that meet a variety of need in a range of communities while also providing the Ministry with the ability to develop common standards and measurement protocols.
## Summary of Phase One

<table>
<thead>
<tr>
<th>The Programme</th>
<th>The intervention suite</th>
<th>The targeted population</th>
<th>The costs</th>
<th>The outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phased implementation of new service model for primary and community care</td>
<td>Proposed suite of services, based on best available evidence of ‘what works’, that will address spectrum of need in primary care and community care are:</td>
<td>High need groups including Quintile 5 Maori and Pacific with mild to moderate mental health and addiction needs and living in complex social circumstance.</td>
<td><strong>Cost breakdown</strong></td>
<td><strong>Health and social gain:</strong> Improved health outcome and reduced health and social cost for at least 35,000 high needs people in primary care</td>
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</tbody>
</table>
| Phase one is the establishment of eight development sites across New Zealand to develop an overarching service model, system leadership structures, common data standards and commissioning models | - self-management support  
- General practice interventions  
- Accredited integrated mental health and addiction practitioners within primary care team  
- Social interventions  
- Extended talking therapies  
- Shared care between primary and secondary care  
- Virtual integration with National Telehealth Service | Phase one will be available to a high needs population of approximately 390,000 and would be accessed by no less than 9% of this group | **- One-off Establishment costs:**  
$4.5 million  
- Operational costs per year for phase one of two years across eight development sites:**  
$14.9 million per year  
- Total phase one:**  
$34.3 million | **System improvements:**  
- Primary and community mental health and addictions service specifications established  
- leadership structures established  
- data standards established  
- applied commissioning model defined |
The proposed next steps are summarised below:

1. The Ministry of Health, in partnership with the key stakeholders involved in developing this paper, and other key sector representatives, work to further refine and describe the detail of the proposed approach

2. The Ministry of Health leads a further consultation process to seek feedback on the proposed approach

3. The overarching model is finalised, including further work to estimate the cost of full implementation

4. Further work is undertaken to identify the projected health, social, financial and health sector impacts

5. An implementation plan for phase one (based upon the available budget)

6. Establishment of the data set and mechanisms for evaluation of phase I

7. Establishment of the infrastructure and mechanisms to implement and evaluate phase I

8. Implementation of phase 1.