



*cutting through complexity*

Supported by the University of Otago

# Value for Money review of Sexual and Reproductive Health Services

## Final Report

Ministry of Health  
1 February 2013



KPMG Centre  
10 Customhouse Quay  
P.O. Box 996  
Wellington 6011  
New Zealand

Telephone +64 (4) 816 4500  
Fax +64 (4) 816 4600  
Internet www.kpmg.co.nz

Hingatu Thompson  
Group Manager Māori Health Services Improvement  
Sector Capability & Implementation (SCI)  
Ministry of Health  
PO Box 5013  
Wellington 6145

1 February 2013

Dear Hingatu

### **Value for Money review of Sexual and Reproductive Health in New Zealand**

Overall we believe there is a substantial opportunity for the Ministry and for the sexual and reproductive health sector of New Zealand. We commend the Ministry for commissioning this work. This was the right first step to obtain a broad overview of the sector and to understand the basis for the way forward.

We found there to be a strong morale in the sector and a passion to improve services. We also found a strong and consistent view, across almost all sector representatives, for the Ministry to play an increased role in leading this sector. There is a real appetite for clarifying the sector scope, agreeing sector objectives and defining a sector-wide way forward, or strategy. This will help tackle significant issues of inconsistency, funding complexity and the lack of robust performance KPIs and data. It would also help workforce development and optimise its deployment. Taken together, we believe this will lead to significant improvements in the Value for Money the sector provides, and from this, improved sexual and reproductive health for the people of New Zealand.

Finally, just to add, the whole team particularly enjoyed this work, in particular engaging with yourself and your team at the Ministry and with the 100 or so representatives of the SRH sector across New Zealand. It was a privilege to be involved.

We hope this report and the actions the Ministry and the sector take as a result will deliver substantial and sustained improvements to the sector.

Yours sincerely

Mike Bazett – Director KPMG and Project Leader

Sue Pullon - Associate Professor and Head of the Department of Primary Health Care & General Practice

#### **Disclaimer**

#### **Inherent Limitations**

This report has been prepared as outlined in the Introduction section of this report. The procedures outlined in the Introduction section constitute neither an audit nor a comprehensive review of operations.

The findings in this report are based on a qualitative study and the reported results reflect a perception of Sexual and Reproductive Health (SRH) services funded by the Ministry and District Health Boards (DHBs) in New Zealand based on information provided from the Ministry of Health, DHBs and the SRH sector.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by the Ministry of Health, DHBs and sector representatives consulted as part of the process.

KPMG has indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

#### **Third Party Reliance**

This report has been prepared at the request of the Ministry of Health in accordance with the terms of KPMG's contract dated 24 September 2012. Other than our responsibility to the Ministry of Health, neither KPMG nor any member or employee of KPMG undertake responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

Responsibility for the security of any electronic distribution of this report remains the responsibility of the Ministry of Health and KPMG accepts no liability if the report is or has been altered in any way by any person

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# 1.0 Executive Summary

**Section 1 – Executive Summary**

**Section 2 – Introduction**

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## Value for Money Review of Sexual and Reproductive Health Executive Summary – Introduction and approach

### Introduction and approach

The Ministry of Health commissioned KPMG, supported by the University of Otago, to undertake a time limited Value for Money (VfM) review of those Sexual and Reproductive Health (SRH) services of New Zealand that are funded, or part funded by the Ministry and DHBs.

The aim is to provide a time limited overview of SRH services for the Ministry. This review is not about devising or refreshing strategy or setting out clinical recommendations. Both these areas are fully outside the scope. Rather this review aims to provide a starting point by collecting and presenting the views and facts of the SRH sector from a value for money perspective. This report aims to form the basis for further work and identify areas for the Ministry to explore.

The specific objectives set by the Ministry were to:

1. Gather baseline information on the current funding and delivery of SRH services funded by the Ministry and DHBs
2. Examine the VfM and sustainability of SRH services
3. Review current evidence, including SRH outcomes data, performance measures and best practice models with international comparators
4. Consider the VfM of SRH services with respect to SRH needs and outcomes of Māori, Pacifica and Young people
5. Provide advice to the Ministry about whether services are delivered in the most efficient and effective way.

Overall, VfM is the extent that funds used produce the desired outcomes. So it raises the question, is tax payer's money being spent wisely given the level of sustained improvements in outcomes being achieved? Driving VfM is challenging especially for government. Outcomes are frequently hard to define and harder to track. In particular, typically, many factors affect the outcomes so assigning attribution to specific government initiatives ranges from complex to not feasible. That all said, focusing upon VfM in order to maximise the sustained outcomes from government's investment is the right thing to do.

A factor that complicated this review is that there is no agreed definition for the scope of SRH services for New Zealand. In discussion with the Ministry Advisory Group, a specific definition for the scope of the sector was agreed solely for the purposes of this review. (See Section 2 for scope definition).

The starting point for this review is that critical aspects of the sexual and reproductive health of the people of New Zealand are lagging well behind other similar countries. In addition, this has not improved significantly over the past ten years and in some areas it has declined. There are high levels of Sexually Transmitted Infections (STIs), especially Chlamydia, and very high teenage pregnancy rates - the third highest in the OECD. In terms of trends, evidence indicates the prevalence of STIs has increased from 2006 to 2011.

A decade ago, estimated national Chlamydia rates were considerably higher than those in the UK, Australia and many other OECD countries. This situation remains. While absolute numbers are much lower than for Chlamydia, the rates of gonorrhoea and syphilis (and drug-resistant infections) have increased since 2005. Notifications of HIV-AIDS have also increased over the last decade, albeit with still small numbers and year-on-year variation. Viral STI trends are harder to quantify but rates are probably increasing for most, with the possible exception of genital warts.

To address these challenges, government is currently spending in the order of \$56M per annum to help improve the sexual and reproductive health of New Zealanders. The question this report seeks to address is, is the government getting value from this spend?

The general approach taken has been to undertake a high level overview of the in-scope SRH spend in order to identify the most significant opportunities the sector can focus upon to improve its performance – an 80/20 approach. This review enables high level options for improvement to be identified and will assist in focusing further more detailed work going forward.

The approach comprised four distinct elements: a condensed scan of the relevant national and international literature, an analysis of the data available from Ministry contracts and DHBs, consultation sessions/workshops with over 100 of the key people across the sector, and finally an analysis of the key drivers of value for money.

This time limited programme of work was undertaken by a team of 1.5 FTE over a 16 week period leading up to February 2013.

## Value for Money Review of Sexual and Reproductive Health Executive Summary – Key findings

### Summary of key conclusions and options for improvement

Overall, the sector:

- Is undertaking good work in a challenging environment. People are committed and energised with areas of real innovation and collaboration
- Meets the needs of many, although not all, service users
- Has an environment where collaboration is driven by individuals rather than a strategy
- Would benefit significantly from clearer direction and leadership at the Ministry level
- Would also benefit from better data and information, not only about STIs and unintended pregnancies, but also on service usage and outcomes
- Has funding arrangements that are complex with a fragmented delivery landscape that may benefit from being simplified.
- Is at an early stage in its VfM journey. Currently there is a lack of robust comparable data, to provide a quantitative assessment of VfM

### Review findings and limitations

This review has achieved the five specific objectives on the previous page in the limited time period and identified a number of areas where the sector can work towards improving its VfM. In addition, through the stocktake, this review has set out for the first time an overview of the SRH funding from a VfM perspective. Taken together, the options for improvement identified present a major opportunity to take a much more strategic and holistic approach which will enable the sector to improve VfM and the services it provides to service users.

Clear findings emerged from this review as summarised below. These areas were drawn from a synthesis of the findings from the literature scan, stocktake data analysis, consultation and driver analysis. While sufficient comprehensive hard data is lacking, this triangulation and the consistency in which these points were raised, provides confidence that these are the right areas upon which to focus upon going forward.

#### Limitations

While clear findings emerged, a number of factors have combined to make this review challenging. These factors also mean that, at this stage in its VfM journey, it is not possible to reach an overall evidenced based conclusion on the VfM provided.

Factors that have restricted this include:

- Lack of clarity and agreement on the scope of the sector, i.e. what is included and what is excluded
- Lack of clarity on the outcomes for the sector – few clear key and agreed performance indicators
- Lack of comprehensive information regarding the funding of the sector, what it is targeted upon and what it aims to achieve.

## Value for Money Review of Sexual and Reproductive Health Executive Summary – Key findings (Cont.)

### Current position

From the stocktake and literature scan, the key features of the current SRH sector in NZ are:

1. **There is little agreement on the scope of the SRH sector.** Both nationally and internationally, there is little agreement on what is covered or not covered by this sector. Different groups and different reviews have adopted scopes that vary widely. The rationale for the grouping together of a range of sexual and reproductive health services for all is well spelled out in the Ministry of Health's Sexual and Reproductive Health Strategy 2001. "...positive sexual identity and sexuality are fundamental to our sense of self, self-esteem and ability to live a fulfilling life". Health related issues such as the promotion of safe sexual behaviors, prevention of infection and unintended pregnancy, and appropriate early detection and management of illness and distress are all part of promoting positive sexuality.
2. **Management information and data is scarce.** Robust and consistent data is scarce. This makes it hard to understand what is working best and what is not. It also makes it hard to communicate performance. Without consistent and robust data it is difficult to manage the sector and drive up VfM. Examples of data that would support better management of the sector include, more complete data for national and regional STI incidence and prevalence, contraceptive failures and service usage by Māori, Pacifica and youth as well as for other key risk groups such as Men who have sex with Men (MSM).
3. **Access for service users is relatively good.** The provider landscape appears to be vast with reasonably good coverage across the country. Service users generally have a variety of options when accessing services. However, as ever, the provision of equivalent services to rural communities is challenging.
4. **Ethnicity and age are both important. Services must be tailored to fit needs.** Youth are the critical target area, for example, 70% of those affected by Chlamydia are aged between 15 and 24. The general point around tailoring services to individual needs and backgrounds will come as no surprise. However, while both Māori and Pacifica have high proportions of STIs, they also have high proportions of youth. 52% of Māori are under the age of 24.
5. **Language and definitions are inconsistent making communication and the aggregation of information challenging.** For example, all evidence confirms that youth are the critical target area. However, DHBs and other providers classify youth in many different ways for example, under 24, under 18, 14 to 24, 10 to 24 etc.

6. **The funding arrangements are complex and the provider landscape fragmented.** Mapping out the flow of funds from government to those providing service has revealed a highly complex picture. It is likely that administrative costs are high given the number of providers and the number of contracts that will be required. It appears this model has emerged organically rather than by design.
7. **Density of spend on SRH services varies widely but not always with a clear rationale.** For example, SRH spend in Tairāwhiti is \$38 per head of population while in Hawke's Bay it is \$6 per head. It is unclear why.
8. **Limited research has been undertaken on service usage.** Scanning the national and international literature, including from the United Kingdom and Australia, there is little published research on service usage or service usage measures for SRH. Some providers do collect information on service usage but this is rarely used for research purposes.
9. **Research and evidence for Māori and Pacifica STI rates and teenage pregnancy rates appears stark, but this needs careful interpretation.**

### Strengths

A clear message emerging from this work is that different providers from across the country are taking innovative approaches, collaborating effectively and are delivering outstanding services. Often this collaboration and innovation is undertaken in the absence of central direction and robust management information. Rather, as far as possible, various individuals and organisations are doing the right thing and the sector has a number of highly trained specialists in SRH care. It is these areas of excellence that represent an exciting opportunity. With a greater degree of central direction and improved management information, these successes can be built upon and spread across the country to benefit all.

A second strength is access. The converse side of the complex funding and fragmented provider landscape is that services are generally provided across the country, and many are tailored to the diverse needs and situations of service users. While this is a strength, there remains an opportunity to go further, in particular, by simplifying the landscape. Access for rural and more isolated communities remains a challenge.

Broadly speaking, doors for services are available when and where needed, but lack of awareness of services, and fear of judgemental / culturally inappropriate attitudes limit access for some sectors of the population.

Value for Money Review of Sexual and Reproductive Health  
**Executive Summary – Key findings (Cont.)**

**Areas for improvement**

The main opportunities for improving SRH services identified in this review are listed below. Acting on these areas will we believe, lead to increased delivery of outputs and outcomes for the government's spend and so increase VfM. To increase VfM, the Ministry needs to:

- 1. Develop a clear vision and strategic action plan with strong leadership and support from the Ministry and sector.** This needs to be undertaken by bringing together a representative sector group to ensure the approach going forward is both right and bought into. This is the most important area for improvement. The sector has consistently expressed a need for greater direction. Clearer direction and focus on quality improvement is an important enabler of most of the areas for improvement identified below.

*“We are bits of a jigsaw ... But the picture on the front of the box is missing”.*

- 2. Collect comparable performance data and ensure SRH services are monitored and evaluated effectively.** In the sector funding diagram (refer to page 35) there are complex and detailed flows of funds from government to the providers, but little equivalent flow of reporting back in the opposite direction.

*“It's hard to determine VfM if there's no proper reporting”*

- 3. Increase effective collaboration between providers and cross-government to improve outcomes.** While a number of organisations in some places are collaborating effectively, there is an opportunity to increase this and so create more efficient services as well as make the experience of service users more seamless and comfortable. Cross -government collaboration is needed to develop consistent language, streamline services and support provider collaboration.

*“Services are not connected. As professionals we are not sure what is available. And if we don't know...”.*

- 4. Reduce the complexity of the funding model and the fragmentation of the delivery landscape.** It is likely that there is the opportunity for simplifying this model by integrating some providers, without losing appropriate and necessary choices for the many different people using SRH services. The logic for funding and integration needs to be determined so that the provider landscape can be amended to match.

*“We all agree its a mess”*

- 5. Ensure funding fosters and incentivises collaboration rather than inhibits it.** “Patch protection” may be encouraged by the funding model. Funding models should be reviewed to ensure they encourage the right behaviours and make it financially worthwhile for different providers to collaborate.

- 6. Improve accessibility for youth and ensure it is timely.** While, as described above, access to a range of service providers for many is a strength, young people in particular need to find access as easy as possible and free of charge at the point of consultation. A \$3 cost is a big barrier to youth. An ‘any door is the right door’ philosophy was generally supported. Youth one stop shops were considered an effective way of reaching youth.

*“Young people need to trip over services before they find them”*

- 7. Determine the optimal split between preventative (including Health Promotion) and reactive services.** While hard to determine, the balance of funding between preventative and reactive services is critical. Applying a whole of life cost approach is likely to increase the proportion of investment on preventative services. It is important that messages are consistent and communicated efficiently.

*“SRH is perceived as a service for those who have done something wrong”.*

- 8. Ensure services provided to Māori and Pacifica are delivered in ways that are culturally appropriate.** In particular, services need to be cognisant of both individual and whānau/family perspectives. Young Māori and young Pacifica are significantly under-represented in the SRH workforce. Attention should be given to address this.



## Value for Money Review of Sexual and Reproductive Health Executive Summary – Key findings (Cont.)

### Areas for improvement (Cont.)

9. **Streamline communication across the sector.** Nationally consistent messages will help to reduce fragmentation within the sector.

*“we are all singing the same song, it’s just to a different tune”.*

10. **Ensure all rural health providers have the capability to provide a high level of general SRH services, with the ability to readily seek specialist advice and referral as required.** Active support for on-going professional development in SRH for rural health providers is likely to be cost effective. Telephone, online and other e-service provision initiatives should be a priority for rural communities, especially those with high numbers of youth.

11. **Enhance the efficiency and effectiveness of the SRH workforce.**

This can be achieved through:

- Reviewing opportunities for optimising the use of the workforce. This is about ‘ensuring the right skills for the right task’. The sector considered that the roles of Nurses (and potentially Kaiāwhina) could be optimised, however, inconsistent messages were received in relation to how this could occur. To clarify this and understand where nurses can be used more efficiently and effectively the Ministry need to review the scope for using nurses and support the implementation of any necessary changes
  - Developing a consistent programme of professional development for primary care providers. The sector also advocated that a broad view be taken of the SRH workforce, inclusive of the work undertaken by SRH educators and teachers in schools, with a focus on providing these roles with SRH professional development
  - Developing career pathways for the SRH workforce.
12. **Ensure consistent evidence based SRH education is an integral part of the curriculum and is comprehensively delivered across all schools.** Seek support from the Ministry of Education to increase the priority for high quality, effective and comprehensive SRH education.

13. **Increase the consistency of practice and language in order to improve communication and efficiency.** The eligibility criteria for access to targeted services needs to be agreed and applied consistently over time at a national level . Agreement should be reached nationally as to what services are to be made universally available and at what cost to the user. Regional decision making has resulted in variable criteria. For example in the stocktake for this review, seven different classifications were used to define youth.

14. **Develop a research agenda that is driven by an overall strategic action plan for the sector.** Currently there appears to be a lack of research focused upon evaluating the current model for SRH service delivery. There is also a lack of research on diagnosis and treatment of STIs, and contraceptive use in New Zealand.

Note, it is beyond the scope of this report to identify specific KPIs in relation to clinical quality.

### VfM Driver analysis

Thirteen of the most relevant drivers or factors that affect the VfM for the SRH sector were identified. While not quantifiable due to lack of robust data, the most relevant are:

- Achieving the best split between prevention and response
- Matching task needs to capability and cost structure – ensuring the right skills for the right task
- Improving the customer experience of their interaction with the sector including access
- Increasing knowledge of sector performance and quality of management information.

### Sector passion and energy

A final point to note is the very clear passion and commitment that exists right across this sector. This is a critical and impressive foundation that should not be underestimated. Much can be built upon this foundation.

It has been a privilege to work with this team and we hope this report will enable the sector to continue and accelerate its direction forward.

# 2.0 Introduction

**Section 1 – Executive Summary**

**Section 2 – Introduction**

**Section 3 – Literature Scan**

**Section 4 – Stocktake**

**Section 5 – Consultations**

**Section 6 – Driver Analysis**

**Appendices**

## Value for Money Review of Sexual and Reproductive Health Objective and scope

### Objectives

The Ministry of Health requested a VfM review of SRH services funded or part funded by both the Ministry of Health (“the Ministry”) and DHBs. KPMG was commissioned to undertake the review in September 2012 after a competitive procurement process.

The overall objective of this review was to help improve SRH services for the people of New Zealand. The aim was to assess the economy, effectiveness and efficiency of the current SRH service delivery and identify areas for improvement. The review had five specific objectives:

1. Gather baseline information on the current funding and delivery of all SRH services funded by the Ministry and DHBs
2. Examine the VfM and sustainability of SRH services
3. Review current evidence, including SRH outcomes data, performance measures and best practice models with international comparators
4. Consider the VfM of SRH services with respect to SRH needs and outcomes of Māori, Pacifica and Young people
5. Provide advice to the Ministry about whether services are delivered in the most efficient and effective way.

## Value for Money Review of Sexual and Reproductive Health Objective and scope

### Scope

Phase one of this review 'high-level overview' collected baseline information on funding flows and services within the SRH sector. This phase included a broad scope that included the services below:

1. Ministry-funded public health providers of SRH services including:
  - DHB public health units
  - Māori and Pacifica providers
  - Family Planning Association (including clinical services)
  - New Zealand AIDS Foundation
  - New Zealand Prostitutes Collective
2. DHB-funded specialist sexual health services/clinics
3. DHB-funded Primary Health Organisation (PHO) SRH services
4. DHB-funded youth health services (e.g. Evolve Wellington Youth Service; Auckland Youth Line; Palmerston North Youth One Stop Shop)
5. SRH services delivered through mainstream General Practice/primary care providers
6. Telephone help services
7. Acute sexual abuse/rape services.

The analysis for phases two and three of this review excluded 'Telephone help services' and 'Acute sexual abuse/rape services'.

### Scope (Cont.)

Due to time and funding constraints, the following areas were excluded from all aspects of this review. There would be benefit in reviewing each of the areas below in future VfM reviews:

- Abortion services
- Fertility services
- Gynaecology services
- Dedicated cervical screening services
- Sexual orientation services related to mental health
- All in hospital secondary care services that may relate to SRH e.g. specialist HIV services.

## Value for Money Review of Sexual and Reproductive Health What is Value for Money?

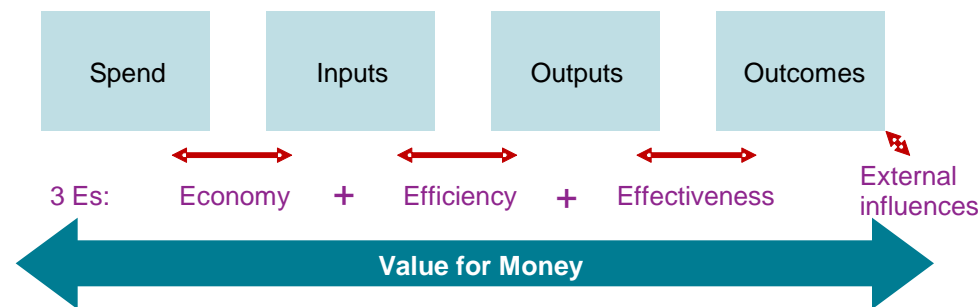
### What is Value for Money?

Classically, VfM describes the optimal balance of spend and inputs in order to deliver optimal outputs and outcomes. In economist's language, VfM is about maximising the net present value of (government) spending, subject to other non - quantifiable constraints. In plain English, it is about getting "more bang for your buck."

In the context of sexual and reproductive health, the Ministry and DHBs have an obligation to ensure that all programmes that are supported meet a clear VfM test. VfM is about improving the efficiency and effectiveness of spending. VfM should seek to support service quality whilst lowering unit costs and should help agencies to manage growing public expectations for public services and growing demand, whilst supporting those most in need.

There are three key components of VfM; these are Economy, Efficiency, Effectiveness (commonly referred to as the three Es). The diagram below illustrates the relationship between the components of VfM and Spend, Inputs, Outputs and Outcomes and how collectively they contribute to VfM.

Figure 1: VfM Components



Source: KPMG

### What is Value for Money? (Cont.)

In a VfM review, where data is available, significant emphasis is placed on assessing the three Es achieved from the area under review.

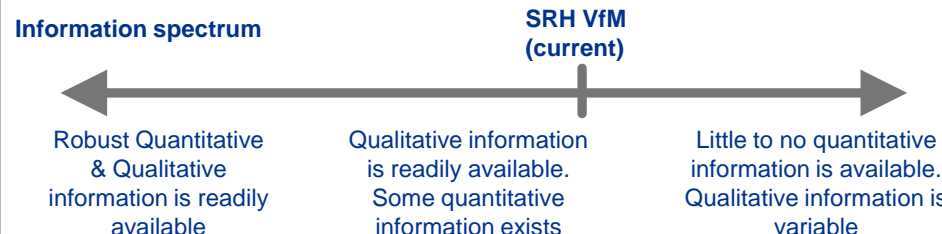
**Economy – Spending less.** This assesses if a reasonable price is paid for each unit of input. For example, are salaries per person in line with market? Could any of the input costs be minimised while retaining the same quality? How could we spend less but retain the same outputs and outcomes?

**Efficiency – Spending well.** This assesses if we receive good productivity. Could we get more for what we spend? Could any unit costs be reduced. For example, are the outputs per person reasonable?

**Effectiveness – Spending wisely.** This assesses if the actual results are the same as the intended results. Are we getting the right outcomes. For example, are the outputs of services achieving the government's desired outcomes?

### The VfM journey

To provide a firm quantitative assessment of the VfM of an area, in particular for government, is a tall order. But while this is challenging, it must remain the right question to ask. To quantify VfM robust and comparable data is required on inputs, outputs and outcomes. Evidence is also required to support clear causal relations between what the sector does and what outcomes are achieved. This attribution is always challenging. Finally, a suitable comparator must exist in order to assess performance. The SRH sector is part way down the track on this VfM journey, as illustrated below.



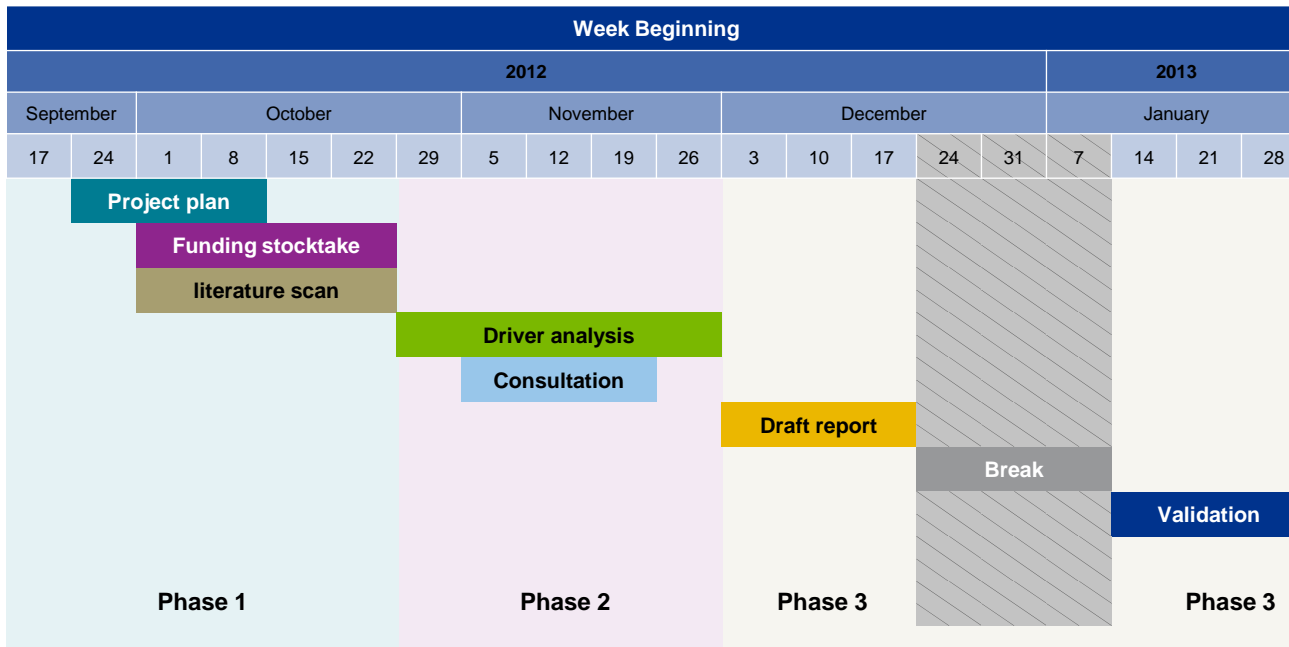
For the SRH sector, little comparable quantitative information is available for analysis. In view of this, the VfM analysis in this report has had to rely significantly upon qualitative information and sector consultations.

## Value for Money Review of Sexual and Reproductive Health Approach

### Timeline and key phases

The approach to this VfM review has been tailored to achieve the review objectives. The review commenced on 24 September 2012 and a final report was provided to the Ministry on 1 February 2013. The diagram below sets out the timescale for this review and provides an overview of key phases of our approach.

Figure 2: Timeline



### Key phases in the project were:

- Phase 1: High-level overview
  - Project Plan
  - literature scan
  - Funding stocktake
- Phase 2: VfM analysis
  - Driver analysis
  - Consultation
- Phase 3: Consolidated analysis and reporting
  - Draft report
  - Validation forums
  - Finalise report

These key phases in the project will each be discussed in more detail on the following pages.

## Value for Money Review of Sexual and Reproductive Health Approach

The diagram to the right illustrates the overall approach to completing this review and the three phases to the review.

### Phase One

The aim of phase one was to plan for the project and provide the Ministry with a high level stocktake of the SRH sector to provide an overview of SRH services. The high level overview had two components, a high level literature scan and a stocktake, each of which is discussed in the following sections.

### Project Plan

This was the planning stage of our project in which we met with the Ministry to confirm the scope of the review and refined our methodology.

### Literature Scan

Relevant New Zealand and International literature to SRH was scanned to identify emerging trends, identify gaps and validate SRH service delivery. The literature scan guided the scope of phases two and three of this review. The findings from the literature scan are included in section three of this report.

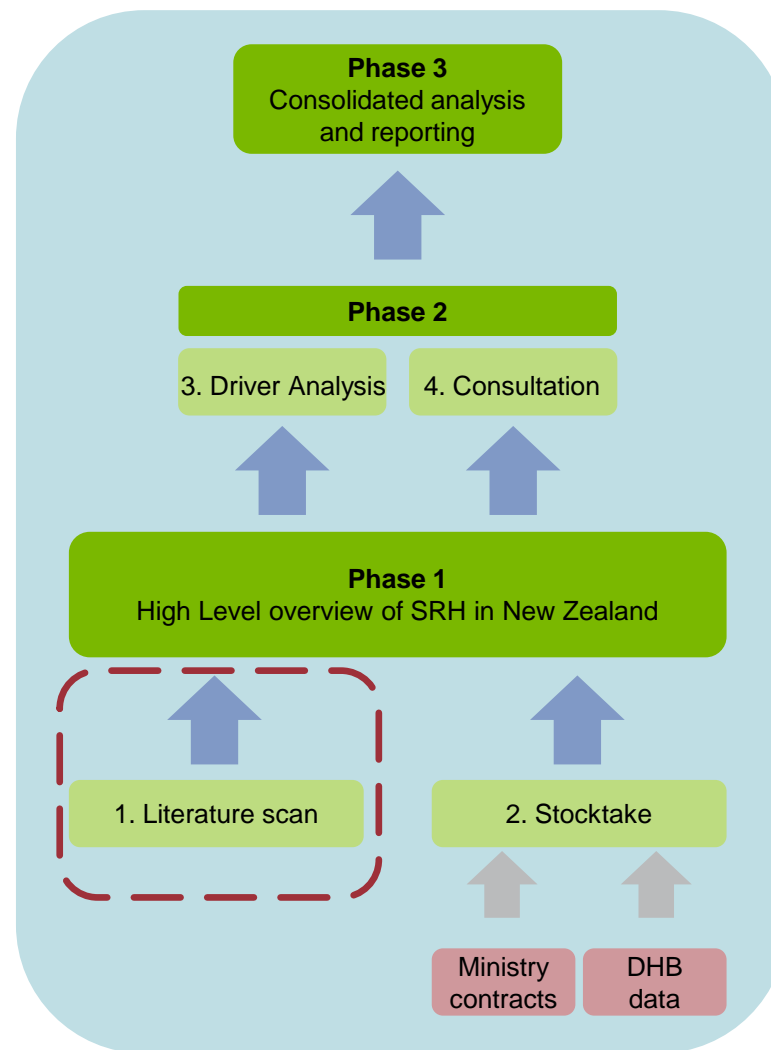
### Stocktake

The purpose of the stocktake was to provide baseline information on key sources of funding, main funding flows, recipient organisations and the services each recipient organisation provides

Data for the stocktake was obtained from two sources:

1. A data request sent to all DHBs
2. A review of contract data held for Ministry funded providers.

The analysis from the stocktake is included in section four of this report.



## Value for Money Review of Sexual and Reproductive Health Approach

### Phase Two

The scope of phase two was further refined (as set out in section 2.1) and included two streams of work; consultation sessions with representatives from the SRH sector and VfM driver analysis, each of which are discussed in more detail below.

#### Consultation sessions

Consultation sessions focused primarily on identifying key issues and improvement opportunities from sector representatives. KPMG facilitated thirteen sessions with the SRH sector, including Ministry funded providers, DHB representatives and other SRH providers. Both clinical and managerial staff attended these sessions.

#### Driver Analysis

Driver analysis considers the VfM of SRH services by developing measures for the three Es and collecting and reporting quantitative and qualitative information to report on these.

The drivers we selected were drawn from our knowledge of this sector and from knowledge of key drivers of VfM from numerous other sectors in both the private and public sectors. The final list of drivers employed are those that we believe have the greatest impact upon overall VfM.

### Phase Three: consolidated analysis and reporting

Phase three consisted of detailed analysis of the VfM drivers and themes from consultation and reporting. The report included analysis of all four components of this review, that is:

1. Stocktake of funding and services
2. literature scan
3. VfM drivers
4. Consultation.

### Feedback on draft report

Our draft report was issued to the Ministry on 21 December 2012. A meeting was held with the project Advisory Group (refer to page 16 for the composition) to discuss the report and obtain feedback on 23 January 2013. Subsequent to this, the Ministry provided written feedback.

Three validation forums were held with the sector between 28 and 29 January 2013 in Auckland, Wellington and Christchurch. The purpose of these validation forums was to obtain feedback from the sector on aspects of the report and the sessions involved a discuss of the strengths and areas for improvement within the executive summary. Material was not provided to participants in advance of these forums.

The report was updated in response to feedback from the Ministry and the validation forums and issued to the Ministry in final on 1 February 2013.



Value for Money Review of Sexual and Reproductive Health  
**KPMG Project Team and Ministry Advisory Group**

**KPMG Project Team**

The following people formed the KPMG team which completed this VfM review.

Name	Role
Mike Bazett	Project Leader
Blair Wightman	Project Manager
Associate Professor Sue Pullon	SRH subject matter expert – University of Otago
Mereraina Piripi	Analyst
David Loveridge	Analyst

The Ministry of Health formed an Advisory Group to oversee this project. The Advisory Group are a subset of the SRH Steering Group and performed a number of functions throughout the project. This included:

- Informing the project scope,
- Providing feedback on the stocktake, and
- Providing feedback on the draft report.

**Advisory Group**

The following people formed the Advisory Group for this VfM review.

Advisory Group	Role
Hingatu Thompson	Group Manager, Maori Health Service Improvement, Sector Capability & Implementation (SCI)
Dr. Api Talemaitoga	Chief Advisor, Community Health Service Improvement, SCI and Chair, across Ministry Steering group for SRH
Grant Storey	Principal Technical Specialist (Blood) Communicable Diseases, Clinical Leadership, Protection and Regulation (CLPR)
Manaia King	Manager, Chronic Diseases, Public Health, National Health Board (member across Ministry SRH steering group and advisory group, VfM review)
Pania Ellison	Senior Advisor, Maori Health Service Improvement, SCI and Project Manager for the review
Helene Carbonatto (until January 2013), replaced with Virginia Brind	General Manager Planning, Funding & Population Health, Tairāwhiti District Health

## Value for Money Review of Sexual and Reproductive Health Limitations in analysis

### Limitations in analysis

The complexity of the SRH sector posed a series of challenges in completing this review. SRH services are funded by many different organisations, funds often pass through two to three organisations before reaching the provider who delivers the care. Each transfer of funds between organisations complicates analysing and reporting.

### Identifying SRH component (spend & inputs)

A large proportion of SRH services are delivered by primary care organisations such as general practices that are funded by PHOs, consequently distinguishing between SRH and non-SRH services in both funding and reporting can be challenging. PHOs receive capitation funding based on their enrolled population with the payment made determined by the likely need for care for each member. It is therefore not possible (apart from some specific SIA contracts for SRH) to calculate how much PHOs receive for SRH services and it is also highly challenging to determine the volume of SRH services delivered in this context.

The challenge of identifying the SRH component of services also applies to school, university and prison-based clinical services. SRH services are delivered in these contexts but the specific spend and service usage is unclear. These challenges meant that the field that listed the contract value was unable to be populated for approximately 20% of contracts listed in our request to DHBs.

The Ministry of Education funds SRH education in schools but it is not possible to determine the level of funding associated with this as services are often delivered by existing resources as part of the health curriculum.

### Service usage data (reporting on outputs)

Reporting on service usage is highly variable between providers. Not all funders receive reporting on service usage. Reporting that is available is inconsistent. Some reporting does not include ethnicity and gender information and when this is available, the age brackets or ethnicity definitions vary.

Many providers only prepare narrative reports with little quantitative data and where data is available it is often high-level, for example '3,000 consultations were held in the last six months'.

### Effectiveness data (Outcomes)

The sector indicated, in consultation sessions, that they were unclear on the outcomes that they were working to achieve. Consequently service providers do not consistently collect and report data on outcomes.

Outcomes reporting for clinical services is currently limited to reporting on STI incidence. This reporting has numerous limitations for analysing effectiveness. The current STI surveillance system relies on limited, voluntary data collection from some clinical providers: specialist SH Services, Student Health Clinics, Family Planning Clinics and some Student Youth Health Clinics. This is augmented by test result data from diagnostic laboratories. Laboratory data is limited to conditions that can be and are tested for; repeat testing cannot be accounted for. Other than laboratory data, there is no routine collection of STI data from primary care.

### Good practice

Pockets of good practice exist in the sector, for example, the Family Planning Association collect and report data on:

- Clinical services: data is available on the volume and type of consultations held with clients. This includes demographic and geographic data.
- Education / health promotion data: Family Planning Association collects outcomes data after education sessions. This is based on a survey issued to participants on their enjoyment, what they learned and the level of detail of the course.

# 3.0 Literature Scan

**Section 1 – Executive Summary**

**Section 2 – Introduction**

**Section 3 – Literature Scan**

**Section 4 – Stocktake**

**Section 5 – Consultations**

**Section 6 – Driver Analysis**

**Appendices**

Value for Money Review of Sexual and Reproductive Health  
**Approach – Literature Scan**

**Objectives, scope and approach**

This literature scan provides a high level summary of the qualitative information available in the area of SRH services for New Zealand and International to identify:

- High level target areas for phases two and three of the review and aims
- Effective approaches to the provision of SRH services
- Information on the use, economy, efficiency, and effectiveness of SRH services in improving outcomes.

Note, the scan is not and does not aim to be a comprehensive ‘academic’ assessment of all literature related to sexual and reproductive health. This literature scan has focused on the areas where the most value can be gained.

**Sources used**

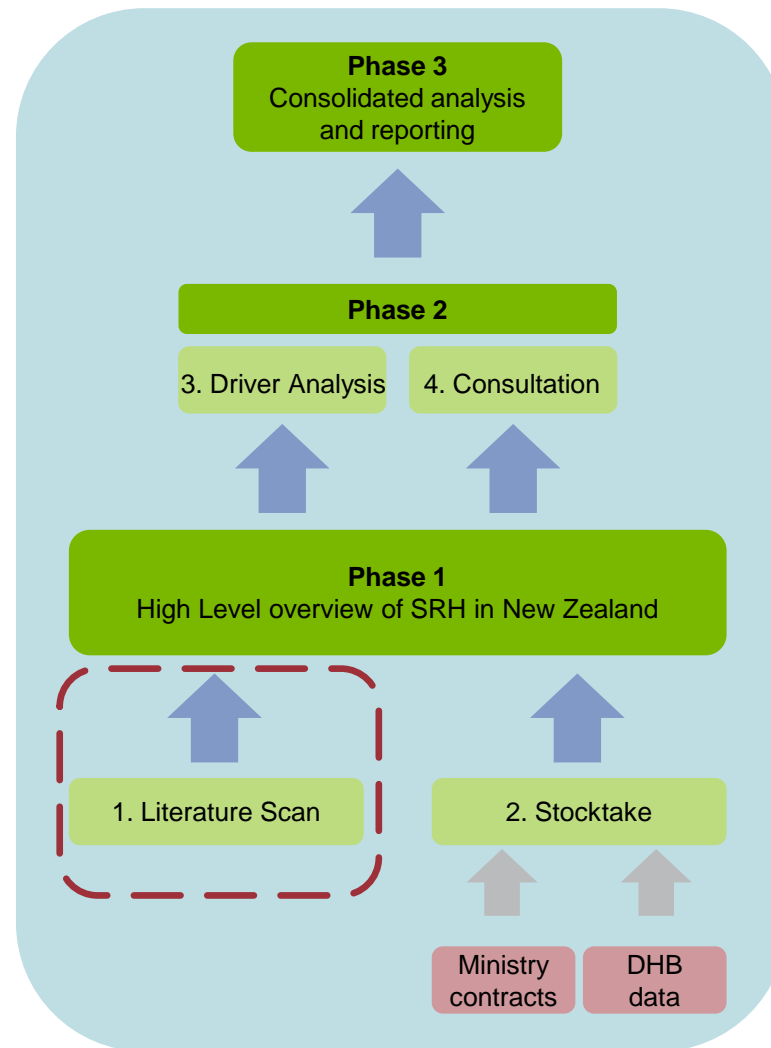
Sources searched included academic databases, both science and social science focussed, (PubMed, EBSCO, Web of Science, Proquest), as well as internet, official government statistical sources, and non-government organisation websites.

**Approach**

This literature scan :

- Collates and presents the research and evidence available on SRH in New Zealand, identifying key areas of data strength and weakness in the New Zealand environment, and identifying critical target areas
- Outlines the range of research available on effective approaches to SRH service provision both in NZ and internationally
- Presents research to date on VfM in SRH services, both in New Zealand and internationally.

A bibliography of research sources is set out in Appendix C.



## Value for Money Review of Sexual and Reproductive Health Summary - Literature scan conclusions

### Key conclusions from this literature scan:

- 1. Robust, consistent data on service use appears to be generally lacking for NZ.** Routinely collected data, and research into, access, availability, appropriateness and use of health services is hard to find for New Zealand.
- 2. Youth is the critical target area.** Strong evidence exists that the 15 to 24 age group experience the great majority of SRH issues (70% of those affected by Chlamydia are aged between 15 and 24), although older adults, especially the disadvantaged also carry some of this health burden. However, youth should be the main focus for phases two and three.
- 3. Reasonably good data exists on pregnancy rates.** This includes by age, ethnicity and region.
- 4. Research and evidence for Māori and Pacifica STI rates and teenage pregnancy rates appears stark, but this needs careful interpretation.**
- 5. Educational and cultural elements are important when considering SRH.** Internationally evidence points repeatedly to the need for educational and health promotion, targeted and tailored to youth and people of different cultures. However, the ERO 2007 report found that the majority of sexuality education programmes were not meeting students needs.
- 6. Little research exists on the use of services and on VfM considerations.** The main focus of research is on the prevalence and incidence of STIs. Little evidence is available from the national or international literature on the use of services and the economy, efficiency, and effectiveness of those services in improving outcomes.

## Value for Money Review of Sexual and Reproductive Health Analysis – Literature Scan

### The New Zealand Environment

#### Data collection

Data on STIs in New Zealand has gaps, but it is clear that:

- Chlamydia Rates are high by international standards, especially for youth
- Teenage pregnancy rates are high – the third highest in the OECD
- HIV rates are low by international standards, rising over the last ten years although falling in the last two years.

New Zealand collects regular data on the prevalence and incidence of Chlamydia, Gonorrhoea, Genital Herpes (first presentation), Genital warts (first presentation), Infectious syphilis and non-specific urethritis through the Environmental Science and Research (ESR) annual STIs in New Zealand Report. This report is one of New Zealand's main sources of data on sexual and reproductive health.

#### SRH Services

SRH services in the New Zealand community are provided by a wide range of service providers.

Mainstream primary care providers (for example: general practices, nurse-led clinics and some Māori providers), provide care for the majority of the population, (Helu 2009, cited in Copland, 2011). Specialist sexual health centres provide for complex care and high risk populations. In some DHBs, young people can seek SRH advice and care from one-stop youth clinics. Family planning clinics provide a comprehensive range of contraception and sexual health advice and care. Mainstream providers are able to refer patients to specialist and family planning clinics as required. Access to such clinics can be difficult in small towns and rural areas.

Current research emphasises that educationally-based and confidential clinical service provisions are key requirements for effective SRH care. New Zealand clinical providers emphasise the provision of education and non-judgmental advice. Advice and education from all providers may be provided online, over the phone as well as face-to-face. Face-to-face consultation at most primary care providers, including Family Planning clinics, require patients/clients to pay a fee at the point of service, whereas specialist sexual health clinics and youth clinics are usually free at the point of consultation.

Set out over the next pages is the detail behind each of the six key conclusions identified.

### 1. Robust, routine data on service use is generally lacking for NZ

Routinely collected data, and research into, access, availability, appropriateness and use of sexual health services is hard to find for NZ.

Although ESR reporting is arguably the most comprehensive reporting published on STI prevalence in New Zealand, it has some significant limitations. Sherwood (2007) notes that *“there are also significant gaps in the information available on the epidemiology of STIs in New Zealand”* and the report itself acknowledges that there are gaps in data: *“In New Zealand, sexually transmitted infections (STIs) are not notifiable. Therefore, surveillance efforts are based on the voluntary provision of data from several different sources (sexual Health Clinics [SHCs], Family Planning Clinics [FPCs], Student and Youth Health Clinics [SYHCs] and laboratories. Population and disease coverage varies with the data source”* (ESR, 2011). We acknowledge that AIDS is a notifiable disease.

Some key limitations to ESR data include:

- ESR data comes from limited sources – only sexual health clinics and family planning clinics routinely report on cases of STI cases/consultations; primary care providers do not, although their laboratory data is accessed by ESR
- Laboratory data does not reflect the full caseload of STIs, as tests are not always taken or requested - sometimes only advice is sought and some STIs are diagnosed by clinical observation alone, (for example: genital warts and recurrent genital herpes).

More accurate caseload data on STIs can possibly be inferred from pregnancy rates, as STIs and unwanted pregnancy are both consequences of unprotected sex and therefore the rate of one can be associated with the other, particularly for teenagers, who have poor knowledge and confidence about protection (Clark 2006, Tripp 2005). Teenage pregnancy rates are reasonably accurate, since births and terminations are consistently recorded – they are a useful proxy indicator for STI rates.

Value for Money Review of Sexual and Reproductive Health  
**Analysis – Literature Scan**

**2. Youth are the critical target area**

Incidence of Chlamydia by age-bracket makes it clear that the majority (upwards of 70%) of those affected are in the 15-19 and 20-24 year age brackets. This further reinforces why the majority of the research and literature on SRH is focused on the younger demographics. This is illustrated in the bar chart to the right.

Note the 0-4 age bracket appears for the West Coast and Auckland DHBs, this is most likely a result of neo-natal Chlamydia rather than a flaw in the data. It is interesting to note the Taranaki DHB's high proportion of 'Unknown' age bracket which, may be due to errors in reporting or because age data is not captured in this DHB.

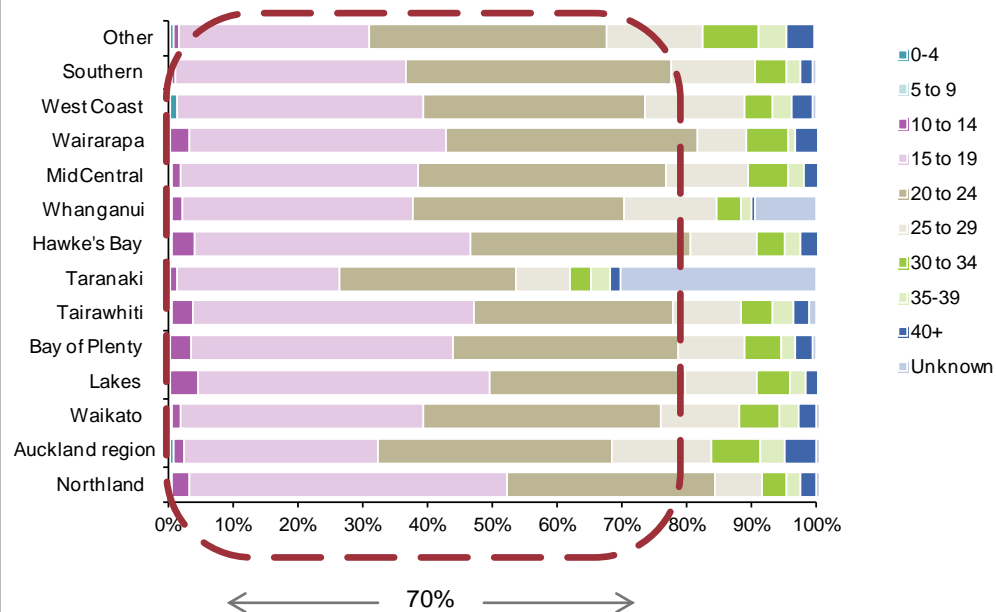
**Inconsistencies in the definition of youth**

The literature scan identified inconsistencies in how youth are defined. An example of this is Brindis et al.. (2005) who look at young women aged between 15-19 who become pregnant and young people under 25 years for HIV infections. This is possibly due to the reporting methods adopted and the sources of information for the journal article. However it does highlight a need for consistent definitions of age groups within the sector to allow for more accurate trending analysis. Additionally, Rogstad (2002) notes young people to be all those under 25 years of age while Tylee et al.. (2007) discusses young people predominantly in the 15-19 year age bracket.

**Key Points**

- Strong evidence exists that the 15 to 24 age group experience the great majority of SRH issues, although older adults, especially the disadvantaged, also carry some of this health burden
- Inconsistencies are common in the definition of the terms 'adolescent' and 'young person' amongst different researchers and organisations. This prevents aggregation and comparisons.

**Figure 3: Percentage of total test-positive Chlamydia cases by DHB by age bracket, ESR STI surveillance report, 2011**



**More than 70% of those affected by Chlamydia are in the 15-19 and 20-24 year age brackets.**

## Value for Money Review of Sexual and Reproductive Health Analysis – Literature Scan

### 3. Reasonably good data exists on pregnancy rates

Statistics New Zealand recorded 63,897 live births registered in New Zealand in the year ended December 2010, up from 62,543 in 2009. Data on pregnancy rates in New Zealand includes breakdowns by age, ethnicity and region.

The rate of teenage childbearing in New Zealand is very high by OECD standards, with 28.4 births per 1,000 girls aged 15-19 in 2010, compared to an average of 13.6 across OECD countries.

Jackson (2004) states that New Zealand has the third-highest teenage pregnancy rate in the OECD, with rates among young Māori and Pacifica women comprising a significant component (Statistics New Zealand, 2001). The statistics show disproportionately high rates for those aged between 20-24 years; again, suggesting that the younger age groups may not know enough to seek termination.

The high teen pregnancy rate demonstrates little use of contraception such as condoms. Moreover, because condoms provide a dual role of contraception and STI protection, it is possible to conclude there is little use of safe sex methods among those adolescents that have high teen pregnancy rates, all things being equal.

Jackson (2004) also goes further to note the existence of a gap between what young people report they know about sexual and reproductive health, and what the statistics tell us about the high rates of STIs and pregnancies among the 15-19 year-old age group.



Value for Money Review of Sexual and Reproductive Health  
**Analysis – Literature Scan**

**4. Research and evidence for Māori and Pacifica STI rates and teenage pregnancy rates appears stark, but this needs careful interpretation.**

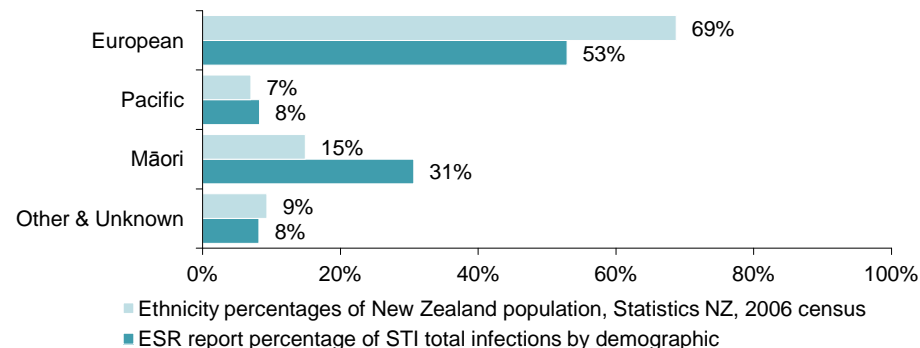
Research and evidence indicates Māori and Pacifica STI rates and teenage pregnancy rates appear high in relation to other ethnic groups, however a number of factors need to be considered.

It is important to factor in both cultural norms and the age profile of Māori and Pacifica demographics when considering teenage pregnancy rates. Māori and Pacifica women giving birth tend to be younger, with a median age of 26 years and 27 years, respectively, in 2009. The median age at maternity was 30 years for Asian women and 31 years for European women (Ministry of Social Development, 2010). The median age of Māori and Pacifica populations is also young relative to other ethnicities. In 2012 53% of Māori and 56% of Pacifica were in the 0-24 age bracket, compared with 33% across the European//Other and Asian populations (2012 Statistics New Zealand population estimates).

The ESR STIs in New Zealand: Annual Surveillance Report 2011, identifies Māori and Pacifica ethnicities as having proportionately higher rates of sexually transmitted infections than Europeans and ‘other’ demographics. Figure 4 to the right shows ethnicities as a percentage of the population and also presents the percentage of all STI infections by demographic.

While Māori represent 15% of New Zealand's entire population, they make up 31% of all reported STI diagnoses. This disparity, with the caveats noted above, highlights the importance of focusing attention of SRH service delivery in these areas and tailoring the services delivered.

**Figure 4: Comparison of STI prevalence data with population estimates by ethnicity**



The relatively young age structure of the population impacts on the appearance of high STI and pregnancy rates for Māori and Pacifica communities.

Value for Money Review of Sexual and Reproductive Health  
**Analysis – Literature Scan**

**4. Research and evidence for Māori and Pacifica STI rates and teenage pregnancy rates appears stark, but this needs careful interpretation (Cont.)**

Figure 5 (right panel) compares two datasets for Chlamydia:

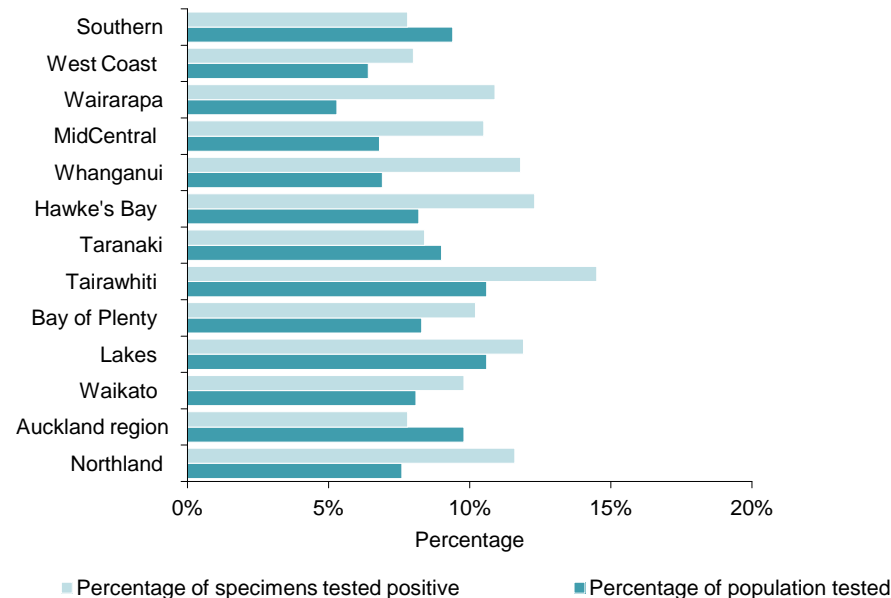
1. The percentage of the DHB population tested (dark green bar)
2. The percentage of these tests that were positive (light green bar)

DHBs where the light blue bar extends further than the dark blue bar indicate a high proportion of positive tests relative to the proportion of the population tested. This is a useful comparison as it mitigates the limitation that low levels of testing result in low positive test results. The variance between the two bars is greatest in regions with a high proportion of Māori, including the Hawke's Bay, Tairāwhiti and Northland.

The Northland Māori Health, Annual Plan 2012/2013, describes the Māori age structure as younger than non-Māori. This is a substantial point when considering Nga Iwi o te Tai Tokerau comprise 30% of Northlands population. Figure 5 (right) shows that, in Northland, 7.6% of the population were tested in the year to June 2011 but 11.6%, (a relatively higher number than other DHBs), had specimens tested positive.

Note: It is likely that many people are tested multiple times in a given year and therefore the test rate is indicative only.

**Figure 5: Number of specimens tested for Chlamydia as a percentage of DHB population and percentage of specimens tested positive.**



### 5. Educational and cultural elements are important when considering SRH

Internationally, evidence points repeatedly to the need for educational and health promotion, targeted and tailored to youth and people of different cultures.

Research stresses the need to tailor approaches to different social demographics, age groups and ethnic groups.

The tailoring of services to the particular demographic is considered by many to be the best approach (Katumba, 2007). Jackson's 2004 work brings Katumba's approach into a New Zealand context - solidifying the notion that SRH services need to be targeted and tailored to the particular demographic they aim to serve.

#### Tailoring to age group

Katumba's theory of tailoring services is still widely accepted; more recently Tylee et al. (2007) identified a growing recognition that young people need services that are sensitive to their unique biological stage and as they developed into adulthood - cognitively.

The importance of tailoring strategies to demographics whilst considering the developmental needs of different age groups and social contexts has also been noted by Bearinger et al., (2007 and Youth '07 report - Adolescent health group 2008, Tripp 2008).

#### Current research at both local and international levels stresses the importance of social and cultural factors, and of the importance of education.

International literature agrees that one of the most effective ways to improve sexual health in the long-term is a commitment to ensuring that adolescents and young people are sufficiently educated to make healthy decisions and actively seek SRH services (Tripp, 2005).

When considering education in 'best practice' SRH programmes, WHO (2011) notes: *"knowledge and information, provided through sexual health education, are essential if people are to be sexually healthy"*. WHO (2011) also suggest education should not be limited to schools but include community and religious leaders to create awareness of the importance of sexual and reproductive health.

The Education Review Office 2007 report on the Teaching of Sexuality in Years 7 to 13 identifies education as an important component to consider in sexual and reproductive health.

The report states that sexual education is one of seven key areas of learning for health and physical education in the New Zealand curriculum. The curriculum is compulsory up to and including year 10.

The report found that the majority of sexuality education programmes were not meeting students' learning needs effectively. Two particular areas were noted as weaknesses in schools :

- Accessing learning about sexual and reproductive health
- Sexuality education not meeting the needs of a diverse range of students.

Value for Money Review of Sexual and Reproductive Health  
**Analysis – Literature Scan**

**6. Little research exists on the use of services and on VfM considerations.**

This literature scan identified little research on the use of services in New Zealand.

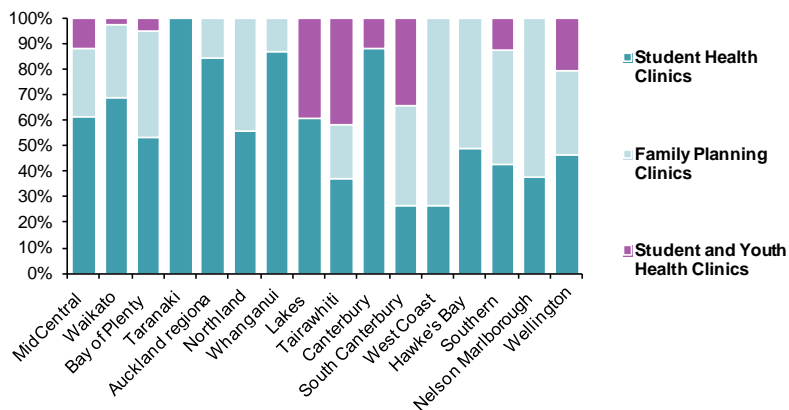
A focus on service usage has not been seen as a key priority for SRH in the New Zealand context. Jackson (2004) proposes future research needs to focus on the understanding of at-risk young Māori, Pacifica youth, rural youth and youth that drop out of school rather than the SRH service delivery methods. The aim of shifting research efforts in this direction is to learn about the factors that might influence these particular demographics in the use of safer and responsible sexual practices.

Research on service usage in a New Zealand context is largely limited to data on the source of Chlamydia cases and comes from the ESR STI Surveillance Report.

Figure 6 below displays DHB Chlamydia cases by clinic type. As reported by:

- Student based Health Clinics (SHC)
- Family Planning Clinics (FPC)
- Student and Youth Health Clinics (SYHC)

**Figure 6: Percentage of total Chlamydia cases reported by clinic type by DHB**



Source: ESR STI Surveillance report, 2011. KPMG analysis.

**Key Points from figure 6:**

- Student Health Clinics represent the most (58%) of reported Chlamydia cases across the 16 DHBs analysed (Family Planning 31% and Student and Youth Health clinics 11%).
- In some areas, there is low or zero reporting of Chlamydia cases from Student and Youth Health Clinics.
- The variation in Chlamydia reported cases by DHB area may be a result of a number of factors. They are:
  - Preference by service users for a particular type of clinic.
  - Varying reporting volumes by each clinic in each DHB area
  - The size of each clinic or the degree of presence the clinic has within the DHB area

Note: Primary health clinic data has not been included in Figure 6 as it was not available for analysis.

## Value for Money Review of Sexual and Reproductive Health Analysis – Literature Scan

### 6. Little research exists on the use of services and on VfM considerations (cont.)

#### International literature on service usage

This review found very limited research on SRH service usage in the UK. The research into UK SRH services tended to focus on reasons for service usage, rather than evaluating service usage or effectiveness. A “Demographic Snapshot” of usage of a UK telephone help service in 2008 analysed the gender and age of callers, and their reason for calling a SRH service help line.

Hearton (2009) suggests SRH services must be based on the needs of the users and address the diversity of the local community. Hearton also suggests that clear information about the services on offer should be provided and SRH service delivery staff need to be adequately trained to deliver services in a non-judgemental manner.

Interactive computer-based interventions for sexual health promotion are also feasible and effective for learning about sexual health in a variety of contexts (Bailey, 2010).

There is also only a small amount of data available on service usage in the Australian or UK context. In the Australian context, Mirza et al. (2001), identifies important differences in the use of services for reproductive health in rural areas, particularly among women. Australian rural populations continue to be significantly underserved.

#### Service Quality

SRH literature in the UK appears to be heavily focussed on the quality of service delivery in SRH services.

The Faculty of Sexual and Reproductive Healthcare (UK) produced a report, (Service Standards for Sexual and Reproductive Healthcare – introduction in November of 2011), that made a number of recommendations for SRH care providers to consider. More specifically, the report stated that SRH services delivered vary considerably and the background (training and experience) of clinicians in community based SRH service providers vary considerably across the United Kingdom. At a high level, the report advocates for a more consistent approach to service delivery, including minimum standards for those trained to deliver services. This recommendation resonates well with comparative literature from a service delivery efficiency perspective, however, from an effectiveness perspective it does not address a key issue, the targeting of SRH services to demographics.

#### Service structure

There is very little research into the structuring of SRH Service delivery. Rogstad et al. (2002) highlights the trade-off between setting up a combined SRH service clinic and a specialised service. Rogstad et al. (2002) continues this argument to suggest a combined service may not be able to provide as comprehensive care as separate ones, the quality of the service that is offered should be equal to that provided elsewhere. Furthermore, Rogstad et al. (2002) comments on those clinics that provide a combined, or for the New Zealand context, ‘general’ service, and how the services need to work closely with those providing specialised services to ensure effective service delivery.

#### Funding

This scan identified a lack of research into the effectiveness of different funding models. Although there is a small amount of recent research available internationally on voucher systems and other funding mechanisms (Montagu and Graff, 2012), this research appears to be limited to the developing world.

# 4.0 Stocktake

**Section 1 – Executive Summary**

**Section 2 – Introduction**

**Section 3 – Literature Scan**

**Section 4 – Stocktake**

**Section 5 – Consultations**

**Section 6 – Driver Analysis**

**Appendices**

Value for Money Review of Sexual and Reproductive Health  
**Approach – Stocktake**

**Introduction**

The first phase of this review is the high-level overview of SRH in New Zealand. This comprises the stocktake along with the literature scan.

The aim of this stocktake is to provide a broad, high level review of SRH in New Zealand. This should provide information on VfM and help drive the focus of phases two and three.

The detailed approach for the stocktake and key findings are provided on the following page.

**Purpose**

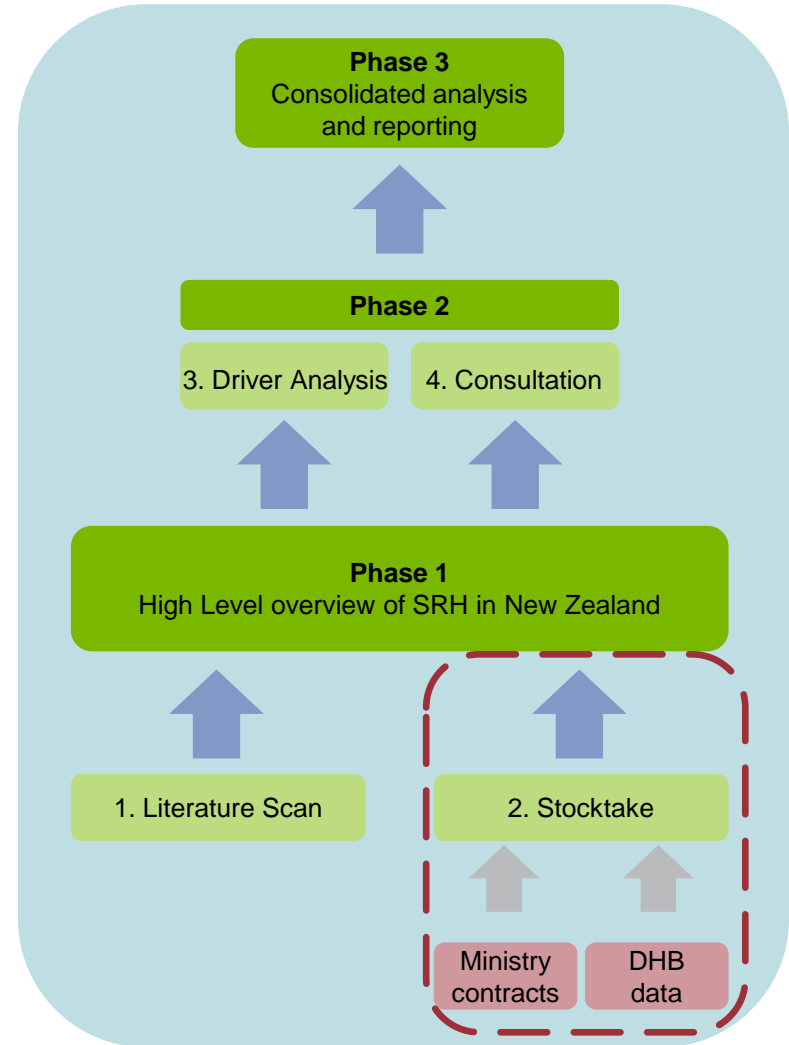
The purpose of this stock is to obtain core information on the sector and aggregate this to present an overview.

**Approach**

The approach, as illustrated below comprised of three stages: Information requests, data aggregation and analysis presentation and reporting. The information request was obtained from two sources:

- Data from DHBs
- Ministry SRH contract data

The flow chart below sets out the stocktake analysis process.



Value for Money Review of Sexual and Reproductive Health  
**Approach - Stocktake (cont.)**

**Information request**

KPMG, with the assistance of the Ministry, developed an information request that was sent to key DHB representatives of all 20 DHBs within New Zealand. The Ministry provided valuable input to the creation and refinement of the structure of the request.

KPMG is grateful to all stakeholders involved with the SRH stocktake information request and thank everyone for the time they made available and their professional support.

DHBs provided information about their SRH services offered within their DHB, particularly identifying:

- Main funder
- Provider
- Target audience
- Basis for funding
- Contract value per annum
- Reporting currently received.

Additionally, services were categorised into six scope 'service types' as defined by the scope of the review. These service types are:

1. DHB-funded out-patient specialist sexual health clinics
2. DHB-funded Primary Health Organisation SRH services
3. DHB-funded youth health services
4. DHB-funded SRH services delivered through mainstream General practice
5. Ministry and/or DHB-funded telephone help services
6. Ministry and/or DHB-funded acute sexual abuse/rape services.

A seventh area of scope – Ministry funded public health services, was also analysed. To analyse this a desk-top review of the Ministry's SRH contracts was undertaken to identify the target audience and regional SRH spend proportions.

**Data aggregation**

SRH stocktake information from DHBs was aggregated with Ministry contract information to form the basis for the SRH sector analysis.

All data was manually 'cleansed' to increase accuracy and ensure integrity. The cleansing process did not include removing problematic data, but rather identifying problematic data and seeking clarification with the relevant DHB.

The main objective of the data cleansing and coding phase was to reduce errors, increase accuracy, completeness and consistency. In addition, all DHBs formally re-confirmed the quality of the data they provided.



Value for Money Review of Sexual and Reproductive Health  
**Summary - Stocktake data**

**Data sources and limitations**

The stocktake is based on information and data provided by District Health Boards and the Ministry of Health through the stocktake request and Ministry SRH contract review.

Data collection focused on the seven SRH service types as identified in the approach section. This stocktake is therefore limited to those SRH services.

This information does not include background or explanatory detail (e.g. differences in population and service configuration across DHBs) and therefore care must be taken with interpretation.

**National spend apportionment**

In a number of cases funding from the Ministry was not allocated to a specific DHB area and needed to be apportioned.

**Funding apportionment method**

In some circumstances Ministry funding was not clearly allocated to a DHB area. To apportion this funding we used one of the three approaches below (listed in the order they were applied):

1. Allocating funding based on any specific DHB allocations within contracts
2. Allocating funding based on actual service user volumes and their location (Family Planning Funding contract only) to apportion funding
3. Used census data to allocate funding based on the population weighted toward age and STI prevalence.

**Data analysis and quality**

Overall, the two sources of information, the DHB stocktake request and the Ministry contracts provided, substantial information.

The quality of data varied. Three categories of data quality have been used as set out below.

Categories	Data quality
1) High Value	<b>Good data is available:</b> Data is representative of the current state.
2) Medium Value	<b>Data has some limitations:</b> data represents the current state however some 'cleansing' and subjective categorisation was required.
3) Low Value	<b>Quality data is not available:</b> Diagrams are purely illustrations.

**Limitations**

It is clear from the high level analysis and discussions with DHBs, that the SRH sector is fragmented, with numerous funding flows and cross over of services. Because of this, separating SRH services from other services was a significant challenge.

Clarification was sought from DHBs and the Ministry to resolve any gaps in the information received. In some instances, subjective categorisations of the types of services provided or the target audience was required as part of the data 'cleansing' process.

Value for Money Review of Sexual and Reproductive Health  
**Summary - Types of analysis**

This table sets out all the types of analysis presented in this stocktake and an assessment of the value of analysis. The following pages present the detail of this analysis.

Analysis title	Purpose	Data quality
<b>Analysis 1 – Sector funding flows</b>	Displays the main funding flows and recipients	Low
<b>Analysis 2 – SRH spend by DHB</b>	Presents DHBs spend from the greatest to the least	High
<b>Analysis 3 –SRH spend per capita by DHB</b>	Presents the map of New Zealand highlighting DHBs that have a proportionally higher SRH spend per capita	High
<b>Analysis 4 - Ministry/DHB spend distribution</b>	Sets out the DHB SRH funding split (Ministry/DHB)	High
<b>Analysis 5 - Ministry of Health - major contracts</b>	Displays a breakdown of the three major contracts the Ministry fund	High
<b>Analysis 6 - Service type funding flows diagram</b>	Displays the flow of funds from their source to the service types that receive them	Medium
<b>Analysis 7 - SRH spend by service type</b>	Presents those service which consume the majority of all SRH funds	Medium
<b>Analysis 8 - SRH spend by ethnicity</b>	Sets out the percentage of total SRH funds dedicated to different ethnic groups	Medium
<b>Analysis 9 - SRH spend by age</b>	Sets out the percentage of total SRH funds dedicated to different age groups	Medium
<b>Analysis 10 - DHB Spend by ethnicity and age</b>	Presents DHB specific SRH funds dedicated to different ethnic and age groups	Medium
<b>Analysis 11 - Ministry spend by ethnicity</b>	Presents Ministry dedicated SRH funds by ethnicity	Medium

## Value for Money Review of Sexual and Reproductive Health Analysis - Sector funding flows (1)

### Sector funding flows

The purpose of the funding flows diagram on the next page is to illustrate the majority of funds used by the SRH sector which flow through to service providers. Due to a lack of data it is not a comprehensive representation of funding flows and does not represent all potential flows.

Fund sources are identified at the top of the diagram which flow down to a number of sources before ultimately funding the providers of SRH services (in orange).

### Sources and data quality

The funding flows diagram was created from a number of sources:

- DHB stocktake data
- Ministry contract data
- Discussions with the Ministry
- Discussions with DHB planning and funding managers
- Feedback from the consultation sessions

A number of funding gaps remain. For example, SIA funding, school based funding and Public Health Nurse funding are under represented or not reported.

Additionally, ACC, other Ministry of Health funds, Ministry of Education, Ministry of Social Development funds and Student levies from universities have all been mentioned as the 'funder' of a service within the DHB stocktake but no quantifiable funds have been attributed.

The funding flows illustration is not comprehensive of all funding flows across the SRH sector. Not represented in the funding flows diagram are the funds from those consumers who pay for SRH services at their GPs. These are significant. Finally, voluntary contributions to charities such as the New Zealand AIDS Foundation are not covered.

### Key Points

- **The funding map is complex.** Given that this diagram is a simplification of reality, it is clear that the path funds take from Vote Health and other sources to eventually the patient or recipient of services is highly complex and often involves a number of intermediaries.

- **There is little flow of information from the bottom up to report on performance**
- **Administrative costs associated with each transfer of funds between two parties are likely to be significant in total.** These costs may be significant. A number of transfers occur between organisations that do not directly provide SRH services.
- **Funding flows appear to lack a top down strategic rationale and oversight**
- **Inconsistent reporting definitions lead to a lack of quality management information.** Information received from DHBs on reporting from providers that they fund was inconsistent across different DHBs for the same services. For example, DHB funded specialist sexual health services/clinics reporting varied by age, periodicity and type.

Questions this diagram raises include:

- Is this complexity planned or has it just happened? What has caused the model to develop in this way?
- What are the flows in the opposite direction, in terms of reporting back on the impact of funding?
- What is the impact of this complexity? Are the negative impacts justified by the advantages? Many providers lead to greater choice.



Value for Money Review of Sexual and Reproductive Health  
**Analysis – SRH spend by DHB (2)**

**SRH Ministry and District Health Board SRH spend analysis**

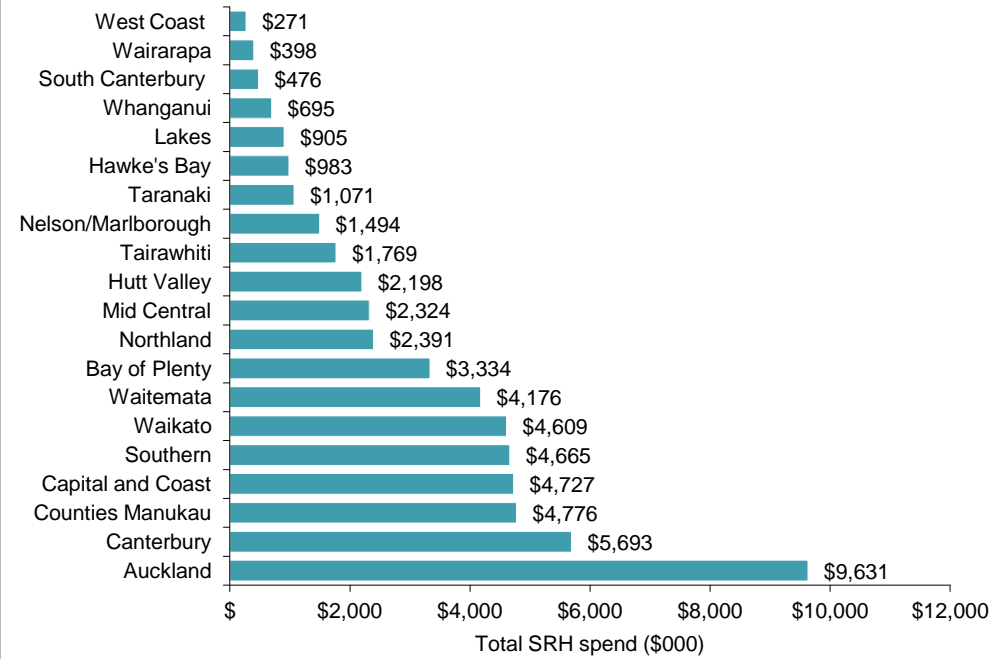
Figure 8 right panel sets out the spend on SRH services (both Ministry and DHB) in each DHB area. The spend is ranked from smallest to largest. The average spend in each DHB area is \$2.8 million.

**Sources and data quality**

The data used for this analysis covers Ministry contract information and stocktake data received from each DHB. DHB stocktake data was reconfirmed by each DHB region to ensure accuracy. Although this analysis does have some limitations in terms of absent information, the data can be considered high quality for this review.

This information does not include background or explanatory detail (e.g. differences in population and service configuration across DHBs) and therefore care must be taken with interpretation.

**Figure 8: Total (Ministry and DHB) SRH spend by DHB (\$000)**



Data Quality: H

Source: KPMG analysis

Value for Money Review of Sexual and Reproductive Health  
Analysis – SRH spend by DHB (2)

SRH spend analysis (Cont.)

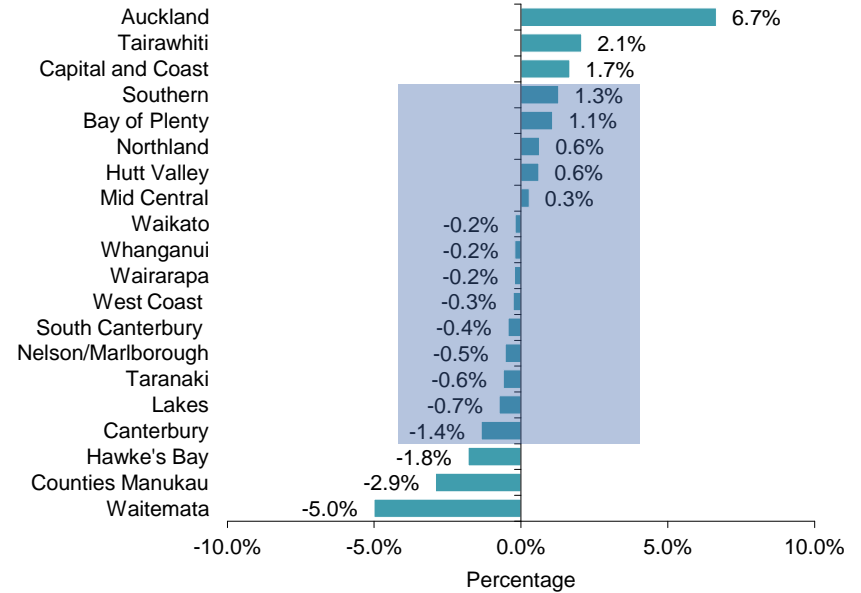
The graph to the right compares two sets of data. Auckland DHB is used as an example to explain this analysis.

1. The spend in each DHB area as a percentage of the total spend across New Zealand. For example the SRH spend in the Auckland DHB area is 17% of the \$56m total spend on SRH services identified by our stocktake.
2. The proportion of the population residing in each DHB area as identified in the 2006 census, 10.3% for Auckland DHB.

By subtracting the population proportion (2 above) from the spend in each DHB area (1 above) we can identify differences in the SRH spend in each area. Subtracting 10.3% of the population from 17% of the spend results in a difference of 6.7% for the Auckland DHB area. This means that a greater proportion of the SRH spend is allocated to the Auckland DHB area than the proportion of the population residing within the area.

The blue shaded area on the graph highlights those regions where the difference between the two datasets is less than 1.5% (both positive and negative). This shows that the proportion of spend in most DHB areas is proportionate to their respective population.

Figure 9: DHB SRH proportional spend by DHB population proportion



Source: Statistics New Zealand, KPMG analysis

Source: Statistics New Zealand, KPMG analysis

Value for Money Review of Sexual and Reproductive Health  
**Analysis – SRH spend by DHB (2) (Cont.)**

**Spend per capita by DHB**

The map of New Zealand on the following page, figure 10, displays New Zealand's SRH spend by DHB. In terms of spend per capita it also shows the density or percentage break down of that spend by Ministry funds, (Ministry-funded Public Health providers of SRH services), and all other DHB-funded SRH services. The top five DHBs with the highest density SRH spend by person are presented in the table below.

**Sources data quality**

This information was collected from the stocktake request from DHBs and the Ministry's SRH contract information.

This information does not include background or explanatory detail (e.g. differences in population and service configuration across DHBs) and therefore care must be taken with interpretation.

**Top five DHBs per capita SRH spend**

Top five per capita SRH spend analysis				
DHB Area	Population	Percentage of total spend	Per Capita SRH spend	Per Capita SRH Spend
Tairāwhiti	46,600	1%	3%	\$ 38
Auckland	456,600	10%	17%	\$ 21
Capital and Coast	294,600	7%	8%	\$ 16
Bay of Plenty	211,900	5%	6%	\$ 16
Southern	306,400	7%	8%	\$ 15

The table below sets out the bottom five DHBs in terms of per capita SRH spend.

**Bottom five DHBs per capita SRH spend**

Bottom five per capita SRH spend analysis				
DHB Area	Population	Percentage of total population	Per Capita SRH spend	Per Capita SRH Spend
Hawke's Bay	155,800	4%	2%	\$ 6
Waitemata	545,700	12%	7%	\$ 8
West Coast	32,900	1%	0%	\$ 8
South Canterbury	56,400	1%	1%	\$ 8
Lakes	103,000	2%	2%	\$ 9

**Key Points**

- Density of spend varies substantially, from \$38 per head in Tairāwhiti to \$6 per head in Hawke's Bay, more than a factor of six. It is unclear why.

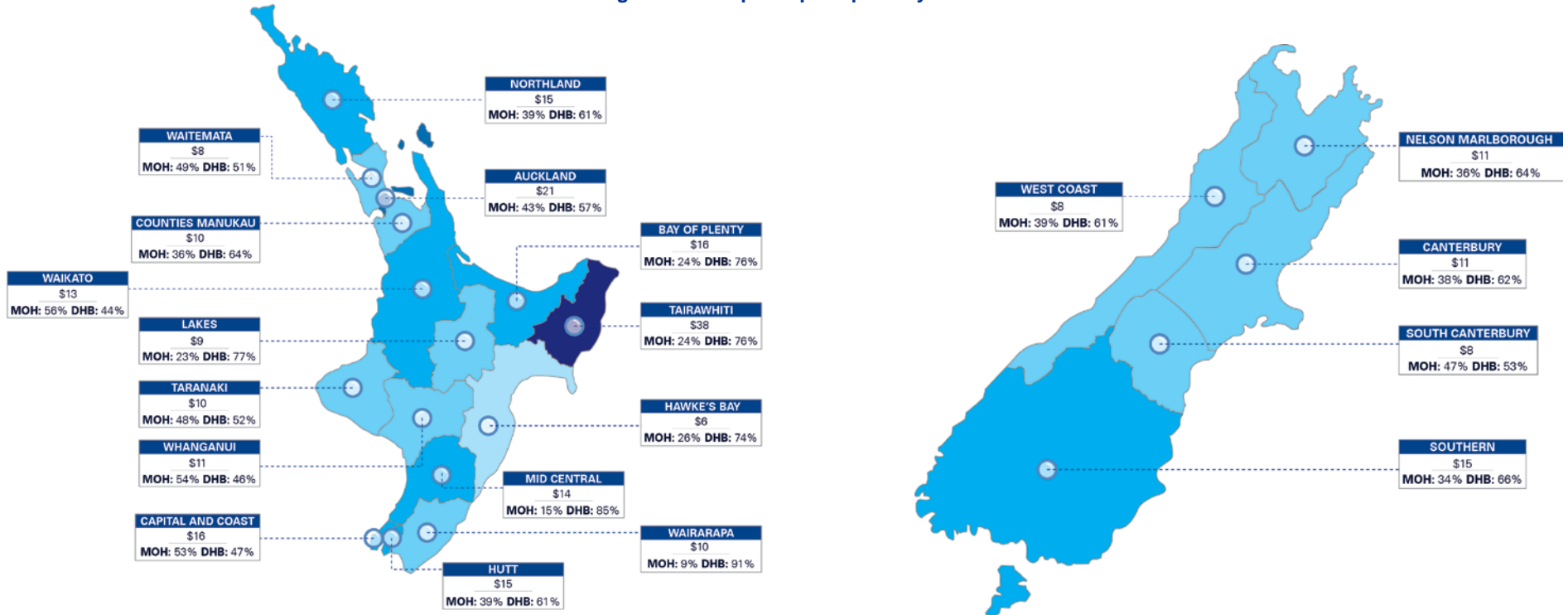
**Data limitations**

As noted in the data limitations in the introduction section of this report (section two), non-dedicated SRH services delivered in a primary care setting, such as GP services, are not included in the analysis.

Source: Statistics New Zealand and KPMG analysis

Value for Money Review of Sexual and Reproductive Health  
**Analysis – SRH spend per capita by DHB (3)**

Figure 10: SRH per capita spend by DHB



The Ministry of Health (MOH) proportion of total funding in each DHB area is determined by:

1. Identifying direct funding from the Ministry into that DHB area, and
2. Apportioning according to the population in each region any funding at a national level not directed to a region

Data Quality:



Source: DHBs, KPMG analysis

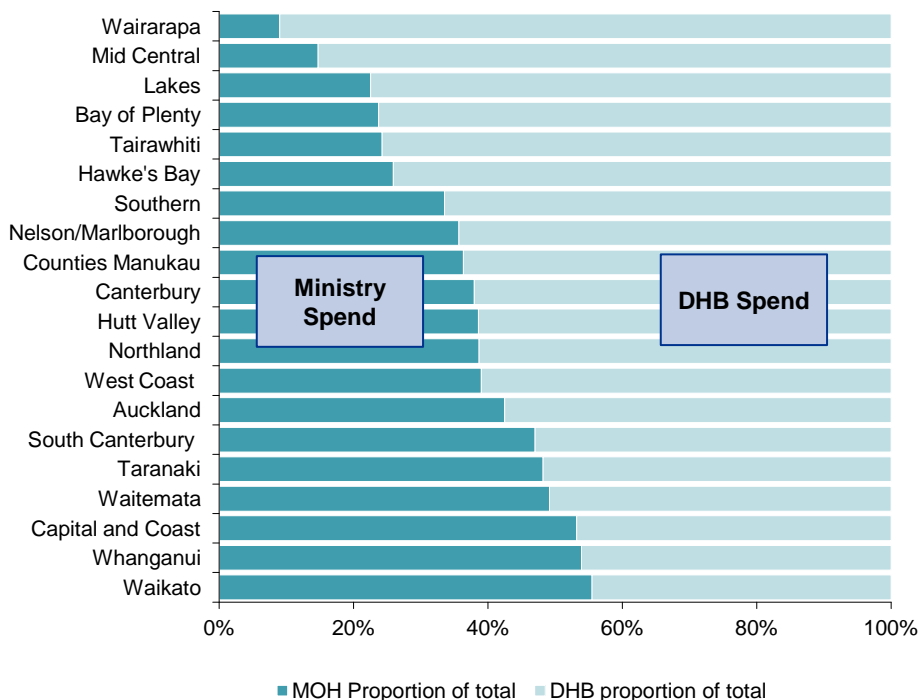


## Value for Money Review of Sexual and Reproductive Health Analysis – Split of SRH spend between Ministry and DHB (4)

### Ministry and District Health Board SRH spend analysis

The figure below sets out the funding split between Ministry and DHB funds for each DHB. The graph is arranged from smallest Ministry component and largest DHB component at the top.

**Figure 11: Total percentage SRH area funding split: Ministry/DHB**



### Key Points

- Wairarapa represents the most disproportionate Ministry/DHB spend at 9% Ministry and 91% DHB
- Tairawhiti, as well as representing the highest per capita SRH spend in New Zealand, is also a highly disproportionate Ministry and DHB SRH spend mix of all DHBs: 24% Ministry funded and 76% DHB funded.
- Most DHBs (17 of 20) have a proportionally higher DHB spend on SRH services than the Ministry in their DHB area, with the three exceptions being Waikato (44% DHB), Whanganui (46% DHB) and Capital and Coast (47% DHB).
- This analysis also raises a number of questions as to why Tairawhiti receives 24% of all regional funds from the Ministry and 76% of funds from the DHB when Tairawhiti stands as an outlier on per capita SRH spend.

This information does not include background or explanatory detail (e.g. differences in population and service configuration across DHBs) and therefore care must be taken with interpretation.

Data Quality: H

Source: KPMG analysis

## Value for Money Review of Sexual and Reproductive Health Analysis - Ministry of Health - Major contracts (5)

### Ministry of Health contracts – scope and main conclusions

The second source of information obtained in order to present a high level stocktake of the SRH sector was a review of the Ministry funded SRH contracts. For the high level overview the analysis focused on:

- Regional spend of Ministry funds
- Target audiences where funds are dedicated
- Age groups who receive funding
- Major contracts.

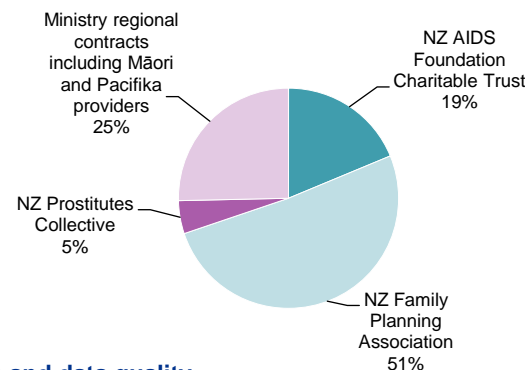
### Conclusions

- Close to half of all Ministry SRH funds are regionally allocated
- 36% of all the Ministry's SRH funds are prioritised at specific ethnicities, although not exclusive
- 6% of all the Ministry's SRH funds are specifically targeted at age. Comparing this statistic with the literature which revealed over 70% of STI cases affect those aged between 15 and 24 years highlights a possible gap in targeting.

### Detailed analysis

Figure 12 and the accompanying pie chart below show the split of Ministry funding between the three major contracts. The Family Planning component represents over 51% of all Ministry funding which equates to 20% of all SRH funding.

**Figure 12: Ministry SRH spend break down by major contracts**



Source: The Ministry of Health, KPMG analysis

### Sources and data quality

The data used was obtained from the Ministry's contracts. This data can therefore be considered to be of a high quality for this analysis.

### Ministry SRH spend break down by major contracts

Ministry of Health SRH spend by major provider		
Provider	Per Annum spend (\$000)	Percentage of total
NZ AIDS Foundation Charitable Trust	\$4,170	19%
NZ Family Planning Association	\$11,369	51%
NZ Prostitutes Collective	\$1,083	5%
Ministry regional contracts including Māori and Pacifica providers	\$5,641	25%
Total	\$22,264	100%

Ministry regional contracts include Māori and Pacifica providers' funded directly by the Ministry of Health.

## Value for Money Review of Sexual and Reproductive Health Analysis - Ministry of Health (5) - Major contracts (Cont.)

### Ministry of Health Major contracts continued

#### Key Points

Of the Ministry funded public health providers of SRH services, over 51% is held with the New Zealand Family Planning Association. This is dedicated to four regions and the balance to a national contract:

- MidCentral (6%)
- South Island (3%)
- Midland (2%), including:
  - Waikato
  - Lakes
  - Taranaki
  - Bay of Plenty
  - Tairāwhiti
- Northland (7%)
- National (82%).

#### New Zealand Family Planning Association of New Zealand

Waitemata and Capital and Coast receive the highest proportion of the New Zealand Family Planning Associations total contract value at 14% and 13% respectively.

The national, (not regionally specific), proportion of the Family Planning contract equates to 82% or \$9.3 million of the total contract value (\$11.4 million). This proportion represents 17% of all SRH expenditure in New Zealand per year, inclusive of Ministry, DHB and ACC funds. It has been apportioned through volume data obtained from Family Planning directly. The national spend which was not dedicated to a specific region was apportioned using Family Planning's DHB areas services volumes data. Based on the number of people attending clinics at each region.

#### New Zealand AIDS Foundation Charitable Trust

Clear evidence exists in the contracts of how New Zealand AIDS Foundation Charitable Trust targets spend based upon risk. Target groups include:

- Open to all at-risk and those most in need, a major focus is the Men who have sex with Men (MSM) population
- New Zealand based African communities
- Gay and bisexual men with a programme responsive to Māori and Pacifica peoples who have sex with men.

Overall, the service schedules within the New Zealand AIDS Foundation Charitable Trust contract have multiple programmes aimed at either the same or similar target audiences.

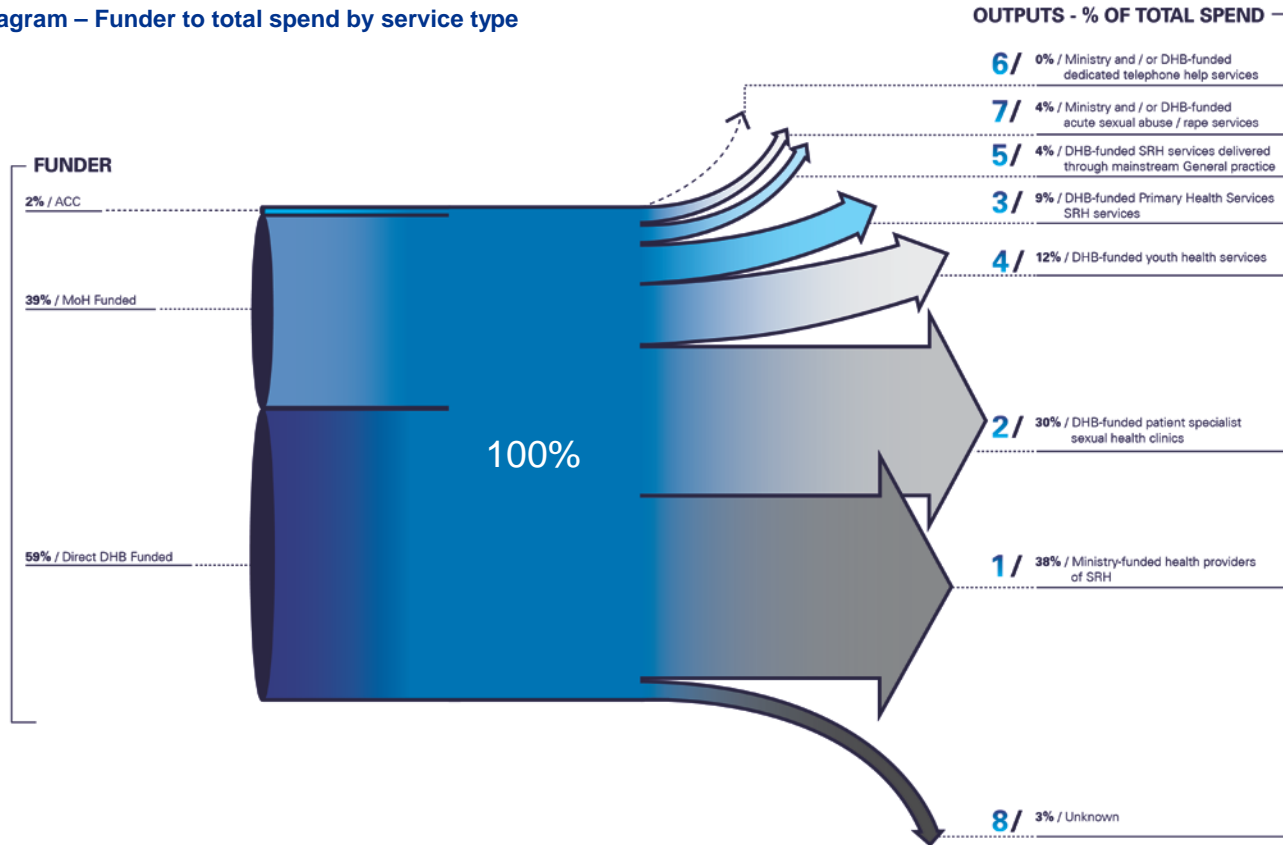
Source: The Ministry of Health, KPMG analysis

Value for Money Review of Sexual and Reproductive Health  
**Analysis – Service type funding flows diagram (6)**

The diagram below highlights the funding flows from their source, as identified in the stocktake and Ministry SRH contract analysis, to the service types with their respective proportions represented. The largest proportion of the funding goes to Ministry-funded public health providers, representing 38% of New Zealand's SRH total spend. The ACC funder component represents only 2% of total funding, however most DHBs could not provide data on ACC SRH expenditure.

Of all the DHBs, six of the nine that identified ACC as a funder of these services were able to quantify the spend. The six DHBs that quantified the spend stated in the comments field of the stocktake that, volumes and overview reports which they send to ACC were their source of information. The majority of DHBs did not have access to this information. Key points from this analysis are set out on the following page.

**Figure 13: Funding flows diagram – Funder to total spend by service type**



Data Quality: **M**

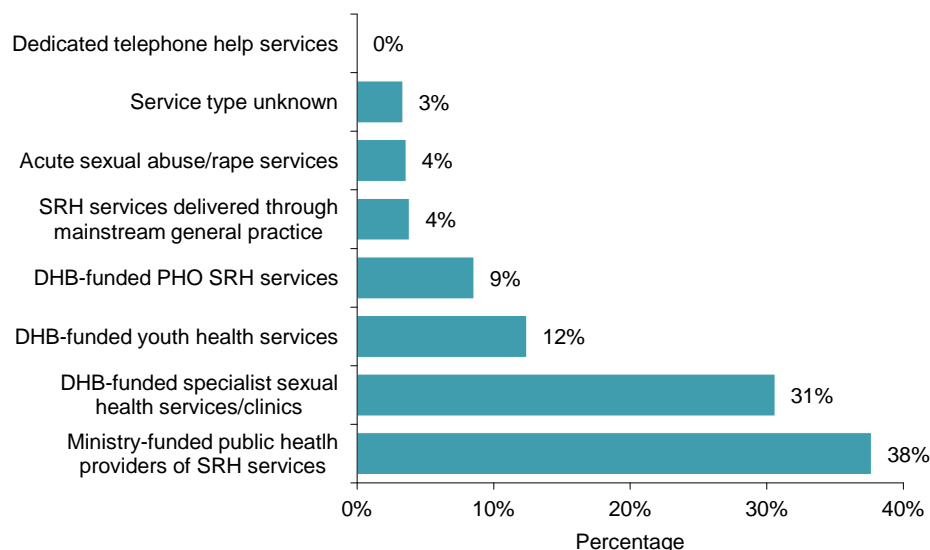
Source: KPMG analysis

## Value for Money Review of Sexual and Reproductive Health Analysis - SRH spend by service type (7)

### SRH spend by service type

Figure 14 below re-presents the right hand side of the service type funding flows diagram on the previous page. This shows the spend by service type. Figure 15, to the right, displays the same data but identifies the significant services that receive the largest proportions of funding.

**Figure 14: Percentage of total SRH spend by service type**



Note: Values in this analysis add to more than 100% due to rounding.

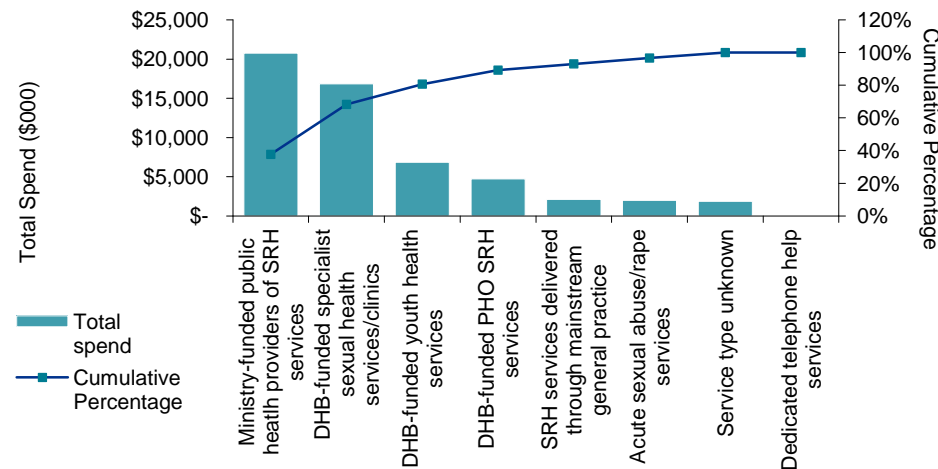
### Key Points

- **Ministry-funded and public health providers and DHB-funded specialist sexual health services/clinic receive over 68% of total SRH funding.** The Majority of Ministry funding flows through to the Ministry funded public health providers of SRH services which is inclusive of the Ministry's biggest contracts: the New Zealand Family Planning Association and the New Zealand AIDS Foundation Charitable Trust.

Data Quality: M

### Service Type Analysis

**Figure 15: Spend by service type**



### Key Points (Cont.)

- The three service types that make up the largest proportion of New Zealand's SRH spend, are:
  - Ministry-funded public health providers of SRH services (38%)
  - DHB-funded specialist sexual health services/clinics (31%)
  - DHB-funded youth health services (12%).
- **DHB-funded youth health services represent 12% of all funding** however, youth (those aged between 15-25), represent the majority of those in need of SRH services. Increased understanding of the age cohort of DHB-funded specialist sexual health services and Ministry-funded public health SRH services serve, will assist further age and service type spend analysis.

Source: The Ministry of Health, DHBs, KPMG analysis

Value for Money Review of Sexual and Reproductive Health  
**Analysis - SRH spend by ethnicity (8)**

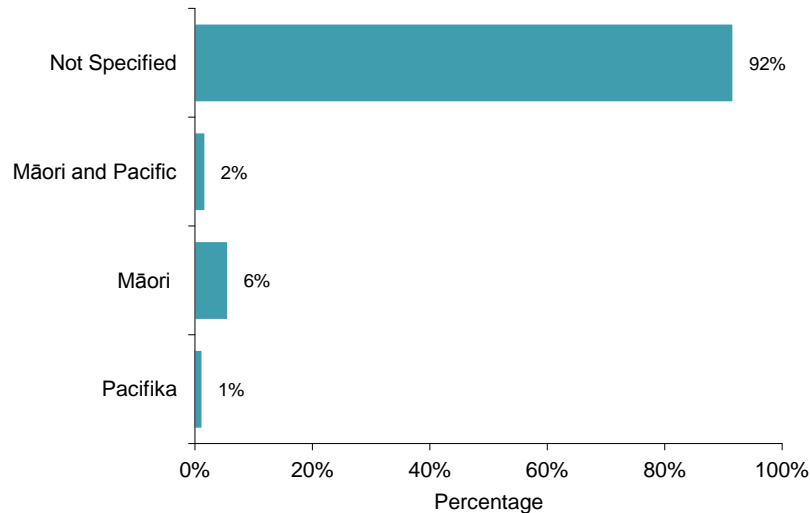
**SRH spend by ethnicity**

Figure 16 below sets out the percentage of all SRH funds that are targeted toward particular ethnic groups. Ethnicity was subjectively ‘cleansed’ by a manual row by row method as the ethnic responses from DHBs were not uniform for analysis.

**Sources data quality**

Ministry contract information and DHB stocktake data is the source of all data for this analysis. Quality is considered to be medium as the data required substantial cleansing to allow for ethnicity categorisation.

**Figure 16: Total SRH spend by ethnicity (where identifiable)**



Data Quality:



Source: KPMG analysis

**Data information**

**Definitions:**

**Not specified.** Funding where ethnicity was not specified. Ministry contracts that did not have an ethnic target audience or one that was not ethnic specific

**Māori and Pacifica.** DHB stocktake data and Ministry contracts that identified both Māori and Pacifica people to be a target audience

**Māori.** DHB stocktake data and Ministry contracts that specified Māori as a target audience

**Pacifika.** DHB stocktake data and Ministry contracts that specified Pacifica people as a target audience.

**Key Points**

- Unspecified ethnicity represents the highest proportion (92%). In future it may be worth defining this more fully.
- The large proportion of funds that flow to an unspecified ethnicity mean that unfortunately, no conclusions can be drawn from this analysis. An important point to make however, is that the majority of SRH spend is not targeted to a specific ethnicity.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - SRH spend by age (9)**

**SRH spend by age**

Figure 17 below sets out the total SRH spend by age. The assessment of whether SRH spend targeted youth was made by reviewing contract data provided by the Ministry and information provided by DHBs. This was subjective, as data quality is low.

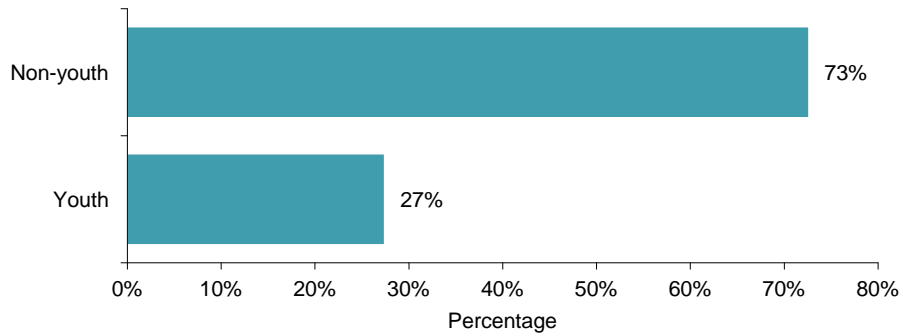
**Sources and data quality**

Ministry contract information and DHB stocktake data is the source of all data for this analysis. Quality is considered to be medium as the data required substantial cleansing to allow for age categorisation.

DHBs were asked whether services targeted a particular age group in our stocktake data request. Responses were highly variable, for example, DHBs reported their target age group for DHB-funded youth health services to be, 14-24, 10-24, under 18, under 25 and all ages. We reviewed all contract data provided and made an assessment whether the contract was targeted at youth. Contracts that were open to all ages or not targeted to youth are classified as 'non-youth'.

The Ministry spend was reviewed to see if contracts had a specific focus on youth, either through the organisation name or contract information.

**Figure 17: Total SRH spend by age (where identifiable)**



Data Quality:



Source: KPMG analysis

**Data information**

**Definitions:**

**Non-youth.** Contracts with Ministry and DHBs which described their target age group as 'general', 'all age groups', or had an alternative focus, for example, victims of sexual abuse.

**Youth.** Contracts that identified children, youth or under 25 year olds as the target audience.

**Key Points**

- 27% of funding was specifically targeted at youth.
- 73% of funding did not specifically focus on youth. This funding was either open to all age groups or had an alternative focus.

**What it means for Value for Money ?**

It would be useful if future analysis matched service usage to funding to determine the attendance at 'non-youth' services by youth. This could be used to apportion some of the associated spend as targeted at youth.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - DHB spend by ethnicity (10)**

**DHB spend – ethnicity analysis**

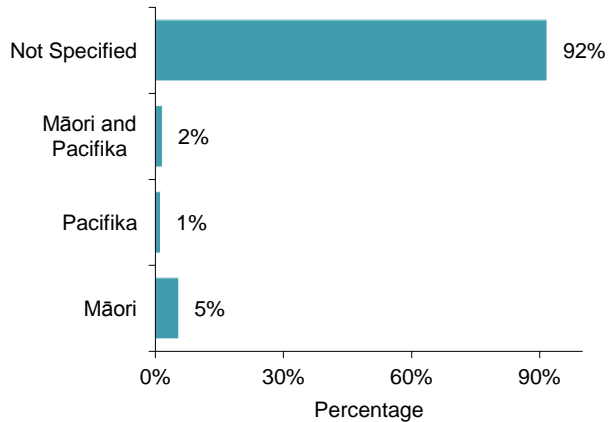
The figure below sets out only that proportion of the DHB SRH spend that is targeted to specific ethnicities. For this aspect of the stocktake, DHBs were asked to describe the target audience their service catered for (e.g. Māori, Pacifica, Youth etc.) and asked if the service or contract was not targeted within their DHB to state 'not targeted'.

**Sources and quality of the data**

DHB stocktake data was received by each DHB. It was then cleansed and aggregated. The core data was signed off by the DHBs. The quality is considered to be medium as the data required substantial cleansing to allow for ethnicity categorisation.

The same definitions used for figure 16 apply here.

**Figure 18: DHB total spend by ethnicity (Where identifiable)**



**Data information**

**Key Points**

- As an ethnicity was not specified for 92% of DHB spend, no conclusions can be drawn
- From the DHB stocktake information received, close to 92% of all DHBs did not exclusively specify a targeted ethnicity they provided SRH services to. Instead the majority of DHBs responded with broad categories, for example: Youth, not sure, not restricted, not targeted, adolescents and adults, etc.

Data Quality:



Source: KPMG analysis



Value for Money Review of Sexual and Reproductive Health  
**Analysis - DHB spend by age (10)**

**DHB spend – age analysis**

Figure 19 on the right sets out the percentage of DHB SRH funds (i.e. non-ministry) that are targeted toward particular age groups.

**Sources and quality of the data**

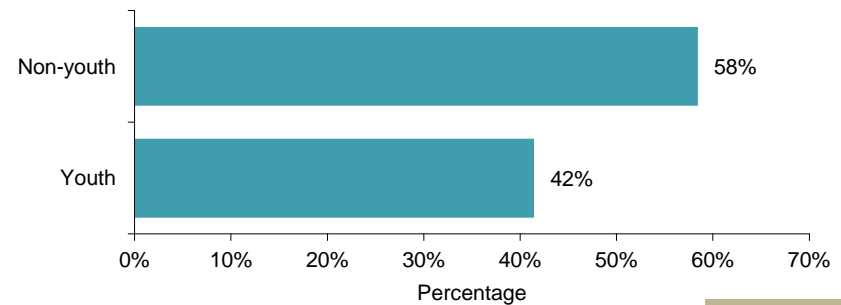
Ministry contract information and DHB stocktake data is the source of all data for this analysis. Quality is considered to be medium as the data required substantial cleansing to allow for age categorisation.

In the stocktake data DHBs were asked whether services targeted a particular age group. Responses were highly variable, for example, DHBs reported their target age group for DHB-funded youth health services to be, 14-24, 10-24, under 18, under 25 and all ages. All contract data provided was reviewed and an assessment made as to whether the contract was targeted at youth. Contracts that were open to all ages or not targeted to youth are classified as ‘non-youth’.

The same definitions used for figure 17 apply here.

**Data information**

**Figure 19: DHB spend by age**



**Key Points**

- 42% of funding was specifically targeted at youth.
- 58% of funding did not specifically focus on youth. This funding was typically either open to all age groups or had an alternative focus.

**Data Quality:** M

It would be useful if future analysis matched service usage to funding to determine the attendance at ‘non-youth’ services by youth. This could be used to apportion some of the associated spend as targeted at youth.

Source: KPMG analysis

Value for Money Review of Sexual and Reproductive Health  
**Analysis – Ministry spend by ethnicity (11)**

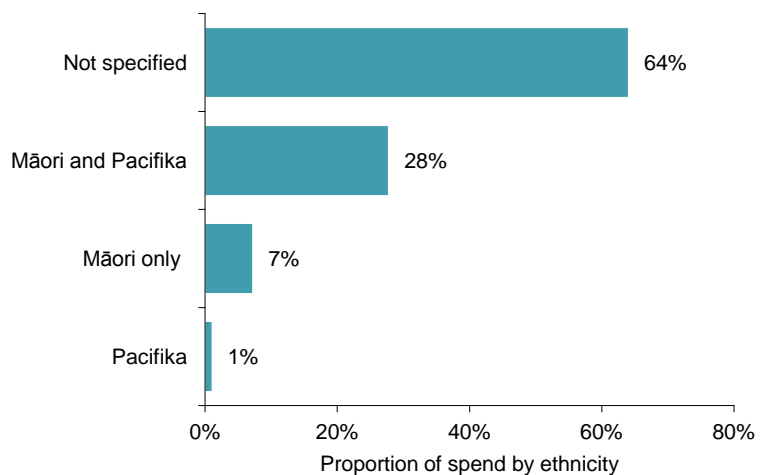
**Ministry of Health Contract - Ethnicity analysis**

The figure below sets out only that proportion of the total SRH spend that is funded by the Ministry with a specific focus on ethnicity.

**Sources and data quality**

Ministry contract information is the source of data for this analysis. Quality is considered to be medium as the data required substantial cleansing to allow for ethnicity categorisation.

**Figure 20: Ministry total spend by ethnicity**



**Data Quality:** M

**Data information**

**Key Points**

- Non-ethnic specified SRH spending by the Ministry accounts for 64% of total expenditure. Māori, Pacifika and 'Māori and Pacifika' people represent 36% of total expenditure across the ethnic specific and combined ethnic specific groups.
- Subjective analysis was required to determine the ethnicities targeted. This was because multiple contracts mentioned a number of target groups.
- Unlike those targeted demographics, 'not specified' represents the highest proportion of the total spend for the Ministry contracts at 64%.

Source: KPMG analysis

# 5.0 Consultations

**Section 1 – Executive Summary**

**Section 2 – Introduction**

**Section 3 – Literature Scan**

**Section 4 – Stocktake**

**Section 5 – Consultations**

**Section 6 – Driver Analysis**

**Appendices**

Value for Money Review of Sexual and Reproductive Health  
**Approach - Consultation**

**Consultation approach**

The fourth component of our review was consultation with the SRH sector.

KPMG facilitated 13 sessions covering over 100 people from across the SRH sector, including Ministry funded providers, DHB representatives and other SRH providers. Both clinical and managerial staff attended these sessions. A full list of session locations and their respective focus are provided in Appendix B.

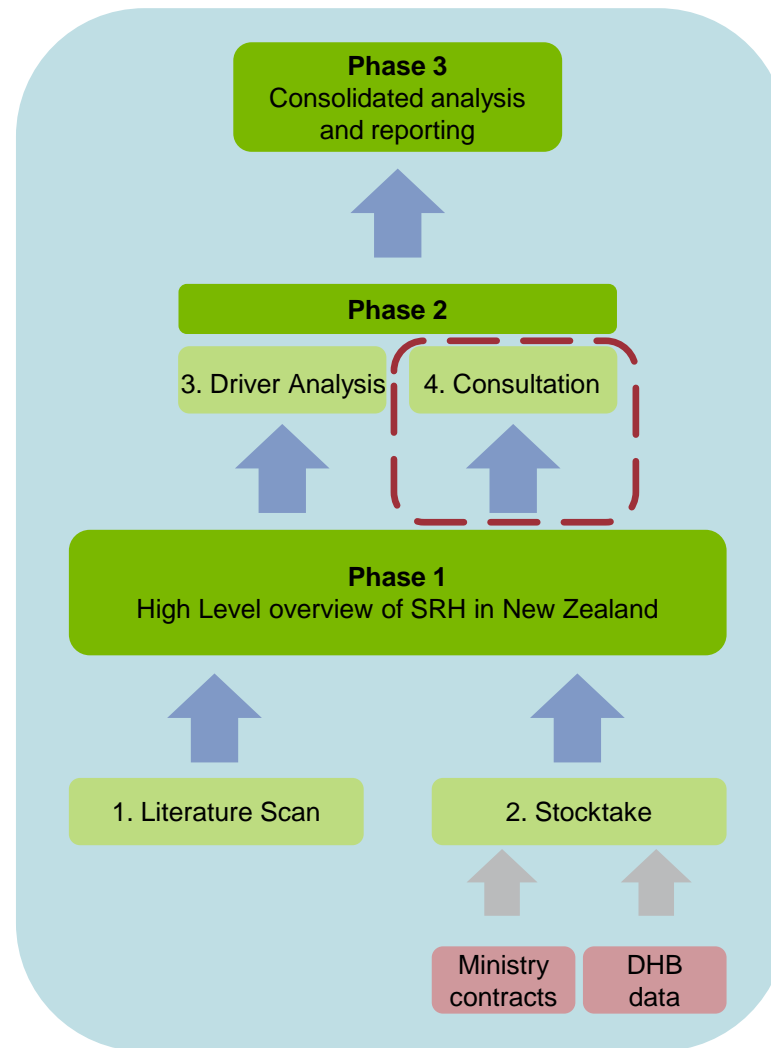
Consultation sessions focused primarily on identifying key issues and improvement opportunities from sector representatives.

A briefing pack was developed to guide and encourage the discussion consistently at each session.

At each session participants:

- Reviewed the consultation briefing pack for relevance; particularly the funding flows diagram (refer page 35)
- Discussed strengths within the SRH sector and areas where improvement opportunities could be made.

At the conclusion of the thirteen sessions, the feedback provided was evaluated, and themes were analysed and reported. The results of this analysis are provided on the following pages. Eleven core themes were identified and these are discussed in detail.



Value for Money Review of Sexual and Reproductive Health  
**Summary - Linkage of key themes to SRH strategy**

**SRH Strategy**

Feedback from participants has been consolidated into eleven overall themes. Each of these themes is described in detail in the following pages. Each of these themes are, or need to be, strongly influenced if not driven by strategy.

The strategy drives many critical elements of service delivery, and ultimately, the outcomes. The strategy must be refreshed by feedback regularly.

Each circle is filled with colour to indicate our assessment of the current state of progress in this area. The area of white within each circle represents an assessment of the opportunity for improvement.

Circles five and six, 'choice and tailored services' and 'access' are currently well positioned whereas '1 Clear vision, strategy and strong leadership' presents a large opportunity for improvement.



Note: this assessment is subjective, based on the results of consultation.

## Value for Money Review of Sexual and Reproductive Health Analysis – Consultation: key themes (1)

### 1. A clear vision, combined with a strategy and strong leadership will help drive sector performance and deliver desired outcomes

- **Clear vision and strategy.** The sector often raised the question, what outcomes are we trying to achieve? It was generally felt that:
  - There is a lack of common understanding or agreement on the specific health outcomes the sector is working to achieve. Is the main focus reducing STIs? Which STIs should we most focus on? Some in the sector questioned why health targets were not established and monitored for SRH.
  - The sector lacks the overarching strategy to guide the delivery of these outcomes. The sector were unclear on the status of the SRH strategy from 2001.
  - ‘An effective STI strategy needs to be placed within a comprehensive and evidence-based framework that also attends to reproductive health issues such as unwanted pregnancies’. ‘NZ lags behind England, Scotland, Australia and several northern European countries that have taken a strategic national approach to sexual health’. (Request for action on development – SHS, 2011).
  - The Royal Australasian College of Physicians stated that prior to an analysis of value of money and service delivery a widely agreed strategy must be in place, including KPIs and benchmarking data or clinical indicators for sexual health medicine based on the New Zealand context (The Royal Australasian College of Physicians, 2012).
- **Strong leadership.** A common theme raised was the need for strong, visible and mandated leadership from the Ministry for the SRH sector.
  - Leadership from the Ministry will help ensure the vision and strategy are understood and implemented consistently across the sector.
  - Leadership needs to be visible and mandated. Many were unaware of the existence of the SRH steering group or its purpose and felt that SRH was not a priority for the Ministry. Those that were aware of the Steering Group felt they had not been effectively consulted in the development of this group and that the group lacked clinical leadership. They felt clinical leadership could be improved through appointing clinical representative(s) to the group, in addition to the DHB Funding & Planning roles.



“We are bits of a jigsaw all put together to make the picture on the front of the box... But the picture on the front of the box is missing”

“What is SRH?”

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (2)

### 2. Challenges in collecting comparable performance data prevent effective monitoring and evaluation of SRH services

- **Data should be collected nationally to allow for monitoring of the SRH sector, including trends in SRH.** This should be broader than current reporting, which is largely limited to the incidence of STIs and include:
  - Service usage by provider type with demographic information
  - The services being provided in consultations
  - STI incidence, including those identified based on symptoms or self-tests rather than through lab tests.
  - Education activity and the associated outcomes

Currently there are a series of challenges to collecting this data.

- **Each funder has different reporting requirements and a common set of KPIs have not been agreed.** The complex and disconnected nature of the SRH sector is reflected in the inconsistency of performance data across regions and individual providers within those regions.

Each organisation delivering SRH services is accountable to their respective funder for what they deliver. Reporting to funders is an important mechanism for accountability to funding but also for providing an understanding of the state of SRH in New Zealand. The complexity of the funding model mirrors complexity in the upstream monitoring and evaluation of efficiency and effectiveness in the sector.

“It’s hard to determine VfM if there’s no proper reporting”

“KPIs and data are really important... BUT it’s also really important that something is done with the data”

- **Current reporting is not centrally collated, analysed and reported. Management information and data is scarce.** Robust and consistent data is scarce. This makes it hard to understand what is working best and what is not. It also makes it hard to communicate performance. Much data is available from different providers but it is not always collected or reported in the same way. Some clinicians indicated they capture detailed information on treatments and were surprised this was not analysed and available. The successful development of a performance measurement tool at a national level will rely on a strong vision and strategy. Family Planning appear to have the most sophisticated data collection and reporting tool specific to SRH, and the Ministry should explore the feasibility of using this, or a similar model across all providers.
- **Information Technology (IT) does not support data collection and reporting.** Information and technology capacity and capability amongst the sector is a significant challenge to ensuring consistency in performance measurement across the sector. Providers use different systems that capture different information and reporting is also variable. In one consultation session two providers shared opposing views on the quality of reporting they can obtain from the same IT system.

Data collection should not create an administrative burden for the sector. There is a frustration within the sector that valuable clinician time is spent on administration instead of patients. It is important that any new data collection regime demonstrates an understanding of this.

The sector suggested a national database such as that used for ‘Well Child, Tamariki Ora’ so that data could be easily input and collected. This would create greater efficiencies in clinician time, increase productivity and service usage rates, while providing a more effective service.

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (3)

### 3. A national strategy will help to direct education and public health activities

- **The rationale for the distribution of funds between clinical and education services is unclear.** The sector collectively agreed the importance of education activities to raise awareness and encourage safe sexual behaviour among the population. However, the lack of a national strategy means that the split between clinical and education services is highly variable throughout the country. The split between these services within each DHB area should be guided by the national strategy with regional variances as appropriate. Specific research in this area would help identify the optimal balance.
- **There is a need for a consistent national awareness campaign to deliver key public health messages.** There is a concern that public health messages are not being delivered at a national level, and that those working in public health are left to develop their own messages. This is inefficient as time spent by educators in each region 'reinventing the wheel' and developing their own messages could be better spent tailoring and delivering these messages to their region.

Those working within the sector advocated strongly for consistent public messages and the dissemination of these messages at a national level through awareness campaigns. The 2008 Sexual Health Awareness campaign was considered useful by the sector but many were disappointed the campaign was not continued. Regional educators were able to plan their own events to leverage off and reflect the messaging of the national campaign.

“SRH needs to be de-stigmatised like mental health has been. Pretty much everyone in New Zealand is having sex. In the past SRH was seen as a minority issue. This was the wrong context and so produced the wrong strategy”

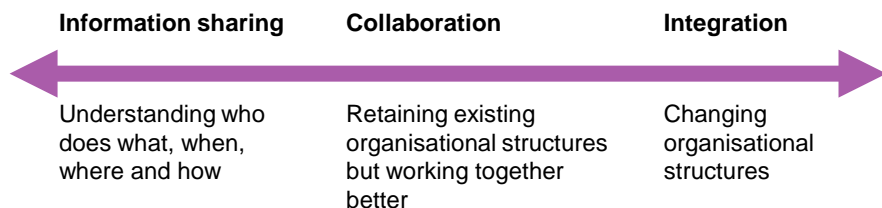
“SRH is perceived as a service for those who have done something wrong”



Value for Money Review of Sexual and Reproductive Health  
**Analysis - Consultation: key themes (4)**

**4. Better collaboration will help improve performance and increase VfM**

**“ We need to be more joined up. There is a spectrum from information sharing to integration ”**



Generally, each part of the sector is disconnected from other parts both from region to region and within regions. It was common for SRH service providers attending the consultation sessions to meet and share contact details. Many found it beneficial to network and understand other services available within their regions.

**Better collaboration was considered to be an area where ‘easy gains’ can be achieved.** Collaboration means providers working together to ensure that the service user receives comprehensive and accurate health assessment and treatment in a way that ‘wraps around’ the needs of the service user. Providing services through collaboration can also lead to greater efficiencies in resource use, and the ability to reduce costs by building on economies of scale.

More than 70% of SRH funding is allocated to providers that operate within a regional network or in isolation rather than on a national basis. Consequently, with the exception of national providers, sexual health services are region focussed, and the delivery of service is adapted to the perceived needs within their region. This can be positive, but there is a need for an appropriate balance of regional tailoring versus national consistency to prevent duplication. Distinct services for, example general practice and dedicated youth services, are often disconnected from each other within a region. Regional services are also disconnected from services that are available at a national level.

**‘Collaboration in action’**

A number of providers or regional collectives attributed greater efficiency and effectiveness to the collaborative relationships they have developed with other service providers. These relationships were both with other SRH providers and other health, social service or education providers.

**Collaboration nationally:** The sector expressed a need for a national database, which the Ministry would administer, that would inform the sector of what providers operate in each of the regions, and their core focus. Participants also expressed a desire for an annual forum that would allow providers to network and collaborate with other national providers.

Strategic direction from the Ministry was seen as key to fostering collaboration between providers.

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (4 Cont.)

### 4. Better collaboration will help improve performance and increase VfM (cont.)

“Collaboration requires a top-down strategy driven by the Ministry”

**Collaboration between service providers requires greater Ministry collaboration with other government departments.** The sector holds a strong view that the SRH of New Zealanders is affected by a number of different factors such as culture, socio-economic status and education opportunities. This is supported by the Rotovegas (2012) youth one-stop-shop who in written feedback reported that ‘population health statistics for clients in our age range [youth] are unlikely to change unless there is a change in the determinants of poor health. Such determinants include social norms of behaviour, and poverty, and these are beyond our sphere of influence’.

To ensure effective service delivery, providers see a need to work more closely with these other services such as youth services, mental health services and addiction services. However, there is also a need for government agencies to collaborate at a National level to ensure effective and efficient collaboration at a service level, and ultimately a more comprehensive health outcome for the service user.

“Services are not connected. As professionals we are not sure what is available and how its available. And if we don't know...”

- **Networking opportunities provide a strong basis for collaboration.** Within some regions there is a strong focus on regional collaboration, however this is not the case in all regions, and at a national level there is very little collaboration amongst service providers in the sector. Those providers who participate within active networks, often reported greater efficiencies and more effective services as a direct result of these networks.

KPMG observed that the consultation sessions for this review allowed providers to network and share their challenges and successes. Participants appeared to enjoy the opportunity to be able to share their views and opinions with others in the sector, as well as develop relationships and future pathways between themselves in the process. Many contact details were exchanged.

- **The current funding and contracting models do not support collaboration.** There is a view that the current funding environment fosters competition within the sector rather than collaboration because it funds services in silos with targets to achieve. Providers are required to compete for limited funds. This competitive model of service provision restricts providers from collaborating with other services or actively seeking to integrate with other non-SRH services. It acts as a barrier for integration between primary and secondary services. Services funded in silos also result in restrictive service specifications, which further prevent effective collaboration between service providers. The funding barrier extends to preventing collaborative or integrative services with other health or social service providers. Service specifications are attached directly to funding, which is usually for one particular type of service delivery. If providers are funded to provide sexual health services, but they identify that a service user needs drug and alcohol counselling, it can be difficult to locate a provider that is funded to provide this service.

“Patch protection”

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (4 cont.)

### 4. Better collaboration will help improve performance and increase VfM (cont.)

- **The diversity of the SRH sector creates both challenges and opportunities for collaboration.** The SRH service delivery model is highly complex, consisting of a range of distinct services delivered by national providers, regional providers, DHB's, PHO's, GP's and other NGO's.

Each type of provider offers a range of services, with varied locations, standards of practice and eligibility criteria. Increased awareness of and information about the availability of services at both a regional and national level will support collaboration. Although the diversity within the sector is currently seen as a challenge to collaboration, the general feeling amongst participants is that this diversity is a necessary one and that the challenge can be overcome.

“Organisations are starting to hold back because of competition for funding

”  
“We need to stop duplication”

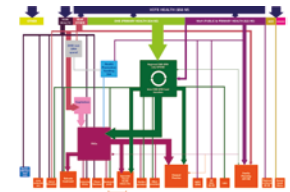
Value for Money Review of Sexual and Reproductive Health  
**Analysis – Consultation: key themes (5)**

**5. The complexity of the funding model creates inefficiencies in the sector and may lead to reduced effectiveness**

The funding model is complex. A degree of complexity is required to deliver services to priority groups and to provide universal coverage. The complexity of the SRH sector does not appear to be strategically driven.

- **The funding model is not designed so that funds flow efficiently and maximise the effectiveness of service delivery.** It is clear from the complexity that the funding model has not been designed to be economically efficient. Funds flow through a number of sources before they reach the service delivery organisation. Up to 113 different flows exist with an average of three organisations handling funds. In one situation funds flow backwards.
- **There is a fundamental tension between centrally funded providers and devolved funding services.** Direct funding relationships allow for greater autonomy, more efficient use of funds and robust reporting and information mechanisms. The New Zealand AIDS Foundation attribute their ability to use funding in an integrated way that aligns activities as key to successful achievement of outcomes.  
  
For those operating in a devolved funding environment, (such as those funded through DHBs), autonomy is decreased, funds are diminished through the 'clipping of the ticket' and reporting and data collection mechanisms are weaker.
- **Capturing the right information to measure outcomes from spend is a challenge.** There are a number of SRH services that are provided but are not recorded or reported. For example visits where SRH issues were not the initial reason for the visit. This ambiguity makes it difficult to centrally measure the efficiency and effectiveness of SRH spend. The complexity in the funding model is reflected in the complexity in monitoring and evaluating the outputs and outcomes of the sector.

Feedback provided on the funding flows diagram during consultation workshops (Refer to Figure 7 on page 35 for the full diagram)



“None of us understand the whole”

“We all agree it’s a mess”

“It’s very fragmented”

“Mud”

“By the time funding gets to grass roots there’s nothing left”

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (6)

### 6. Service users need choice and services tailored to their needs

- **A multi-faceted service delivery model is the most effective way to deliver service to clients.** Service could be delivered more efficiently and for less if the model had less choice, but this model would not meet the needs of all people. Research suggests that this would be less effective.

When considering the overall service delivery model, there are a number of factors to take into account including the distinct nature of the service, service user confidentiality, access to services, integrated service delivery, and the unique needs of population groups. In order to be able to deliver effective service that takes into account all of these factors, a multi-faceted service delivery model is essential. There needs to be good accessibility and awareness of services. Promotion of sexual health services in the community should be carried out jointly between service providers across the continuum so that consumers have information about the full range of options. This is reaffirmed by the Current Status of Sexual Health Service report by the Hawke's Bay DHB, 2012.

- **SRH services could be integrated with other services to gain efficiencies and provide more comprehensive care to service users.** The sector see a need to provide more integrated services for service users, using models similar to the 'youth one-stop-shop' model or the Whānau Ora model. These models will not be appropriate in all circumstances but can allow for more comprehensive, and therefore more effective, delivery of services. There is also an opportunity to gain greater efficiencies in the sector through integrated services. The integration of services would build on the desired collaboration within the SRH sector, the wider health sector, and the social service sector. Although the current funding model doesn't encourage the 'one-stop-shop' approach, those that are making it work are collaborating effectively to overcome funding challenges.

- **A patient centric approach to service delivery can improve the efficiency and effectiveness of services.** The sector identified that where the specific needs of the patient are incorporated into service delivery they are able to provide more effective service delivery.

For example, forestry workers in the Gisborne area have been identified as a high-needs population. However, SRH services are not easily accessible for them because there are no after hours services provided. If a service can be provided with more flexibility around hours to suit service user needs take up is likely to be higher, as is productivity while also maintaining effective service delivery.

- **Using peer group representatives or community champions within communities is an effective way to deliver health promotion messages.** There is a strong view within the sector that school children and young people respond well to peer led sexuality education services. There are a number of examples within the sector where the use of peer group representatives or community champions has enabled effective delivery of health promotion messages within their connected peer groups. This strategy has also been identified as a successful workforce development tool within the Peer Sexuality Support Programme (PSSP) in Auckland. A number of peer sexuality support students have transferred the skills they learned in their peer support roles within schools to peer sexuality support educator roles within the PSSP.
- **Service delivery models need to be appropriate to the service user.** Māori Providers believe service delivery models developed within a Māori framework incorporating cultural competencies, holistic health and wellbeing, a focus on strengthening identity, and a whānau approach, serve the Māori population in the most effective way.

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (7)

### 7. Access is critical, service users need to have multiple points of access and services need to be readily available to high need populations or communities

- **Services for young people need to cater to the nature of the lifestyle that young people lead as well as their use of technology.** The majority of the sector felt that free services for young people, due to their high priority and low income status is an important component to ensure effective service delivery.

Services that are easy to access, available at the times that suit them and comprehensive treatment services that meet all the health needs of the service user are key to effective and efficient service delivery for young people. It is also identified that the integrated provision of SRH services with youth related services such as alcohol and drug services, relationship counselling services and other mental health services, is an important factor to deliver effective and efficient service delivery for youth.

“Any door is the right door”

“Young people need to trip over services to find them”

- **High needs communities can be reached through national providers working with other service providers to provide more efficient and effective service. Family Planning are the largest national provider of SRH services, but predominantly deliver services to large centres of population across the country, and primarily to women.**

Feedback from the sector has suggested Family Planning have the potential to provide services in conjunction with GP clinics or other community based services to gain efficiencies and contribute effective delivery of service to high needs communities. It was suggested an integrated or collaborative arrangement between Family Planning and other service providers could also see better usage of Family Planning training services to ensure more effective service delivery in high needs communities. The New Zealand Prostitutes Collective also collaborate with other providers to ensure the specific needs of their population are met, in order to gain efficiencies within their service.

- **Transient populations that exist as pockets in communities around New Zealand have high SRH needs.** There are a number of transient populations within New Zealand, including seasonal workers and tourists who are unable to access free or readily available SRH services because they don't meet eligibility for subsidised or free healthcare. The sector expressed significant concern at the effect that these populations are having on the wider New Zealand population through sexual interaction, and the associated sexual health issues.

There is an opportunity to improve the VfM of SRH services by investigating how to provide services to transient populations. It may be that providing free or subsidised sexual health care to tourists under a particular age positively affects the wider population.

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (7 Cont.)

### 7. Access is critical, service users need to have multiple points of access and services need to be readily available to high need populations or communities Cont.

- **Youth are disengaged from primary care.** Ways need to be found to make more mainstream services more youth friendly. This could be achieved through building collaboration between primary care and youth specific service providers, while maintaining appropriate confidentiality. This is particularly an issue for rural and provincial New Zealand where youth specific services are not always available.

One in six students (17%) in a survey of 9,107 secondary students had not seen a doctor or nurse when needed in the last 12 months... Māori students, Pacifica students and students living in neighbourhood with high levels of deprivation were more likely to report foregone healthcare (Denney et al., 2011). Denney et al. (2011) suggests confidentiality concerns are an important barrier which young people face when accessing health care, especially those with sexual health concerns.

The sector also indicated that cost was a barrier to youth accessing SRH services. "A quarter of the eligible 13-24 year old population use a free sexual health service in the Waikato" (Waikato DHB, 2012).

“\$3 for youth is a big barrier”

“Youth are disengaged from Primary care, and they are the highest need”

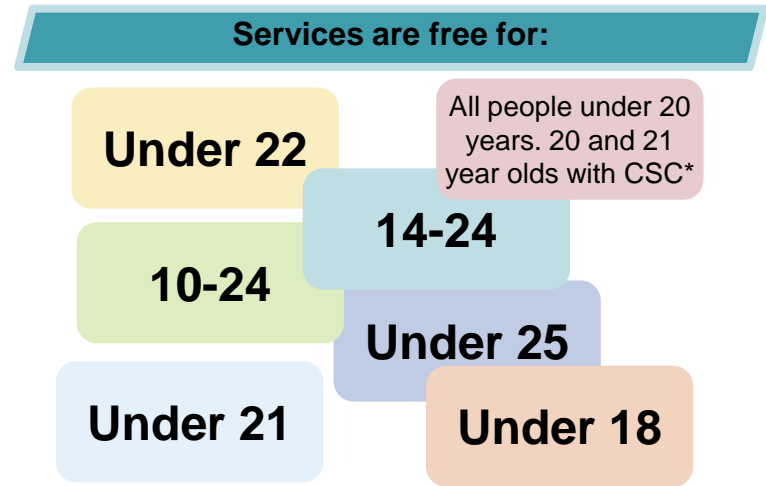
Value for Money Review of Sexual and Reproductive Health  
**Analysis - Consultation: key themes (8)**

**8. Nationally consistent practice would help bring the sector together and increase efficiency**

The lack of a national strategy has resulted in inconsistent standards of practice across the sector including: eligibility criteria, workforce competency measures, key performance indicators, health promotion messages and commonly used definitions.

- **Eligibility criteria for service access are highly variable.** Regional decision making has resulted in highly variable eligibility criteria for free SRH services. The diagram to the right includes seven different youth eligibility criteria for services, as provided in the stocktake. This can create confusion for both service users and those working within the sector. Referral pathways are more difficult and this also acts as a barrier to collaboration between providers and a barrier to access for service users. Standardised eligibility criteria for free SRH services nationally, as is common across other areas of health, (for example free health for under six year olds), would provide clarity to service users and mean that clinicians can refer to other services with confidence.
- **Māori service delivery models will better meet the needs of Māori service users.** Māori providers consider holistic health services, that include a whānau based approach in a Māori context to be important and there are a number of service delivery models that incorporate holistic health. The sector recommended the use of existing models that are developed within a Māori context including Te Whare Tapa Wha, Te Wheke and Te Pae Mahutonga.
- **Standardised workforce competency frameworks and KPIs.** To measure and compare the efficiency or effectiveness of the workforce in a consistent and comparable way, the sector will need to use standard workforce competency frameworks and key performance indicators. The application of consistent competency frameworks and key performance indicators to the sector will allow for greater accountability across the sector

The development of competency frameworks and key performance indicators should be consistent with the development of a vision and strategic direction for the SRH sector. The information and technology capability of organisations and the means by which this data can be collated on a whole will be a challenge. The development of key performance indicators for providers of sexual and reproductive health services is necessary in order to establish appropriate national benchmarks of performance. This requires the support of a comprehensive, timely surveillance system for accurate measurement of the outcomes of interest. (Sexual Health society - Feedback to KPMG Value for Money Review of Publically Funded Sexual and Reproductive Health Services, 2012)



\*Community services card



## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (9)

### 9. Efficient use of the SRH workforce and continued workforce development will help improve efficient and effective service delivery.

- **Nursing resources need to be utilised to their maximum scope in order to gain greater efficiencies in service.** The sector advocated for more clarity about nursing scopes of practice in relation to SRH. Nurses already do a great deal of work in this sector, and could do more. There is uncertainty and regional variation as to optimal use of existing structures (e.g. standing orders), and clear national guidelines were called for. Although optimal use of existing structures is likely to need supporting with some training and regular updates, this is likely to be achievable more quickly and at lower cost than extended additional training needed to enable nurses to prescribe independently. Both options need consideration as complementary roles, alongside clinical nurse specialists and nurse practitioners. Currently there are a number of barriers in place that limit the ability to fully use the nursing workforce. These include limited access to appropriate enhanced training, current nursing guidelines, scope for delivery and legal requirements.

The nursing profession has the potential to complement the medical, health promotion and counselling professionals working in Sexual Health by providing clinical care through the complete patient journey and providing nursing support to patients requiring complex management by Sexual Health Physicians. Within some DHBs this is already occurring but there is no national plan for developing the nursing workforce... (Sexual Health Society' March 2012 – service specs & request for action, 2011).

Family Planning advocate the standing order arrangement as an effective and efficient method of operation. Other clinicians are keen to see further development in nurses' ability to treat and prescribe for service users, although the need for service users to also have ready access to medical advice and more complex prescribing was acknowledged. Overall, there is frustration within the sector at what is seen to be a limited scope for delivery for nurses.

There are however inconsistent views around nursing scope for delivery and more work is needed to consider how best to provide seamless delivery of services for clients that is administratively efficient, safe and effective, and youth friendly. Primary care already provides a substantial proportion of such care, although role clarification and increased training/update refresher training options are needed for the sector. To reduce inconsistency within the sector, and identify greater opportunities for efficiency the Ministry may need to review nurses' scope for delivery within an SRH framework.

- **Core competency frameworks and guidelines specific to the SRH sector would allow greater understanding of workforce capacity and development needs.** Core competency frameworks and SRH specific guidelines for clinicians and health promotion workers will enable the sector to identify workforce needs more clearly and maximise the effectiveness of SRH spend. Māori and Pacifica providers believe it is important to incorporate key cultural competencies into these frameworks to enable more effective service delivery to these populations. Core competencies and guidelines should be developed in accordance with a national vision and strategy for the sector.
- **The Māori and Pacifica workforce is underdeveloped.** Although there are dedicated services for Māori and Pacifica, dedicated providers want to see Māori working with Māori and Pacifica working with Pacifica to provide a culturally appropriate service. At present, there are a lack of Māori and Pacifica clinicians within the workforce, with no specific strategy or pathway towards increasing this workforce. It is perceived that service for Māori by Māori or Pacifica by Pacifica is more effective for these populations due to increased cultural competency and awareness.

The Ministry has commissioned a Best Practice Framework for the delivery of Sexual Health Promotion services to Pacific communities in New Zealand. (Analosa Veukiso-Ulugia, 2012)

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (10)

### 10. Comprehensive SRH education within schools is essential to better outcomes for young people

- The outcomes gained from comprehensive education within schools have a flow-on effect on the long term SRH status as the population ages. However, it is perceived that the majority of schools are unable to deliver SRH services effectively. SRH education is a part of the core curriculum, but the challenges to delivering this curriculum effectively lie in the nature of the funding, the limited resource capability and capacity within schools, in addition to the ability of school governing bodies to restrict or limit SRH education within schools. Which can act as a significant barrier. Of particular concern to the sector are those students that are prevented from receiving any SRH education due to decisions at school governance level.
- Effective service delivery within schools requires teachers, or others, to understand and relay comprehensive SRH messages, but it also requires school students to have access to clinical services that are tailored to their needs. To provide a comprehensive SRH education effectively, a number of options exist. One option put forward is for the re-distribution of funds from education to health. This would allow SRH educators from within the health sector to provide more effective service within schools, however this would not provide students with an available resource within the school to deal with issues on a consistent basis. The other option is training teachers to deliver, as for any other part of the curriculum.

## Value for Money Review of Sexual and Reproductive Health Analysis - Consultation: key themes (11)

### 11. The development of a research strategy within an overall SRH strategy will provide evidence to inform effective service delivery

- **There is a lack of evidence to support the current state of SRH within New Zealand, and the unique SRH factors that affect New Zealand.** Although some countries, such as Australia and the USA, have relatively advanced SRH research practices, there is a lack of evidence to support the efficiency and effectiveness of service models within New Zealand, and how these apply to New Zealand's unique SRH factors. For example, the New Zealand Prostitutes Collective have used research funding from outside of the Ministry to establish evidence that informs practice and service delivery, and have identified this evidence as key to effective service delivery for their organisation.
- **The development of a research strategy to provide evidence and analysis that informs practice will enable the Ministry and providers to adjust funding or service delivery models to New Zealand's unique features.** The incorporation of a research strategy within the overall SRH strategy will ensure that research and evidence informs a more efficient or effective practice.

# 6.0 Driver Analysis

**Section 1 – Executive Summary**

**Section 2 – Introduction**

**Section 3 – Literature Scan**

**Section 4 – Stocktake**

**Section 5 – Consultations**

**Section 6 – Driver Analysis**

**Appendices**

Value for Money Review of Sexual and Reproductive Health  
**Approach - Driver Analysis**

**VfM Driver approach**

This fourth component of our review involves identifying a series of drivers of VfM that are relevant to this sector and measuring and reporting on these. A driver is any factor that causes or affects VfM. Examples of drivers include: the extent that the supply of services matches demand, the level of administrative costs or the quality of contract management. So, one is able to state, the greater the extent that the supply of services matches demand, the greater the overall VfM: all other things being equal.

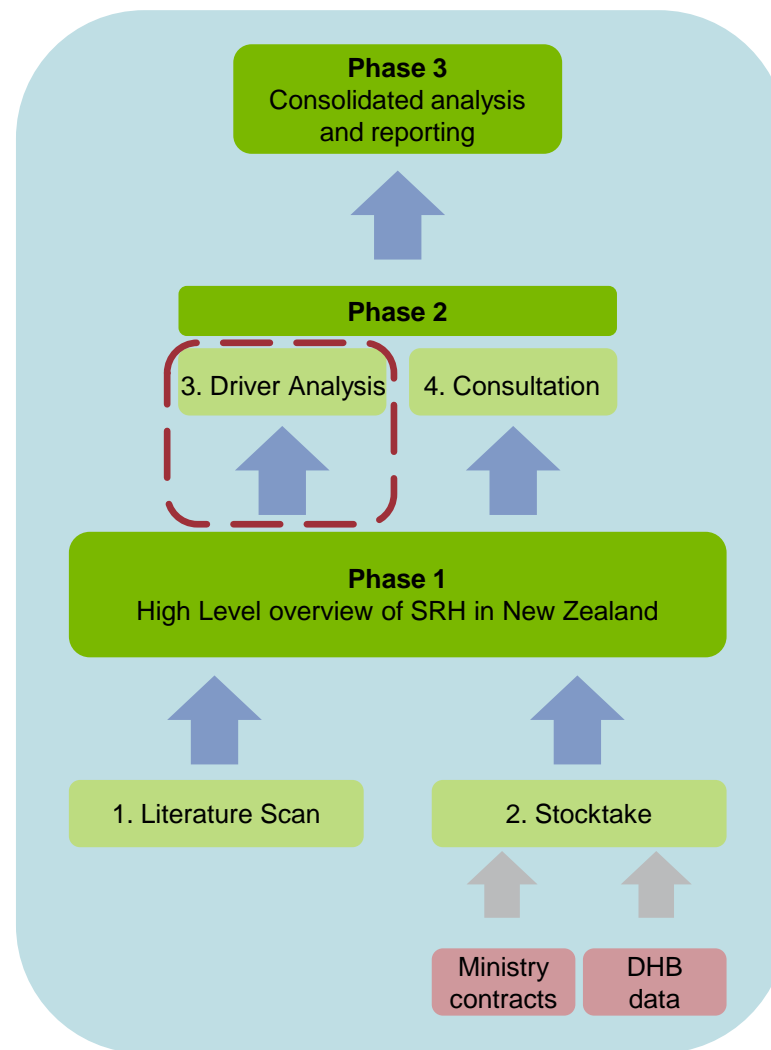
The drivers were drawn from knowledge of the sector and from knowledge of key drivers of VfM from numerous other sectors in both the private and public sectors. The final list of drivers employed are those that have the greatest impact upon and are most relevant to the overall VfM for the SRH sector.

For each driver a description of the general concept behind the driver and its relevance to the public sector is set out plus, the relevance of the driver to the SRH sector and observations on the current state of the driver and a conclusion. For most drivers, data was not available to allow to the driver to be quantified.

Typically in a VfM review, the VfM drivers would form a unique component of the review. Significant quantitative analysis would be undertaken involving comparisons of New Zealand SRH services with other areas of health and overseas. In this review, this was not possible due to:

1. **Inconsistency in data available:** When data was available from providers, it was not consistent with other data provided. Available reporting covered different measures, definitions and timeframes.
2. **Data gaps:** Data was requested on service usage and outcomes from a sample of DHBs. A small amount of data was provided related to school-based services. However, data on service-usage and outcomes was not available for general practice and specialist sexual health services. In addition, where data was available it did not provide the necessary detail to separate SRH services from all other health services.
3. **Timeframes:** The review was completed over a 16 week period.

The list of the 13 drivers most relevant to this sector are set out in the table on the next page. These are broadly ordered in terms of the process.



Value for Money Review of Sexual and Reproductive Health  
**Summary - VfM Driver list**

Driver title	Relevance to SRH
1. Best split between prevention and response (Proactive vs. Reactive)	Very high
2. Optimal split of delivery of services between different providers.	High
3. Optimal channel usage	High
4. Matching supply of services to demand – by time. Does the supply of services meet demand or need as it varies during the day, week, month or year?	Medium
5. Matching supply of services to demand – by demographics and geography	Medium / high
6. Matching task needs to capability and cost structure. ‘Ensuring the right skills for the right task’	Very high
7. Accuracy of initial risk, complexity and needs assessment of customers presenting to services. Extent this assessment drives appropriate customer segmentation and tailoring of services to clients. Matching services to risk/complexity/need	Medium
8. Knowledge of the effectiveness of services. ‘Knowledge of what works’.	High
9. Decisions are driven by expected through life costs, not single event costs	High
10. Cost awareness by service providers and the Ministry	Medium
11. Customer experience of their interaction with the sector – their journey. Includes accessibility to services.	Very high
12. Knowledge of sector performance and quality of management information	Very high
13. Level of sector administrative costs	High

## Value for Money Review of Sexual and Reproductive Health Analysis - VfM Driver (1)

### Driver 1: Best split between prevention and response (Proactive vs. Reactive)

#### Key messages

- The current split between prevention and response in terms of funding is unknown. This is due to large contracts which include both proactive and reactive expenditure.
- There is limited research into the optimal split of proactive and reactive services for the SRH sector in New Zealand.
- Baseline data needs to be collected to determine the current split between proactive and reactive expenditure for the sector for further analysis to take place.

#### General VfM Principle

This issue is highly relevant and topical right across the public sector. The issue is commonly described as the difference between an expensive ambulance at the bottom of the cliff compared to a cheap fence at the top. A common challenge is obtaining robust evidence on the effectiveness of preventative interventions such as public health. At times, the organisational structure of government agencies works against having an optimal split. For example investing in the justice sector when additional investments in social services, housing, education, health, i.e. the factors that drive crime, might be more effective and efficient.

#### Relevance to SRH sector Very high

This driver is highly relevant to SRH as prevention is a central strategy for this sector so getting the balance of investment right is crucial.

In the SRH sector, some clinical services, such as the provision of contraceptives are considered preventative measures. Education takes two definitions here: training and health promotion. Training in terms of education for professionals and health promotion in terms of increasing good health as a whole for the population.

#### Observations and assessment

A high proportion of the funding for SRH services relates to the treatment of STIs and services to support services to prevent unintended pregnancy. The termination of unplanned and unwanted pregnancies. STIs and unwanted pregnancies are preventable and are influenced by societal values and practices, and education on risky sexual behaviours.

An appropriate driver of VfM is therefore the balance between preventative and reactive services or to quote a cliché, the fence at the top of the cliff rather than the ambulance at the bottom. A theme that emerged from our consultation sessions with the sector was, on the whole, stakeholders supported a greater level of spend on education services, but not at the cost of reduced spend on clinical services. However, in terms of VfM this needs to be considered a zero-sum game i.e. funding is assumed to be fixed.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (2)**

**Driver 2: Optimal split of delivery of services between different providers**

**Key messages**

- Split of services needs to be planned both geographically and by service type and driven by the SRH sector strategy.
- Providers need to understand other services offered within their region.
- The relative costs and benefits of specialist versus general services should be explored.

**General VfM Principle**

Where a number of providers exist, each with their own speciality or focus, unless this is managed strategically, an efficient mix of services may not be provided. So is the rationale clear on who provides which services and why? Do some customers receive suboptimal services as a result? Suboptimal can be in terms of the cost structure - so leading to reduced efficiency or they may receive services that are less effective. The cliché example is that if you ask a surgeon what service is required, they may be more inclined to suggest surgery. Different providers have different costs and capabilities – these need to be matched to the task.

Funding mechanisms can distort the services provided. They may incentivise providers so that you get ‘Patch Protection’. For example, if a service is funded on a fee for service basis, where payment is made based on the total number of face-to-face consultations, then providers will naturally want to maximise their own consultations wherever possible. This system works well if providers are already busy, but not so well if they are not.

**Relevance to SRH sector** High

This driver is highly relevant to SRH. The SRH sector requires services to be provided by different providers, in different geographic locations, to meet the needs of the population. Therefore ensuring the optimal split of service delivery between different providers will lead to more efficient and effective delivery of services.

**Observations and assessment**

From the consultation sessions it emerged that in many cases people were not aware of who was doing what. This knowledge is a necessary, but not on its own, sufficient requirement to enable the suite of services to be provided effectively. Its the strategic point.

Based on the initial risk assessment (driver seven), providers need to be able to direct service users to the provider that is best suited to deal with their needs, even if it is not within their own clinic.

Optimising the split between different providers will require a clear strategy for the sector for which a common goal and language can be developed. This will serve as the foundation for increased collaboration amongst service providers adding to the effectiveness of services.

A clear SRH sector strategy will help drive the optimal split of service provision between providers and break down any perceived silos by:

- Enhancing trust and boosting understanding between providers leading to increased collaboration. If a provider understands the capabilities of other providers, collaboration is more likely
- Increasing management's understanding of service provision overlaps and gaps between service providers
- Helping people see the bigger picture and work towards a common goal.

**Specialist versus general/primary care**

The 39 specialist SRH contracts reported in the stocktake of funding received funds of approximately \$17m. Without specific data on demand it is not possible to assess the cost per visit at these providers, but it is a reasonable assumption to assume that these specialist services are higher cost than primary care.

Self-referral to secondary care is important in the SRH sector as stated by the Association of Salaried Medical Specialists (1999) ‘Multiple entry points for patients to access sexual health treatment, inclusive of specialist and specialised sexual health services and other primary health care providers are necessary for prompt diagnosis and treatment, which is a basic strategy for preventing poor sexual health’.

So assuming the higher costs of specialists services and the process of self referral, there may be instances where more experienced specialists services are provided when general services are both lower cost and more appropriate.

The relative costs and benefits of specialist versus general services should be explored. To improve efficiency it may be beneficial to ensure secondary services are targeted on high risk groups such as those discussed above. Lower risk groups might be required to attend primary care services for their initial consultations.



## Value for Money Review of Sexual and Reproductive Health Analysis - VfM Driver (3)

### Driver 3: Optimal channel usage

#### Key messages

- There is a need for internet-based service delivery to be more centralised and coordinated.

#### General VfM principle

Services can often be delivered through a number of different ways, or channels. For example face-to-face (which has several distinct types), telephone or internet. Selecting the best channel on grounds of both efficiency and effectiveness is about channel optimisation (providing the same service through different means). This is occurring for many government services as internet penetration and computer ownership increase and as more people, especially young people prefer to interact via the internet. Simple tasks move to the web, slightly more complex interactions move to a call centre approach, leaving specialist services as face-to-face. Optimal use can reduce costs/increase efficiency substantially. Optimal/multiple channels also lead to greater accessibility.

Relevance to SRH sector **High**

There are two ways in which optimal channel usage is relevant to SRH. They are:

1. **The type of provider:** the SRH sector is unique in health in that service users are able to directly approach secondary care (self-referral specialist SRH services) without requiring referral from primary care. Our understanding is that self-referral to specialist services is important to meet the needs of high-risk SRH populations including sex workers and MSM.
2. **The platform for delivery:** Many services have to be face-to-face and these are inherently expensive. However, the internet provides confidentiality and is particularly preferred by youth – a key target audience in this sector.

#### Observations and assessment

##### Greater use of the internet

The use of internet based applications for service delivery and communication were raised at most of our consultation sessions. Many providers are innovating in this area although this work does not appear to be well coordinated.

Some providers are in the early stages of investigating service delivery over the internet. Consultations via the internet may assist with areas where access to services is a challenge in terms of clinic hours, geographic barriers or where clinic attendance is challenging due to stigma. Of course, internet delivery does have some basic practical limitations in respect of prescribing and diagnosis.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (4)**

**Driver 4: Matching supply of services to demand – by time. Does the supply of services meet demand or need as it varies during the day, week, month or year?**

**Key messages**

- Little data is available on the times of highest demand and services need to be matched to demand.
- Feedback in our consultation sessions indicated that services that offer non-standard hours, in particular access during the evenings, or mobile services to work around issues with services hours experienced high demand

**General VfM Principle**

The demand for most government services varies. Variation often occurs through the 24 hours of the day, during the week and in particular at weekends as well as seasonally. Public holidays often affects demand. However, the supply of services is typically easiest for government and lowest cost during the weekly standard nine to five working period of the week. Mismatches between supply and demand leads to either the under use of costly services at times of low demand and excess demand or pressure on services at peak demand. This in turn causes a drop in quality of service or rationing by means of lengthy waits for customers. Two potential changes can be made. Either services are matched to the demand profile (rostering to demand), or actions are taken to change or manage the demand profile, in particular by flattening the peaks.

**Relevance to SRH sector** Medium

The needs of users of SRH services are highly diverse. Many of the target groups that the sector seeks to reach have unique needs in relation to the accessibility of services, in particular the time they need services. Demand for SRH services cannot easily be flattened and a better approach is to match services to demand.

Forestry workers and sex workers are two groups with specific needs. The nature of forestry work means these people are working in remote areas for long days, where it is difficult to leave the task at hand for short appointments. If a forestry worker needed to visit an SRH provider with standard nine to five hours they would need to take the entire day off work which is generally not feasible. The same is true for those that live out of town where transport is not readily available. The demand by sex workers for SRH services is typically highest in the late afternoon onwards.

**Observations and assessment**

Currently little data is available on the times of highest demand for SRH services. Feedback in our consultation sessions indicated that services that offer non-standard hours, in particular access during the evenings, or mobile services to work around issues with services hours experienced high demand. The extent that services match the time of demand needs to be explored further. For example, a service user survey completed by one youth health service provided to us through our review found that although a high proportion (88%) of service-users were satisfied with the opening hours, a common theme for improving the service was more late night hours (Rotovegas, 2012)

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (5 and 6)**

**Driver 5: Matching supply of services to demand – by demographics and geography**

**Key messages**

- Services need to be placed where there is the greatest need.
- This requires an understanding of the need and each region’s demographic make-up

**General VfM Principle**

The demand for government services varies by demographic group (i.e. age, gender and ethnicity) and also by region. The first step to meeting the needs of each area and the demographic make-up of that area is to understand the demand. Once the demand for services is understood, services can be tailored to meet that demand in the most efficient way.

**Relevance to SRH sector** Medium / high

A key theme as noted in the consultation sessions with the sector was the need to place services where there is the greatest need, both in respect of the needs of population groups and regions.

**Observations and assessment**

To meet demand, first demand needs to be understood within the region as different areas have different demographic profiles. Understanding each region’s make-up of people is the first step to understanding how services can be adequately tailored to meet the demand.

Ensuring that the supply of SRH services is tailored to meet the demand of the population is an important driver of efficiency. Mismatch between supply and demand creates two VfM issues:

1. Services utilisation is not maximised as the right type of services are not available to meet the needs of the population. Our review of literature (refer section three) shows that the burden of STIs falls disproportionately on youth. Many stakeholders in our consultation sessions highlighted how the traditional basis for receiving treatment in the healthcare sector of scheduling an appointment in advance is ineffective for reaching youth.
2. Demand exceeds supply across the sector or for parts of the sector. Here the symptom or indicator will be wait times. Through our consultation sessions with the sector we were advised of a wait time of between 4 and 6 weeks for contraceptive advice from some SRH providers. Other service providers indicated that same or next day services were available.

**Driver 6: Matching task needs to capability and cost structure. ‘Ensuring the right skills for the right task’**

**Key messages**

- The sector advocated for much greater use of nurses. Views differed on the optimal role for nurses and this is an area that warrants a review of its own.

**General VfM principle**

A trend across government both nationally and internationally is to develop intermediary skilled positions to take some services away from the most costly staff group and so to provide the service more efficiently, and often more effectively. Examples of this include: Nurse Practitioners; Non-Sworn Police Officers and Teaching Assistants. This trend is set to continue. In many situations making these changes not only leads to significant efficiency gains but also greater effectiveness. The more costly resource often has insufficient time and may have less interest in the task.

**Relevance to SRH sector** Very high

The sector advocated for much greater use of nursing resources, particularly in relation to initial assessment, and the dispensing and prescribing of oral contraception and oral antibiotics, where the choice or diagnosis is clear and the supply/treatment straightforward. There was a range of views as to the type of training required, optimal use of existing systems (standing orders), or introduction of new systems (e.g. wider prescribing rights). A need to balance increased nursing scopes generally with the need for service users to have also have ready access to medical advice and prescribing when required was acknowledged. More role and responsibility clarification for nurses and GPs in primary care would be helpful, as both nursing and medical skill sets are needed. Increased training options for primary health care professionals may well be needed.

**Observations and assessment**

The sector had varying views in this area and they ranged from those who backed greater prescribing rights for nurses and greater use of standing orders to using nurses more in non-prescribing roles.

This is an area that warrants a review of its own. Some in the sector reported nurses operating efficiently with a high-degree of autonomy, including prescribing tasks whereas others reported obstacles to achieving this. It does appear that there is inconsistency across the sector more broadly. There is an opportunity to take examples of using Nurses and Nurse Practitioners and apply this consistently across the sector.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (7)**

**Driver 7: Accuracy of initial risk, complexity and needs assessment of customers presenting for services. Extent this assessment drives appropriate customer segmentation and tailoring of services to clients. Matching services to risk/complexity/need**

**Key messages**

- Getting the risk and needs assessment of service-users right is a major driver of efficiency and effectiveness.
- Measuring this is possible but would require data from across the whole sector.

**General VfM Principle**

In many areas of the public sector, a critical VfM driver is the initial risk, challenge and need assessment when the customer presents. This drives all of the following services/treatment and spend. Getting this right is a major driver of efficiency and effectiveness. High quality initial work or interventions is critical. Two areas require focus. First, is the initial risk / need assessment accurate, second, given this risk / need assessment, are services appropriately tailored as a result.

**Relevance to SRH sector** Medium

This driver is relevant to SRH as it covers the quality of the clinical assessment and associated services, such as diagnostic laboratory testing.

**Observations and assessment**

Accurately assessing risk and completing a comprehensive diagnosis in the first consultation will help direct the client to the most suited service provider. The extent that diagnosis are comprehensive varies across service providers. For example, a Student Health Clinic has a blanket approach, where a full assessment is carried out. These take an hour for each patient. At other primary care providers, a similar level of care can be completed in much less time. This is because an assessment of the level of care required is made, which is based on risk.

In some instances, a STI can develop without any signs or symptoms, presenting a challenge for risk assessment. Risk assessment needs to take a holistic approach that goes beyond the STI symptoms. During the initial risk assessment, consideration needs to be given to the service users' demographic and socio-economic factors. Additionally, in terms of the holistic approach to risk assessment, there needs to be a discussion surrounding the service user's sexual history and sexual partners.

Within the initial risk assessment, the holistic approach will provide the clinician with a better understanding of the potential risk and guide their decisions for assessment and referrals.

During the consultations with the sector, the holistic approach to risk assessment was raised a number of times and it seems to be a widely used practice. However there was a suggestion that there might be an opportunity to improve the holistic approach to risk assessment through tailored training sessions. The tailored trainings sessions would be for GPs and cover the specific population they serve as well as their particular needs.

Participants during the consultations noted that the SRH sector referral system is confusing from the patients perspective in terms of the services available from different clinics. This further reinforces the need for accurate initial risk assessments and diagnosis which provide the service user with a clear path to access the correct service. When a service user is directed to the correct service initially there is no need for re-assessments or re-referrals to other service providers.

Measuring this driver will require data collection across the sector from all DHB areas. The potential measures include:

- Proportion of service users requiring re-diagnosis – this is the 'getting it right the first time' point
- Proportion of service users requiring re-treatment
- Proportion of service users requiring re-referral.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (8 and 9)**

**Driver 8: Knowledge of the effectiveness of services. ‘Knowledge of what works’**

**Key messages**

- For services to be effective they need to be tailored to a community’s socio-economic level, demographic make up and age profile.
- Little is known about the effectiveness of the some aspects of clinical treatment, in particular counselling and advice.

**General VfM Principle**

Knowledge of the effectiveness of services is a key metric which can be used to gauge how a service delivery technique is performing compared with other potential service delivery techniques. It will help identify what services are most effective. This is a major issue across parts of government. Services are provided, but no one really knows, or has the hard evidence to confirm if they are effective.

**Relevance to SRH sector** High

This driver is highly relevant to the SRH. Many services are provided, but is there solid information available that shows how effective they are? Did it achieve the planned outcomes?

Knowledge of the effectiveness of services needs to be considered for both prevention (i.e. health promotion) and treatment (i.e. clinical services). Knowledge is crucial when identifying areas for improvement. As the literature scan identified, for services to be effective they need to be tailored to a community’s socio-economic level, demographic make up and age profile.

**Observations and assessment**

For treatment services, much research is completed into the safety and efficacy of antibiotics for treating STIs and the safety and effectiveness of contraceptive devices and medications. Less is known about the effectiveness of other aspects of clinical treatment – counselling and advice and whether this is effective and which aspects are most effective for particular groups.

Effective clinical services can be measured through the:

1. Accessibility and use of services by consumers (Volumes attending),
2. Appropriateness and sensitivity to both general and target groups: youth, Māori or Pacifica, MSM (Retention or re-attendance at services by people from these groups),
3. Appropriate examination, assessment of service-user history and lab testing, including not testing where there is no indication (or in some cases where testing will not alter treatment)
4. Partnership with the service-user to inform, explain and develop a management plan,
5. Implementation of the management plan and follow-up (appropriate advice around contraceptive devices and education around future safe sex).

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (8 and 9)**

**Driver 9: Extent that decisions are driven by expected through life costs, not single event costs**

**Key messages**

- Long-term implications should be considered when evaluating the cost of treatment.
- Understanding the underlying cause of issues affecting service users is important.

**General VfM Principle**

This is a common issue and opportunity across the public sector. Decisions are often made based on the cost and benefits of the existing situation. However, customers often have many issues stretching over a number of years. Taking account of full life costs makes the case for prevention stronger. The Ministry of Social Development is adopting this approach as a core principle of the Ministry’s strategy to transform itself. This is sometimes referred to as an actuarial approach.

**Relevance to SRH sector** High

This driver is relevant to SRH in many areas. Two examples are:

**Considering the cost of treatment against the long-term implications.** In the short-term, Chlamydia treatment can be expensive but the long-term effects of untreated Chlamydia infections are serious. Women can experience pelvic pain, ectopic pregnancy, infertility and their babies neonatal Chlamydia. Men can experience grumbling inflammation, testicular pain, infertility and prostatitis.

**Understanding the underlying cause of issues that service users present with.** When service users present for services, it is important that the clinician takes the time to explore their history and other issues to determine the underlying issues affecting the service user. This time has a cost. In the long term underlying issues such as sexual abuse, insufficient understanding of protection and alcohol or drug abuse can result in STI re-infection, which if not addressed carry a greater cost.

**Observations and assessment**

Evidence from the sector is that SRH is an area of health where decisions are made by considering through life costs. Measuring this would require data collection across the sector from all DHB areas on service users

Potential metrics include:

- Knowledge of through life costs for service users types or segments
- Awareness of through life costs by those that are making the decisions
- Application of through life costs to key funding decisions. The proportion of key funding decisions that take into account through life costs. Measuring this would involve taking a sample of key decisions and evaluating the extent that through life costs are taken into account.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (10)**

**Driver 10: Cost awareness of service providers and the Ministry**

**Key messages**

- Providers need to be aware of the cost of different treatments and their respective benefits, to be able to provide information to the service-user that is best suited to their situation.

**General VfM principle**

This is the awareness by policy makers and service providers of what are the full actual costs of providing a service. Knowledge of this cost is fairly scarce across government.

Being aware of the real and full costs of a service is the first step in the decision making process. The second is to actually do something different as a result of this information. It is relatively common for decisions to be made on services without a clear understanding of the full costs involved.

**Relevance to SRH sector** Medium

A common example in the health sector which also applies to the SRH sector is the awareness of the cost of pharmaceuticals and laboratory tests. It is important when deciding upon pharmaceuticals and tests that the costs (both to the patient and to the taxpayer) are factored into the decision.

**Pharmaceuticals:** More expensive branded pharmaceuticals may be used rather than generic even though the constituents are identical. Conversely, a less good choice of medication or method of contraception may be made because of lack of a patient subsidy and therefore higher cost to the patient (particularly relevant for youth).

**Laboratory testing:** Differing levels of testing are available and there can be a tendency to recommend more expensive and comprehensive tests, when less expensive tests would be appropriate.

**Observations and assessment**

Providers need to be aware of the cost of different treatments and their respective benefits, to be able to provide information to the service-user that is best suited to their situation.

For example, contraception in New Zealand has a number of methods each with different costs and duration of effect. Method reliability varies – the less dependent on the user, the more reliable; if suitable for the user, the LARCs are very reliable, but have high up front costs. Youth are generally resistant to high up front costs, preferring pay as you go methods.

Clearly the clinical outcome or effectiveness must be the overriding principle, however, when the different treatments are equally effective, the costs should be factored in to help make the right decision.



## Value for Money Review of Sexual and Reproductive Health Analysis - VfM Driver (11)

### Driver 11: Customer experience of their interaction with the sector – their journey. Includes accessibility to services

#### Key messages

- To ensure each interaction on the end to end journey for the service user is efficient, effective and intuitive

#### General VfM principle

How customers feel about their experience when interacting with the government is of course critical in its own right but, in addition, it can have a critical impact on the sector's efficiency and effectiveness. If customers have a bad experience, they may in future not turn to the sector until the situation becomes critical. Conversely, if they have a particularly good experience, and one that exceeds their expectations, they are likely to share this with their peers. This type of peer-to-peer organic communication is highly effective and low cost.

A common approach to customer satisfaction is to ask the customer how satisfied they are, but also to determine the key drivers of customer satisfaction and assess these.

#### Relevance to SRH sector **Very-high**

For this sector, the service user experience is even more relevant compared to other sectors. It is vitally important that service users have a positive experience and share this with their peer group. There is a significant degree of stigma and fear associated with approaching this sector. The service user experience is one of the main ways to combat this.

The service user experience is impacted by many factors including: choice, access, availability, who provides the service, where it is provided and of course how it is provided.

#### Observations and assessment

Many providers monitor the level of service user satisfaction. However for this review it has not been possible to obtain any robust and comparable customer satisfaction information as this is not centrally collated. Relevant measures include:

- Service user experience and satisfaction
- Barriers to service usage. Factors that delayed service users seeking help
- The proportion of service users presenting for treatment later than ideal
- Service user waiting times
- Level of positive and negative recommendations from peers.



Value for Money Review of Sexual and Reproductive Health  
Analysis - VfM Driver (12)

**Driver 12: Knowledge of sector performance and quality of management information**

**Key messages**

- An organised approach to collecting robust management information will aid decision making for the allocation of resources to improve service delivery effectiveness and efficiency

**General VfM Principle**

To optimise the value for money of a system, robust information is required providing evidence of performance. This information should be monitored and appropriate action taken where required. Without data we are blind. 'If you cannot measure it, you don't manage it'.

**Relevance to SRH sector** Very High

This is highly relevant to all sectors. Management information is a foundation of and underpins many of the drivers within this report. Key performance and management information with the SRH sector includes:

**Service user perceptions**, As discussed in Driver 13 - Customer experience of their interaction with the sector – their journey. Includes accessibility to services.

**Financial information**, As discussed in Drivers '12 Cost awareness by service providers and the Ministry', '11 - Level of sector administrative costs' and '3 - Decisions driven by expected through life costs not single event costs'.

**Demand**, As discussed in drivers 7, 8 and 9 'Matching supply of services to demand by time, geography and demographic'.

**Observations and assessment**

Knowledge of organisational performance and the quality of management information is unclear. From discussions with representatives from across the sector it is clear that organisations do have a greater level of information than is reported to their contract managers and funders. However this, information is not collated centrally. The lack of consistent and collated management information is the reason it is not feasible to conclude on many drivers and ultimately on the VfM of SRH services in New Zealand.

Many organisations within the sector internally monitor service user satisfaction, outcomes delivered and demand. As an illustration, figure 21 below provides an example of outcomes reporting prepared by the Family Planning Association. This measure reports on the results of education sessions run in schools and asks students that attended 'how much did you learn?'

**Figure 21: Bi-annual evaluation of the education sessions delivered to years 9 - 13 students.**

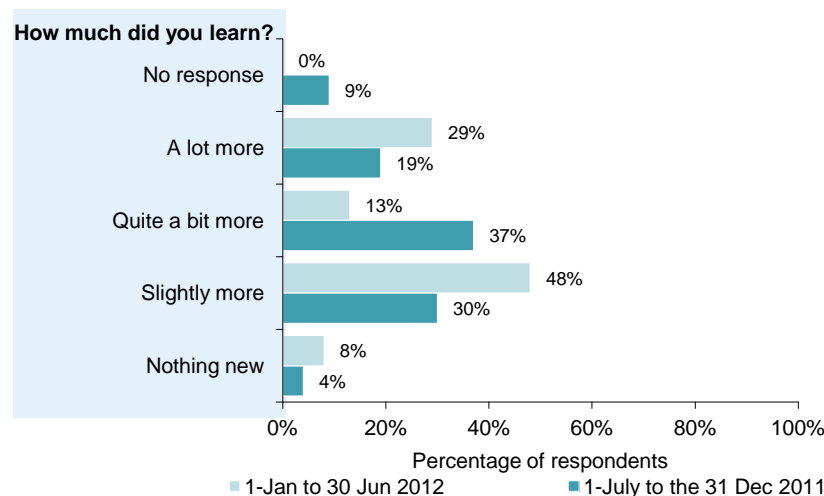


Figure 21 shows that:

*Source: ESR, KPMG Analysis*

- the majority of respondents reported learning either slightly more, or quite a bit more at the conclusion of the course
- reasonable numbers reported learning 'a lot more'
- small numbers reported learning 'nothing new'.

Obtaining and presenting this performance information helps to manage the service. This data indicates no significant overall change over the two reporting periods. This reporting provides a baseline for future reporting and will indicate if amended approaches are effective or not. In addition, this data can be used to compare equivalent services across the country.

Value for Money Review of Sexual and Reproductive Health  
**Analysis - VfM Driver (13)**

**Driver 13: Level of sector administrative costs**

**Key messages**

- Administrative costs need to be optimised to provide the desired value, high administrative costs should transpose to high levels of monitoring and data collection. Conversely, low administrative costs imply limited monitoring capability
- The administrative costs and associated output from those costs need to match sector requirements

**General VfM principle**

Clearly administrative costs are required to deliver services, however these costs need to be minimised. It becomes an issue if the administrative cost is excessive and adds little value.

**Relevance to SRH sector** High

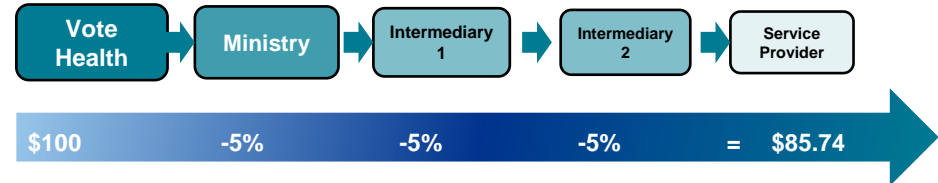
As with any sector, SRH has administrative costs. Administrative costs are defined here as expenses incurred in controlling and directing funds, managing contracts and reporting between the Ministry, intermediaries (such as DHBs and PHOs) and ultimately the service providers. The high number of fund transfers, (refer to the funding flows diagram), in the SRH sector suggest that these administrative costs may be significant.

**Analysis and commentary**

Data on administrative costs is either not available, not always quantifiable or not necessarily dedicated to a particular function within the organisation. Figure 22 below illustrates the impact of administrative costs on \$100 as it moves from Vote Health through intermediaries and on to the service provider. For this example, administrative costs are taken as an arbitrary 5%. Figure 22 indicates how the overall impact is a 14% reduction in the size of the funding pool. If all sector funds passed through two intermediaries, administrative costs for the sector would equal \$7m per annum.

This is a simplistic example and we acknowledge that not all funds pass through two intermediaries. The funding flows diagram (Figure 7, page 35) has 113 possible avenues for funds to flow from Vote Health and other sources through to the service provider. Analysis of the funding flows diagram indicates that the average number of organisations funds will flow through is 2.4 with some funding flowing through as many as four organisations.

**Figure 22: Funding flows illustration**



*Source: KPMG Analysis*

Sector administrative costs can be reduced in two ways:

1. Reducing the administrative costs associated with each transfer of funds between organisations
2. Reducing the number of transfers of funds between organisations.

With little transparency over the administrative costs within the SRH sector it is not known what proportion of the total spend the costs represent and whether or not they add value or contribute to the sectors strategic objectives.

# Appendices

Appendix A – Supporting tables

Appendix B – Consultation locations

Appendix C – Bibliography

Appendix D – Glossary of terms

**Section 1 – Executive Summary**

**Section 2 – Introduction**

**Section 3 – Literature Scan**

**Section 4 – Stocktake**

**Section 5 – Consultations**

**Section 6 – Driver Analysis**

**Appendices**

## Value for Money Review of Sexual and Reproductive Health Supporting tables to stocktake analysis

### Spend per infection

The table below displays the total number of Chlamydia and Gonorrhoea cases by DHB with the total SRH DHB area spend (Ministry and DHB) used to calculate a cost per infection.

This analysis has been included, however it has an analysis rating of 'low' as we cannot separate the cost per infection from other SRH expenditure, such as education and other STIs. Furthermore, only 13 of the 20 DHBs are reported on for this analysis. This is because the data on Chlamydia and Gonorrhoea cases was not available for seven DHBs. The purpose of this table is to highlight a potentially significant metric that could be used for future comparisons.

DHB area by STI: Chlamydia and Gonorrhoea test-positive cases, 2011					
DHB Area	Chlamydia Cases	Gonorrhoea Cases	Total Chlamydia and Gonorrhoea Cases	Total DHB area spend (\$000)	Spend per infection
Auckland	11062	1117	12179	\$9,631	\$791
Bay of Plenty	1777	127	1904	\$3,335	\$1,751
Hawke's Bay	1560	140	1700	\$5,694	\$3,349
Lakes	1321	75	1396	\$905	\$648
MidCentral	1182	111	1293	\$2,325	\$1,798
Northland	1393	84	1477	\$2,392	\$1,620
Southern	2236	108	2344	\$4,665	\$1,990
Tairāwhiti	703	166	869	\$1,769	\$2,036
Taranaki	682	75	757	\$1,071	\$1,415
Waikato	2883	208	3091	\$4,610	\$1,491
Wairarapa	225	25	250	\$398	\$1,593
West Coast	163	9	172	\$271	\$1,574
Whanganui	479	44	523	\$695	\$1,329
<b>Total</b>	<b>25666</b>	<b>2289</b>	<b>27955</b>	<b>\$37,761</b>	

### Conclusions

There are significant issues with the above analysis which mean we cannot draw reasonable conclusions from the data, these issues are:

- Only two STIs are represented
- No consideration of other SRH expenditure i.e. GP services funded by the service user and ACC services.

### Spend by service type

This table summarises the spend and percentage of total spend on the seven different service types as specified by the scope. Not specified includes areas where DHBs could not allocate their service to one of the seven service types.

Total Spend by service type		
Service Type	Total Spend (\$000)	Percentage of total spend
Ministry-funded public health providers of SRH services	\$22,264	39%
DHB-funded specialist sexual health services/clinics	\$16,854	30%
DHB-funded PHO SRH services	\$4,710	8%
DHB-funded youth health services	\$6,840	12%
SRH services delivered through mainstream general practice	\$2,109	4%
Dedicated telephone help services		0%
Acute sexual abuse/rape services	\$1,972	3%
Not specified	\$1,845	3%
<b>Total (\$000)</b>	<b>\$56,595</b>	<b>100%</b>

Data Quality:

Source: KPMG analysis

## Value for Money Review of Sexual and Reproductive Health Consultation locations

The table below sets out the thirteen consultation sessions that were held in phase two of this review including their focus and location.

No.	Focus	Location
1	DHBs	Auckland
2	New Zealand AIDS Foundation	Auckland
3	Māori providers	Auckland
4	Pacific providers	Auckland
5	New Zealand Prostitutes Collective	Wellington
6	Family Planning Association	Wellington
7	All providers	Wellington
8	All providers	Gisborne
9	All providers	Christchurch
10	All providers	Kawakawa
11	All providers	Rotorua
12	Northland DHB	Telephone
13	Royal Australasian College of Physicians	Wellington

## Value for Money Review of Sexual and Reproductive Health Literature Scan – Bibliography

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## Value for Money Review of Sexual and Reproductive Health

### Glossary of terms

Term	Definition
<b>Capitation funding</b>	The capitation based payment system is based on the enrolled PHO population. PHOs and their general practices and other providers are paid according to the number of people enrolled, not the number of times a provider sees patients.
<b>Economy</b>	Economy – Spending less. This assesses if a reasonable price is paid for each unit of input. For example, are salaries per person in line with market? Could any of the input costs be minimised while retaining the same quality? How could we spend less but retain the same outputs and outcomes?
<b>Effectiveness</b>	Effectiveness – Spending wisely. This assesses if the actual results are the same as the intended results. Are we getting the right outcomes. For example, are the outputs of services achieving the government's desired outcomes?
<b>Efficiency</b>	Efficiency – Spending well. This assesses if we receive good productivity. Could we get more for what we spend? Could any unit costs be reduced. For example, are the outputs per person reasonable?
<b>General Practice (GP) sexual Health Contracts</b>	SH contracts held by PHOs against which member GP practices can claim. This claim allows patients to be seen free of charge, and are usually targeted to those under 20 or 25 consulting for sexual health reasons (including contraception) .
<b>Primary Health Organisation (PHO)</b>	Are funded by DHBs to support the provision of essential primary health care services through general practices and other primary providers e.g. iwi providers , via population based funding (capitation) according to those who are enrolled with the PHO.
<b>Public Health Nurses (PHNs)</b>	A PHN is a trained nurse whose work and focus is on community health. They may work in a variety of settings including in schools, for the government, and for special health projects which are run in the community.
<b>Services to Improve Access (SIA)</b>	Ring fenced funding that can be applied for by primary providers to improve access to existing services. A key priority for implementation of the Primary health Care Strategy is to reduce barriers for the groups with the greatest need through additional service to improve health, and improving access to existing first-contact services.
<b>Student Health Clinics</b>	University or tertiary provider health clinics. Funded in part via tertiary institutions, in part via student levies and in part by small payments. Some also receive PHO capitation funding.
<b>Value for Money (VfM)</b>	A methodology that aims to achieve the optimal balance of spend and inputs in order to deliver optimal outputs and service delivery.





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