



The Pathways to Resilience Project

Pathways to Youth Resilience: Youth Health and Disability Services in New Zealand – a policy overview

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BACKGROUND

This report provides background on youth health and disability¹ services in New Zealand, examining legislation, policy, delivery, statistics and funding. A complementary report covers youth mental health and drug and alcohol services in New Zealand.

In New Zealand the Ministry of Health is the principal advisor to the Government on health and disability policy. The Ministry is responsible for leading and supporting the health sector, and for implementation of government policy through collaborative efforts with District Health Boards². The Ministry funds and purchases health and disability support services on behalf of the Crown, and plays a role in monitoring and improving the performance of health sector Crown entities and District Health Boards.

New Zealand has 20 District Health Boards (DHBs). DHBs are responsible for providing or funding health and disability services in their district, including youth health services. Each DHB is required to have a youth health plan as part of its responsibilities (Communio 2009).

Primary Health Organisations (PHOs) are the local structures for delivering and coordinating primary health care services. PHOs are funded by DHBs and bring together doctors, nurses and other health professionals (such as Māori health workers, health promotion workers, dietitians, pharmacists, physiotherapists, psychologists and midwives) in the community to serve the health needs of their enrolled populations. PHOs vary widely in size and structure, are not-for-profit, and provide services either directly by employing staff or through provider members.

LEGAL FRAMEWORKS

The New Zealand Public Health and Disability Act 2000 and the Health Act 1956, the Accident Compensation Act 2001 guide general health service delivery in New Zealand. These Acts define the purpose and roles of those bodies which oversee health (e.g. the Ministry of Health, District Health Boards, Accident Compensation Corporation). The Acts also promote the inclusion and independence of people with disabilities in society and seek to reduce health disparities. New Zealand has a number of health focussed 'Crown Entities' (e.g. the Health Sponsorship Council) which are guided by a separate piece of legislation. In addition, the Ministry of Health administers a broad range of Acts and regulations (e.g. the Mental Health Act 1992, Misuse of Drugs Act 1975, Health and Disability Services (Safety) Act 2001)³.

While there are no specific pieces of legislation guiding the delivery of youth health, there are international codes particular to this field.

UNCROC (see the Care and Protection Services policy overview for a list of UNCROC Principles), while not legally binding, provides some guidance regarding the rights of young people in need of health support:

- Article 23: “The right to special care and education for children who are mentally or physically disabled”
- Article 24: “The right to the highest attainable standard of health and to facilities for treatment and facilitation”
- Article 25: “The right for children placed away from home to have their treatment reviewed regularly”
- Article 33: “The right to be protected from dangerous drugs.”

The Ottawa Charter for Health Promotion (1986) outlines five action areas for health promotion, focusing on prevention of illness, promotion of health, and empowerment of communities and individuals regarding good health. It provides guidance regarding service delivery to all populations, including young people.

The World Health Organisation (2002) outlines the many challenges faced during adolescence and provides guidance on providing youth-friendly health services. They advocate for an integrated approach in which health services play one part in supporting young people to meet their needs. They note the “legal framework, social policy, the safety of communities and opportunities for education and recreation are just some of the factors of civil society that are key to adolescent development” (World Health Organisation 2002:4).

Consent and Confidentiality

For young people, legal frameworks around consent to treatment, confidentiality and inclusion of family and whānau can be of utmost concern. In New Zealand young people 16 years of age or older can consent to treatment in the same way as an adult, but for children and young people under 16 the common law doctrine is applied. That is, consent or refusal to undergo treatment can be lawful if the clinician judges the young person as having sufficient understanding and maturity (Mental Health Commission 2009).

Codes concerning disclosure of information about the young person to their parent or guardian also depend on the extent to which the young person is deemed ‘competent’ and information can be withheld by clinicians if it is considered in the young person’s best interests. If they are deemed competent to consent to treatment, or are over the age 16 years, their privacy is protected under the Health Information Privacy (HIP) Code, 1994. For a young person deemed ‘incompetent’, other legal considerations apply, as consent to treatment must be sought from a parent or guardian.

POLICY

There are many strategies and policies which impact on the delivery of youth health services in New Zealand; few of these are youth specific. This section outlines these policies.

Universal Policies

The New Zealand Health Strategy (2000) provides overarching guidance to health policies and services, placing emphasis on “improving population health outcomes and reducing disparities between all New Zealanders, including Māori and Pacific Peoples” (Ministry of Health 2003:15). This strategy contains 13 population health objectives including those which aim to:

- Reduce the rates of suicide and suicide attempts
- Minimise harm caused by alcohol and illicit and other drug use
- Reduce violence in interpersonal relationships, families, schools and communities
- Improve the health status of people with severe mental illness and
- Ensure access to appropriate child health care services including well child, immunisation and family health care.

The New Zealand Disability Strategy (2001) aims to “advance New Zealand toward being a fully inclusive society” (Ministry of Health 2003:17). Its fifteen objectives include ensuring rights and equal opportunities for all disabled people, enabling disabled children and youth to lead full and active lives, and valuing families, whānau and people who provide ongoing support. Responsibility for implementing this strategy has now moved from the Ministry of Health to the Ministry of Social Development’s Office for Disability Issues.

He Korowai Oranga (Māori Health Strategy) (2002) aims to achieve whānau ora (healthy Māori families); recognising that Māori health status is poorer across many indicators than for non-Māori (Ministry of Health 2010).

The recently developed Whānau Ora policy⁴ takes a cross-sector view to providing services and opportunities to whānau and families across New Zealand. Its approach is inclusive and culturally anchored, and it seeks to empower whānau as a whole rather than have multiple agencies “focusing separately on individual whānau members and their problems” (TPK 2010:1). The Whānau Ora model is designed to be flexible to meet the particular needs of a whānau. Whānau will have a whānau ora practitioner who will “act as navigators or champions for whānau, helping them to develop a whānau plan and to access seamless health and social services (TPK 2010:2). This version of Whānau Ora is currently in the early stages of development and implementation.

The Mental Health Strategy (embodied in the Ministry of Health’s publications Looking Forward⁵ and Moving Forward⁶) acknowledges that up to 20 per cent of the population have mental health needs at any one time and that 3 per cent of

those have serious mental illness (Ministry of Health 2003:21). These documents along with the Blueprint for Mental Health Services (Mental Health Commission 1997) describe New Zealand's current approach to mental health (refer also to the separate report on youth mental health services).

Youth Specific Policy

In 2002 the Ministry of Health published Youth Health: A Guide to Action. This guide (still current in 2010) recognises that during adolescence young people may be at the peak of their physical health, however the “years between 12 and 24 are also the years when the chances of being caught up in risk-taking behaviour [which negatively impact on health] are high, and where the negative consequences can be lifelong.” (Ministry of Health 2002:15). It acknowledges that in comparison to other age groups, young people have higher rates of mental illness, alcohol and drug use and abuse, suicide and suicide attempts, and sexually transmitted infections. It notes that rangatahi Māori experienced more ill health than non-Māori youth, and that in comparison to other OECD countries New Zealand (in 2002) had higher rates of youth suicide, pregnancy, abortion and injury (Ministry of Health 2002:15). The Guide contains a number of cross sector goals, objectives and specific actions for improving youth health in New Zealand and making services more youth focussed.

A key focus of the guide, consistent with the goals of the Youth Development Strategy Aotearoa⁷ (Ministry of Youth Affairs 2002), is to encourage young people to become actively involved in creating a healthy society. This focus hails a shift away from the notion of youth health as a ‘problem’ to be solved. The guide proposes to establish “realistic indicators of progress, so that in three years time, we can see what impact this Guide to Action has had on youth health services and, consequentially, on youth health”. DHBS however are not required to report on specific indicators of youth health and progress against such indicators is unknown at the time of writing this report.

DELIVERY OF YOUTH HEALTH AND DISABILITY SERVICES

Health Services for young people are delivered by a range of primary care and community-led organisations. While the literature (Matthias 2002; Ministry of Health 2002:17) suggests youth-focussed health services⁸ increase youth access and use of those services, for the most part the health services currently available cater to the broader population. In the past five years, however, there “has been an increase in the number of community-based health services and school-based services nationally. The development of health services in teen parent units, alternative education units, [Child, Youth and Family] care and protection units and youth justice residences have been identified as important areas for development. Recent government funding will see the expansion of nursing services into decile 1 - 2 schools, teen parent units and alternative

education over the next 3 years⁹” (www.nzaahd.org.nz 2010). This funding will cease in 2012 and it is not clear what will happen to this service after this point. There are also health centres run in Universities that provide services to young people; these are run along the lines of a General Practice Service.

The table below describes some of the key health services currently available to young people in New Zealand.

Table 1: Key Health Services for Young People in New Zealand

General Practitioners	For most young people, their first port of call for health services is a general practitioner. In 2007, 93 per cent of students accessing health care had done so through their family General Practitioner (Adolescent Health Research Group: 23). University-based health centres are also used by young people and operate in a similar way to general practices.
School-Based Services	Health services delivered by schools range from first aid assistance through to specialist youth nurses, dependent on the school itself and local support by DHBs and PHOs (Buckley et al. 2009). In 2007, 23 per cent of students surveyed accessed school based health services (Adolescent Health Research Group: 23). In the 2008 Budget the Government announced funding to roll out health services to decile 1-2 schools over three years starting in 2009 ¹⁰ . This funding will cease in 2012 and it is not clear what will happen to this service after this point.
Youth One Stop Shops	A Youth One Stop Shop (YOSS) is a youth focused community-based centre, which provides complementary (and free or low cost) health, social and recreational services to young people in a youth focussed setting (with health and disability work accounting for more than 85 per cent of the work undertaken by a YOSS). There are currently 13 YOSSs in New Zealand ¹¹ . YOSSs may offer health services (general health/primary care, sexual and reproductive health, family planning, mental health, alcohol and drug services), education and employment services, social services, referral services, outreach, mobile or satellite services / evening clinics, services targeted at or configured for rangatahi Māori, and services configured for Pacific, migrant and refugee youth (Communio 2009).
Family Planning Clinics	Family Planning clinics provide education, advice and services regarding relationships, contraception and pregnancy to anyone in New Zealand, and appointments for people aged 21 and under are free ¹² .

Youth One Stop Shops

In 2008 approximately “137,000 occasions of service” were provided by twelve of New Zealand’s then thirteen Youth One Stop Shops (YOSS) (Communio 2009:12).

A 2009 evaluation of twelve New Zealand One Stop Shops found 89 per cent of stakeholders (staff, funders, other health/social service organisations, NZAHD) and 94 per cent of clients (young people) believed YOSS were effective in improving the health of young people using these services. No other measures of effectiveness (e.g. health outcomes) were available.

YOSS in New Zealand may play an important role in addressing health concerns for young people with complex needs. The evaluation found 14 per cent (28) of the 252 young people surveyed for the evaluation accessed health services solely from YOSS, and these clients tended to have higher health and/or social service needs. It stated “most one stop shops are able to transition clients to mainstream [health] services well” but noted barriers in gaining access to some GPs, and that options for high needs young people are limited (Communio 2009:12).

There are a limited number of Youth One Stop Shops in New Zealand, and the evaluation found demand for YOSS services outweighs their capacity to deliver, “...especially for counselling and other mental health services including alcohol and other drug services” (Communio 2009:8).

Funding for YOSS in New Zealand is limited and comes from a range of sources. Currently all of New Zealand’s YOSS receive some funding from a DHB; ten receive funding from a PHO, eight receive funding from other government agencies and five receive funding from various non-government agencies. In the 2008-09 financial year, total funding for YOSS was \$6,857,600 (ranging from \$200,000 to \$1,350,000) of which the total for health funding was \$4,783,600 (Communio 2009:12). The evaluation notes YOSS face challenges in finding consistent funding.

“In general, funding for Youth One Stop Shops is tenuous...Funding models for Youth One Stop Shops vary across the country which leads to inequalities in youth access to services” (Communio 2009:12).

A lack of funding for YOSS by DHBs in particular has been blamed for placing these organisations at risk of closure. Christchurch’s One Stop Shop ‘198’ did not receive DHB funding for 2010 and closed in April of that year, while Southland DHB has recently declined to fund ‘Number 10’, Invercargill’s One Stop Shop. DHBs currently face a range of financial pressures related to national funding which impact on their ability to fund YOSS. There is no national funding of YOSS and currently the national focus for youth health is on school-based services¹³. While there is an argument that YOSS duplicate some existing health services, there is also an argument that YOSS cater particularly to young people with high needs and/or those who may not otherwise access services, and that current capitation¹⁴ funding mechanisms through DHBs do not cater well to these young people.

Youth Disability Services

Disability services in New Zealand are largely funded by the Ministry of Health through their Disability Support Services (DSS). DSS funds information advisory services; home based (personal care/home help) services; residential services; support for caregivers and respite care and supported independent living services (Ministry of Health 2009). Specialist equipment and resources are also available through the Ministry of Health.

Eligibility for DSS funding is determined by whether a person meets the Government's definition of disability which states that: "A person with a disability is someone who has been assessed as having a physical, psychiatric, intellectual, sensory, or age related disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required¹⁵". This definition excludes diabetes, asthma, disabilities caused by accidents and mental health issues which are already addressed through mental health services.

In order to determine whether a young person is eligible for DSS funding they require a needs assessment through their local Needs Assessment and Service Coordination (NASC) organisation. "NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports¹⁶."

In addition to government services, there are multiple community based providers who offer services to young people with disabilities and/or their families. One such organisation is IDEA (Intellectual Disability Empowerment in Action). IDEA is the IHC's¹⁷ service delivery arm and provides accommodation services, supported living, day services, supported employment, family whānau services, behaviour support services, mental health and autism advice.

Other disability support services available include:

- DHB services (mental health services, transport assistance, general health services)
- Housing support (Housing New Zealand, community agencies)
- High Needs funding through Care Plus
- Funding for disabilities cause by an accident through ACC
- Income assistance through Work and Income
 - Invalid's benefit - if individuals have a permanent sickness, injury or disability that stops them working
 - Sickness benefit for people who are temporarily off work because of sickness, injury, pregnancy or disability
 - Disability allowance - reimburses people for ongoing regular costs that they have because they have a disability
 - Child disability allowance - payment made to the parent or guardian of a seriously disabled child who lives at home and requires constant care and attention. This is not currently income or asset tested.
- Employment assistance through Ministry of Social Development (Workbridge and Mainstream Supported Employment Schemes) and community agencies
- Advocacy through the Human Rights Commission, the Health and Disability Commissioner, CCS Disability Action, community agencies

- Support through numerous community agencies¹⁸ (CCS Disability Action, Disability Resource Centre, Parent & Family Resource Centre, Vaka Tautua, Enable, and many more)
- Research, education and information on Intellectual Disability through the Donald Beasley Institute
- Education and Training support through the Ministry of Education's Group Special Education (refer also to education report)
- Transport assistance through Total Mobility.

It is worth noting all of the services described above are available to the general population and are not youth specific.

While diabetes and asthma fall outside of the government definition of disability, services available to young people experiencing these health issues are also available. Diabetes Youth (www.diabetesyouth.org.nz) provides one of the few youth-focussed national health services identified at the time of writing.

A current issue for disability services is funding for residential services. Historically support workers in residential units have been paid a nominal fee for sleeping over at residences. A ruling by the Court of Appeal in 2011 stated that from April 1 2011, staff should be paid the minimum wage for time sleeping on overnight shifts. This ruling has extensive implications for the cost of providing residential services (including backpayments), and for Ministry of Health funding of contracted services. At the time of writing the IHC had taken an appeal to the Supreme Court. While there is also potential for Government to appeal the ruling or change employment legislation to counteract its impact, no decision about doing so has yet been made¹⁹.

Concerns have also been raised about funding for carers who look after family members (including young people) with disabilities. In conjunction with the Carers' Strategy (MSD 2008b), the Guide for Carers (MSD 2009) outlines the code of rights for anyone using a disability service (including carers) and outlines a range of funding and services which disability service users may be eligible for. These include financial payments, respite care services and specialist equipment. Specific payments and services are available for family members who care for children up to the age of 18.

STATISTICS

In 2007, 92 per cent of 9,107 secondary school students (aged 13 to 18 years) reported their health as excellent, good or very good and 83 per cent had received health care in the last twelve months (this did not vary significantly according to age or gender). Of these:

- 93 per cent had accessed health care through their family GP
- 18 per cent accessed health care through a hospital accident and emergency department

- 15 per cent accessed an after hours A&E clinic (Adolescent Health Research Group 2008:23).

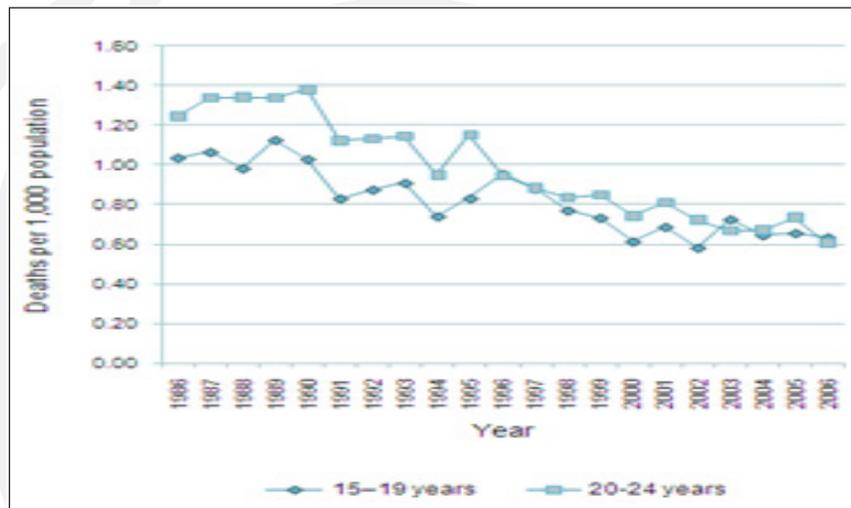
Reasons for not accessing health care included concerns that it would not be confidential (28.2 per cent), not being able to afford the service (32.2 per cent), not feeling comfortable with the provider (21.4 per cent) or not being bothered (55 per cent)²⁰ (Adolescent Health Research Group 2008a:92).

Mortality

In a 2009 OECD report, New Zealand had the third highest mortality rate (of 29 countries) for young people aged 15-19²¹ (OECD 2009: 51). This may be partially attributable to our youth suicide rates which are the highest in the OECD.

Despite this, mortality rates for young people fell significantly between 1986 and 2002, and have been relatively stable since then²².

Figure 1: Age-specific death rate per 1,000 population, ages 15 to 19 and 20 to 24, 1986-2006



Source: Ministry of Youth Development, based on Statistics New Zealand Death Tables

In 1986, our death rate was 1.0 deaths per 1,000 young people aged 15 to 19 and 1.2 deaths per 1,000 young people aged 20 to 24. By 2006, the death rate was 0.6 deaths per 1,000 young people aged 15 to 19 and 20 to 24.

We know that:

- From 2003 to 2007, 15 to 24 year olds had the highest mortality rates for all young people aged 24 years and under (Child and Youth Mortality Review Committee 2009). Mortality rates for this age group have had the smallest improvement over the last few decades²³
- In 2002 and 2003 the mortality rates for young men were nearly twice that for young women
- In 2002 and 2003, the mortality rates for Māori youth were approximately twice that for non-Māori youth²⁴
- The leading causes of death for young people aged 15-24 years are unintentional injury followed by suicide²⁵ (refer to mental health report for further discussion of youth suicide)
- Combined data from 2003-2008 shows unintentional injury as the cause of mortality for 44.2 per cent of youth between 15-24 years, with just over 70 per cent of deaths for this age group being transport-related (Child and Youth Mortality Review Committee: 30)²⁶. “In 2006, New Zealand’s road death rate for youth aged 15–24 years (16.9 per 100,000) was just above the OECD median of 15.8 per 100,000 for that year” (MSD 2008:154). It is worth noting that road death rates for young people aged 15-24 have decreased steadily since 1988²⁷
- Over the same period suicide was the cause of mortality for 26.4 per cent of 15-24 year olds (Child and Youth Mortality Review Committee: 30).

Injury and Violence

Injury rates amongst New Zealand youth are high compared to other age groups²⁸ and the leading cause of death for people aged 1 to 34 in New Zealand²⁹. In terms of non fatal injuries and using data from 2000-2004:

- The leading cause of injuries for 10-24 year olds was from a fall
- For 10-14 year olds the second most common cause of injury was being struck by (or striking against) an object or person, and the third most common cause was from a cycle accident
- For 15-19 year olds the second most common cause was motor vehicle injury, and the third most common was self inflicted injury
- For 20-24 year olds the second most common cause was cutting or piercing oneself followed by other self inflicted injury (Gulliver & Simpson, 2007).

Violence is also a source of injury for youth (second leading cause of injury resulting in hospitalisation for those aged between 10 and 14 years, fifth leading cause for those 15-19 years and sixth leading cause for those 20-24 years (Gulliver & Simpson 2007). The Youth 2007 Survey found on average 41 per cent of students (48 per cent male, 33 per cent female students) reported being deliberately hit or physically harmed by someone in the last 12 months (down from 45 per cent in 2001). Twelve per cent reported being physically hurt at home in the last 12 months, 17 per cent reported witnessing adults hurt a child, and 10 per cent had witnessed adults hurting other adults in their home (up from 7 per cent in 2001) (Clark et. al. 2009).

Young people aged 15-24 reported the highest rates of ‘confrontational offence’ (assaults and threats to someone or to their personal property) committed on them by their partner, with 13 per cent of those surveyed reporting one or more such offence during 2005 (Ministry of Justice 2007: Appendix C).

Multiple Health Risk Behaviours

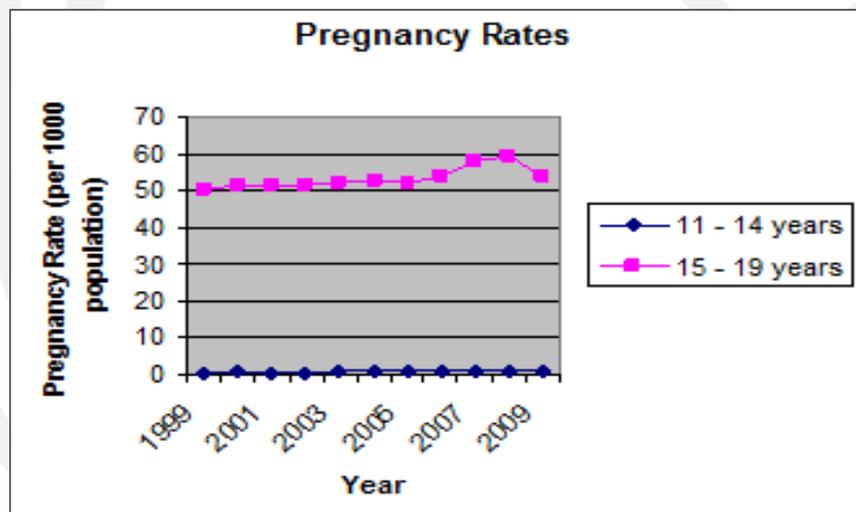
The Youth 2007 survey reported the proportion of young people engaging in five or more health risk behaviours (ever having drunk alcohol, ever smoked a cigarette, ever used marijuana, ever had sexual intercourse, been in a fight in the last year or seriously thought about killing themselves in the last year) has decreased from 12 per cent in 2001 to eight per cent in 2007 (Adolescent Health Research Group 2008:32).

Pregnancy and Sexual Health

New Zealand’s rate of teen pregnancy is considered high in comparison to other countries. Based on 2003 data, New Zealand placed 5th (after Mexico, Turkey, USA and Bulgaria) out of 36 countries for teen pregnancies (OECD 2010).

The pregnancy rate for older teenage women (15-19 years) was 54.1 per 1000 population in 2009. This is down slightly from 59.12 in 2008 and 58.11 in 2007³⁰.

Figure 2: Teen Pregnancy Rates in New Zealand 1999-2009



The pregnancy rate for younger teenage women (11-14 years) was 0.93 per 1000 in 2009, the lowest the rate has been since 2002³¹.

While abortion rates have increased significantly since the 1980s, in recent years abortion rates for young women have been in decline.

- In 2008 and 2009, the abortion rate for young women 11-14 years was 0.7 per 1000 population, down from 0.9 in 2006 and 2007

- In 2009 the abortion rate for 15-19 year olds was 24.5 per 1000 population, the lowest it has been since 2001
- Young women aged 20-24 had the highest rates of abortion in 2009³².

Sexually transmitted infections are also common amongst sexually active youth, and rates of chlamydia and gonorrhoea have increased significantly in recent years³³. Fifteen per cent of sexually active students reported not or only sometimes using contraception, with this proportion being higher amongst students from neighbourhoods with higher levels of deprivation (Adolescent Health Research Group 2008:28).

Despite the statistics reported above, most students surveyed in 2007 reported never having had sexual intercourse (Adolescent Health Research Group 2008:28).

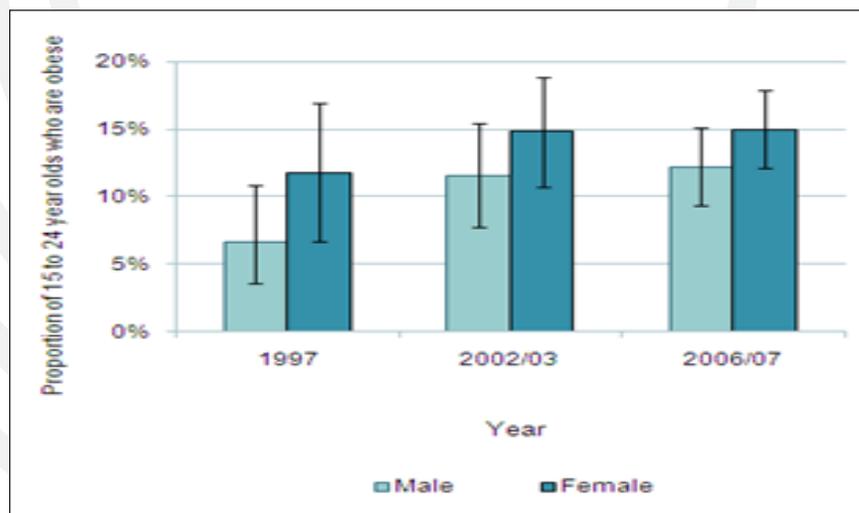
Disability

In 2006, 6.5 per cent of 15-24 yr olds were identified as having some form of disability. Youth aged 15 to 24 with a disability were found to be much less likely to be employed (39 per cent) than those without disabilities (60 per cent). Just 27 per cent of young women aged 15 to 24 with disabilities were employed, compared to 61 per cent of young women without disabilities³⁴.

Obesity

Obesity is a growing problem for New Zealand Youth. In 2006/07, 8.3 per cent of those aged 5-14 years were obese and 14.2 per cent of those 15-24 years, with rates slightly higher for females. Obesity rates among young people increased significantly between 1989 and 1997, and have continued to climb more slowly since then³⁵.

Figure 3: Prevalence of obesity among young people aged 15 to 24, by sex, selected years 1997 to 2006/07



Source: Ministry of Youth Development, based on New Zealand Health Survey Data

A survey of more than 9,000 students showed those from neighbourhoods with higher levels of deprivation were “more likely to be overweight and about three times more likely to be obese than students from neighbourhoods with low deprivation” (Adolescent Health Research Group 2008:19).

Tobacco use

In 2008, 26 per cent of youth between 15 and 24 years smoked cigarettes, the second highest group after those between 25 and 34 years³⁶. The Youth 2007 survey results show the proportion of young people smoking cigarettes has declined significantly since 2000, from 16 per cent regular smokers in 2000 to eight per cent in 2007 (Adolescent Health Research Group 2008).

COSTS AND FUNDING

In New Zealand, funding for health services comes from both the public and private sectors. The amount of funding available from the public sector is determined by an annual Budget process. The distribution of this funding follows a Population-Based Funding (PBF) model. The model uses an aggregate formula to calculate the share of funding that will go to each District Health Board, based on the characteristics of the population living in the DHB catchment area. In calculating each DHB’s share of funding, the PBF formula considers the average cost of services used by different population groups, any disparities faced by particular DHB populations and adjustments for rural populations and overseas visitors. Some services are also funded nationally rather than by DHBs – for example disability services and some public health services.

Primary Health Care Subsidies

Primary Health Organisations receive a set amount of funding per patient (capitation-based subsidies) to subsidise doctors’ visits and pharmaceutical charges³⁷. The funding is based on the numbers and characteristics (e.g., age, sex, ethnicity, whether or not they are a high user of health services) of people enrolled with them.

The current capitation subsidy rates for (non-high users) males aged 15-24 is the lowest rate for all ages and genders. The table below outlines 2009 capitation subsidies for non-high users³⁸ in all age groups in access-funded PHOs³⁹.

Table 2: 2009 Capitation Subsidies for Access Funded PHOs for First Contact Services

Age	Gender	Subsidy Per Annum
00-04	F	\$371.9834
	M	\$391.6461
05-14	F	\$117.7451
	M	\$110.2110
15-24	F	\$108.6480
	M	\$59.7969
25-44	F	\$95.4732
	M	\$61.7157
45-64	F	\$130.7685
	M	\$97.6699
65+	F	\$225.3531
	M	\$194.3414

Source: Ministry of Health 2009⁴⁰

Mean GMS Co-payments for All Age Groups, 2001/02-2007 (by year, with percentage change over the period) (\$)

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007	% change
0-5	0.97	0.93	1.00	1.35	1.38	1.39	1.44	48.5
6-17	11.07	12.00	11.18	10.87	11.14	11.79	11.90	7.5
18-24	22.86	24.32	23.32	23.52	19.48	20.32	19.23	-15.9
25-44	24.16	25.14	24.63	25.32	26.76	27.65	19.72	-18.4
45-64	24.19	25.00	23.96	24.63	26.03	19.92	20.14	-16.7
65+	19.75	20.79	20.55	17.47	18.86	20.18	20.28	2.7

Source: Raymont A, Cumming J, Gribben B. *Evaluation of the Primary Health Care Strategy: Changes in Fees and Consultation Rates between 2001 and 2007*. Wellington: Health Services Research Centre, Forthcoming.

With regard to funding from the private sector, a significant sum is provided by philanthropic trusts including those established by telecommunication companies (e.g. Vodafone, Telecom).

Total Health Spending

Information on health spending across all sectors (public and private) is most recently available for the period 2005/06 (Ministry of Health 2008). Total health expenditure (including public and private funding) for this period was \$15,433 million or \$3728 per capita. Of this spend, \$12,014 million was publicly funded (Ministry of Health, other government, local authorities) and \$3,419 million was privately funded (by households, health insurance, and not-for-profit organisations). Analysis of trends since 1995 show that expenditure per capita on health is growing faster than gross domestic product (GDP) (Ministry of Health 2008).

In 2005 New Zealand ranked 16th of 25 OECD countries on per capita health expenditure, and 11th of 25 countries on health expenditure as a percentage of GDP (Ministry of Health 2008:51-53).

According to the 2010/11 Estimates of Appropriations (Treasury 2010), the Minister of Health is responsible for \$13,574 million for 2010/2011. This includes:

- Just over \$10,044 million (74 per cent of the Vote) for DHBs
- Just over \$970 million (7.1 per cent of the Vote) for national disability support services and just over \$83 million (0.6 per cent of the Vote) for other health and disability services
- Just over \$517 million (3.8 per cent of the Vote) for public health services
- Just over \$182 million (1.4 per cent of the Vote) to purchase primary health care services (Treasury 2010).

Current information on overall health expenditure on young people was not available. However using a microsimulation model, the Ministry of Health (2004) has estimated⁴¹ that in 2001, the average annual spend on males aged 15-19 was \$843, and the average annual spend on females aged 15-19 was \$1111. These sums comprise mainly personal health (primary, secondary and tertiary care, but not including public health spending and disability support services). It should be noted however that this 'average' is likely to be skewed upwards by significant spending on a small proportion of the youth population. These data will now be out of date given the significant increases in recent years in primary health care funding.

In the 2010/11 Estimates of Appropriations (Treasury 2010) just over \$905 million (6.7 per cent of the Vote) is allocated to purchase national health services and provide clinical training for health professionals. Estimates for spending on the youth health workforce specifically were not available.

WORKFORCE

The youth health workforce comprises a range of roles and professions, including nurses, doctors, psychologists, youth workers, social workers, health promoters and other allied health professionals. Several youth-focused networks in New Zealand have an interest in the youth health workforce, particularly with regard to training and professional development.

In 2011, Ara Taiohi was formed, amalgamating the New Zealand Aotearoa Adolescent Health Development⁴² (NZA AHD) and the National Youth Workers Network Aotearoa⁴³. Recognising a need for enhanced coordination and professionalisation of the youth work sector, the purpose of Ara Taihoi is to “connect the sector...raise the standards...[and] champion youth development”⁴⁴.

The Society of Youth Health Professionals Aotearoa New Zealand (SYPHANZ) works alongside NZA AHD and the National Youth Workers Network, with a specific focus on health issues. SYPHANZ was set up to support the development of youth health professionals and the youth health sector in Aotearoa New Zealand, particularly in response to the recent increase in the number of nurses, doctors and allied health professionals working in the youth health sector. SYPHANZ are interested in improved coordination and training of the youth health workforce.

“The youth health sector is currently fragmented and service delivery is inconsistent. Therefore, I believe it is critical to build a capable and competent workforce to ensure young people receive the health care and support they deserve⁴⁵.” Maria Kekus, Executive Officer SYPHANZ.

SYPHANZ have recently developed a framework for workforce development in order to identify areas for development and enhance integration in youth health⁴⁶.

SUMMARY

In New Zealand, the Ministry of Health provides leadership for the health sector and delivery through District Health Boards (DHBs), who are responsible for the provision of youth health services. Primary Health Organisations (PHOs) are local service delivery structures.

The New Zealand Public Health and Disability Act 2000 and the Health Act 1956 guide general health service delivery in New Zealand. UNCROC, The Ottawa Charter for Health Promotion (1986), and The World Health Organisation (2002) provide guidance on youth health. Young people under the age of 16 years require parental consent to receive or refuse treatment unless the clinician deems the young person as having sufficient understanding and maturity to make their own decisions.

Youth Health: A Guide to Action is one of New Zealand’s few youth specific health policies and provides an overarching framework. It emphasises encouraging young people to become actively involved in creating a healthy society and hails a shift away from the notion of youth health as a ‘problem’ to be solved. DHBs are not, however, required to report on specific indicators of youth health and progress in improving youth health is currently unknown.

New Zealand has the third highest youth mortality rate amongst OECD countries (OECD 2009). Recent statistics also show that in comparison to other age groups, young people have higher rates of injury, 'confrontational offence' (i.e. violence), mental illness, alcohol and drug use and abuse, suicide and suicide attempts, and sexually transmitted infections. Young people aged 15-24 are the second highest users of tobacco and obesity is an increasing concern particularly in low decile areas. Rangatahi Māori experienced more ill health than non-Māori youth. However, multiple health risk behaviours for young people decreased between 2001 and 2007. In 2006, 6.5 per cent of those aged between 15 and 24 years were identified as having some form of disability, and youth with disabilities are less likely to be employed than other youth.

There are few organisations delivering youth specific health services, although there has been recent investment in this area, in particular nursing services in low decile schools. While a recent evaluation reported favourably on New Zealand's youth one stop shops, funding for these services is tenuous. Similarly, we were unable to identify youth specific disability services. General disability services are largely funded by the Ministry of Health through their Disability Support Services (DSS). There are also multiple community based providers who offer services to young people with disabilities and/or their families.

Health funding comes from both the public and private sector. In 2005 New Zealand ranked 16th of 25 OECD countries on per capita health expenditure, and 11th of 25 countries on health expenditure as a percentage of GDP (Ministry of Health 2008:51-53). In 2005/06, total health expenditure (including public and private funding) was \$15,433 million although we were unable to establish what proportion was spent on young people. State subsidies to PHO's for (non-high users) males aged 15-24 is the lowest rate for all ages and genders.

The youth health workforce comprises a range of roles and professions. Professionalisation and coordination has been a key concern for the youth workforce and two key organisations - The Society of Youth Health Professionals Aotearoa New Zealand (SYPHANZ) and Ara Taiohi, work to support, coordinate and professionalise the youth health and youth work sectors respectively.

ENDNOTES

¹ Including intellectual, physical and emotional disabilities

² <http://www.moh.govt.nz/moh.nsf/indexmh/mentalhealth-about>; retrieved March 2010

³ <http://www.moh.govt.nz/moh.nsf/indexmh/aboutmoh-actsandregulations>

⁴ See full notes on Whanau Ora policy in separate Child Protection paper.

⁵ Ministry of Health 1994

⁶ Ministry of Health 1997

⁷ The Youth Development Strategy Aotearoa outlines a youth development approach to describe how government and society can support young people to develop the skills and attitudes they need to take part positively in society, now and in the future. It was developed by the then Ministry of Youth Affairs (now Ministry of Youth Development) in collaboration with young people and a number of youth focused organisations.

⁸ Characteristics valued by young people include that services are free or affordable, confidential, culturally and gender appropriate, with staff who relate well to youth (Ministry of Health 2002).

⁹ www.nzaahd.org.nz/index.php/youth-health/youth-health-professionals; accessed July 21 2010

¹⁰ www.nzaahd.org.nz/index.php/youth-health/youth-health-professionals, accessed 21 July 2010

¹¹ The Christchurch One Stop Shop – 198 – was closed in 2010 partly due to funding problems.

¹² www.familyplanning.org.nz; accessed 21 July 2010.

¹³ [http://www.moh.govt.nz/moh.nsf/pagesmh/7786/\\$File/minutes-yhag-21oct-08.doc](http://www.moh.govt.nz/moh.nsf/pagesmh/7786/$File/minutes-yhag-21oct-08.doc)

¹⁴ Refer to funding section later in document for further discussion of capitation funding

¹⁵ <http://www.moh.govt.nz/moh.nsf/indexmh/disability-fundedservices-nasc-faq>

¹⁶ <http://www.moh.govt.nz/moh.nsf/indexmh/disability-aboutds>; July 26 2010.

¹⁷ The IHC is New Zealand's largest provider of services for people with an intellectual disability

¹⁸ Further information on these services is available through the Ministry of Health (<http://www.moh.govt.nz/moh.nsf/indexmh/disability-contact-dias>), the NZ Federation of Disability Information Services (<http://www.nzfdic.org.nz/>) or the New Zealand Disability Support Network (<http://www.nzdsn.org.nz/>). Overarching guidance on disability issues is available through the Office for Disability Issues (<http://www.odi.govt.nz/>) run out of the Ministry of Social Development.

¹⁹ <http://www.stuff.co.nz/nelson-mail/news/4675244/Sleepover-ruling-puts-jobs-in-doubt>

²⁰ Young people were able to provide multiple responses to this survey question.

²¹ Based on 2004 data.

²² <http://www.youthstats.myd.govt.nz>; 1 Feb 2010.

²³ <http://www.moh.govt.nz/moh.nsf/indexmh/youthhealth>.

²⁴ <http://www.youthstats.myd.govt.nz>; 27 September 2010.

²⁵ <http://www.moh.govt.nz/moh.nsf/indexmh/youthhealth>; 27 September 2010.

²⁶ The results of Youth '07 show that while 74 per cent of young people reported always wearing seat belts (up from 66 per cent in 2001), in the month leading up to the survey:

- 23 per cent reported having been driven by someone who had been drinking (down from 28 per cent in 2001)
- 8 per cent reported drinking before driving and
- 24 per cent reported being in a car which was being driven dangerously (down from 39 per cent in 2001).

²⁷ <http://www.youthstats.myd.govt.nz/indicator/safe/road-deaths/index.html> (13 September 2010).

²⁸ <http://www.moh.govt.nz/moh.nsf/indexmh/youthhealth>; 27 September 2010.

²⁹ <http://ipnanz.org.nz/page.php?p=102#427>.

³⁰ <http://www.stats.govt.nz/infoshare/ViewTable.aspx?pxID=cd4155d9-f411-47f9-a6e7-7550ae11b2e2>.

³¹ <http://www.stats.govt.nz/infoshare/ViewTable.aspx?pxID=cd4155d9-f411-47f9-a6e7-7550ae11b2e2>.

³² http://www.stats.govt.nz/browse_for_stats/health/abortion/AbortionStatistics_HOTPDec09.aspx.

³³ <http://www.youthstats.myd.govt.nz/indicator/healthy/contraception/index.html>; 19 September 2010.

³⁴ <http://www.youthstats.myd.govt.nz/indicator/healthy/index.html>: 1 Feb 2010. Data extracted from Statistics New Zealand's 2006 New Zealand Disability Survey.

³⁵ <http://www.youthstats.myd.govt.nz/indicator/healthy/index.html>: 1 Feb 2010.

³⁶ <http://www.youthstats.myd.govt.nz/indicator/healthy/index.html>: 1 Feb 2010.

³⁷ As well as capitation subsidies for first contact services, PHOs receive other funding for health promotion programmes, to provide services to improve access and to provide continuous care under the Care Plus programmes, as well as for management support services.

³⁸ Additional subsidies are available where clients hold a high user health card.

³⁹ Access PHOs and practices had high (over 50%) proportions of low-income, Māori and Pacific peoples enrolled with them - groups that have traditionally had poorer health outcomes than the rest of the population. Since 1 July 2002, all people enrolled with general practices in Access-funded PHOs have been eligible for subsidies to lower the cost of doctors' visits.

⁴⁰ <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-funding-capitation-rates>.

⁴¹ This data was drawn from the Ministry of Health Expenditure database, which the author of this paper was unable to locate.

⁴² www.nzaahd.org.nz.

⁴³ www.youthworkers.net.nz/index.html.

⁴⁴ <http://arataiohi.org.nz/>; retrieved 25 March 2011.

⁴⁵ <http://foundation.vodafone.co.nz/what-we-fund/world-of-difference/2010-recipients>.

⁴⁶ <http://www.youthhealthworkforce.co.nz/te-remu-tohu-workforce-framework.html>.

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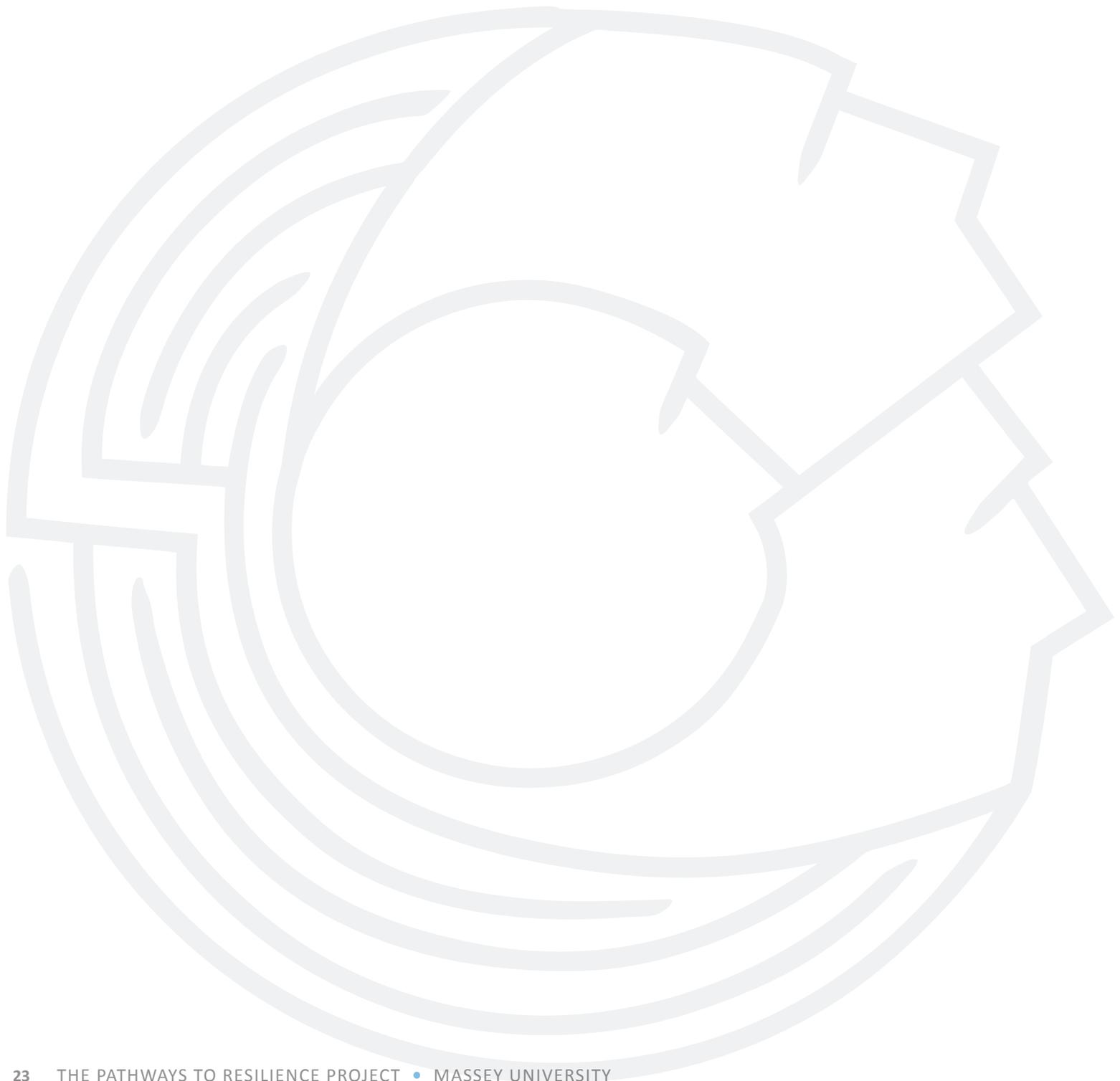
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