THE TREASURY
Kaitohutohu Kaupapa Rawa

# **Treasury Report:** Health Budget 2010 State of Play

| **Date:** | 6 November 2009 | **Report No:** | T2009/2463 |
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## Action Sought

| | **Action Sought** | **Deadline** |
|---|---|---|
| Minister of Finance<br>(Hon Bill English) | **Note** the current issues and 2010 Budget arrangements for Vote Health | |
| | **Refer** a copy of this report to the Minister of Health | Monday 9 Nov |
| | **Consult** the Minister of Health on the attached ECC paper to establish a tagged Health Contingency for 2009/10 | Meeting Tuesday 10 Nov |
| | **Sign** the attached ECC paper and submit it to Cabinet Office | 10am Thursday 12 Nov |

## Contact for Telephone Discussion (if required)

| **Name** | **Position** | **Telephone** | | **1st Contact** |
|---|---|---|---|---|
| [withheld – privacy] | Senior Analyst, Health | [withheld – privacy] | | ✓ |
| Claire Douglas | Manager, Health | [withheld – privacy] | [withheld – privacy] | |

## Minister of Finance's Office Actions (if required)

If the Minister of Finance agrees, forward a copy of this report and the attached Cabinet paper to Hon Tony Ryall, Minister of Health.

**Enclosure:** **Yes**

6 November 2009

# **Treasury Report:** Health Budget 2010 State of Play, and Establishing a 2009/10 Health Contingency

## Executive Summary

You are scheduled to meet the Minister of Health on Tuesday 10 November to discuss issues in planning for Health for Budget 2010. To inform that discussion, this paper:

Describes current arrangements and processes to prepare the 2010 Health budget;

Identifies key operating budget issues for Vote Health, including:

- When and how to signal to DHBs of their likely operational funding for 2010/11, and how this links to Cabinet's budget decision-making processes;
- The treatment of underspends and savings in 2009/10 – we recommend that:
  - i. normal baseline management approaches be applied for underspends identified up to the time yearend forecasts are finalised for Budget 2010;
  - ii. any other underspends in departmental appropriations and Ministry-managed non-departmental appropriations should be returned to the centre; and
  - iii. any year-end underspends in appropriations for DHB deficits should be added to Vote Health in 2010/11 contingencies for DHB deficits;
- Seeks your agreement to the attached paper for Cabinet Expenditure Control Committee proposing the establishment of a $92.646 million tagged operating contingency for Vote Health in 2009/10 only, based on 2008/09 underspends.
- Updates you on Health capital processes for Budget 2010, and summarises current pressures and options for Budget 2010 – we recommend you
  - iv. refer all proposals to the NHB capital committee, and to delay consideration of projects until officials have advised on
    - o The long-term affordability of capital investment in the health sector;
    - o A sustainable capital investment strategy for Health, including service configuration, investment options and timing of investments
  - v. set a Budget 2010 Health capital allocation in the context of wider state sector pressures and advice from the NHB
  - vi. note that ongoing investment in health capital infrastructure will be needed; a low allocation in Budget 2010 may require a larger Budget 2011 allocation
  - vii. agree that there will be no operating to capital swaps in Budget 2010
  - *viii. [deleted – confidentiality of advice].*
  - *ix. [information deleted in order to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials].*

The following table provides a summary of the key issues for discussion at your meeting with the Minister of Health.

**Health Budget 2010 issues**

| Topic and current position | Issues | Recommended new position |
|---|---|---|
| *[information deleted in order to maintain the effective conduct of public affairs through the free and frank expression of opinions]* | *[information deleted in order to maintain the effective conduct of public affairs through the free and frank expression of opinions]* | *[information deleted in order to maintain the effective conduct of public affairs through the free and frank expression of opinions]* |
| *2009/10 Contingency*<br>Agreed with Minister of Health; Aug 10 letter confirms (attached). A draft ECC paper (attached) sets out the details.<br>Changes from the letter: softer definition of reprioritisation; later expiry of contingency (March)<br>Contingency: $93m; pressures against contingency: Pandemic/Measles/MRG implementation | The Minister of Health wants to maximise the flexibility of the contingency | Agree draft ECC paper as-is: changes so far provide sufficient flexibility for reasonable use of the contingency. |
| *DHB 2010 funding signal*<br>No signal yet given; the signal is usually given in December | • What the signal should be<br>• When the signal should be given<br>Funding certainty helps DHBs plan, but constrains budget flexibility. | No signal is provided until the 30 November report is agreed by Cabinet.<br>Officials to report back on the level of the signal. |
| *Capital*<br>Current envelope: $203m<br>Projects seeking $700m in funding could come up for approval over the next year<br>DHB intentions (from CAM, over the next 10 years): $3bn; $2bn from the centre.<br>Major affordability challenge.<br>Process change underway: NHB; CAM; MoH; service planning; capital budget process. | • Minister of Health's priorities vs. health sector priorities vs. affordability.<br>• B2010 capital allocation<br>• Reallocations from opex underspends<br>Treasury view: use NHB capital committee. Delay decisions where possible pending better information and process. A modest B2010 allocation is possible, but will defer not stop significant health capex pressure ($100m + p.a. ongoing). Opex unders and overs are unrelated to long-run capital planning. | Agree to refer all proposals to the NHB capital committee, to consider delay pending better information and process.<br>Set B2010 Health capital allocation in the context of other capital pressures following advice from the NHB capital committee.<br>Acknowledge a low B2010 allocation will require a larger B2011 allocation.<br>Agree there will be no reallocations from opex. |
| *Health PPPs*<br>Government supportive in principle. A few proposals coming up, but most are not real PPPs. | Current proposals (Wairarapa) are about escaping budget constraints rather than efficiency.<br>Treasury view: PPPs may help but not a solution to capital challenges, given key role of opex affordability issues. Seek a level playing field: no use of PPPs to escape the budget. | Agree PPPs a source of efficiency, not a source of finance in addition to the health capital envelope.<br>Private credit (including as part of a PPP) should count against the HCE if it increases public supply. Achieved via revised health capital guidelines. |

## Recommended Action

We recommend that you:

a **note** the contents of this report;

b **refer** a copy of this report and the attached Cabinet paper to Hon Tony Ryall, Minister of Health;

*Agree/disagree.*

***ECC Paper to Establish a Tagged Health Operating Contingency for 2009/10***

c **note** that on 2 August you agreed with the Minister of Health to recommend the establishment of a tagged health contingency of $92.646 million in 2009/10 only equivalent to Health's 2008/09 underspends;

d **note** that the attached paper for Cabinet Expenditure Control Committee seeks agreement to establish the tagged contingency, with rules for accessing funding that are less restrictive than those proposed in your letter to the Minister of Health of 10 August, and with a later expiry date proposed for the contingency;

e **note** that the proposed contingency is for operating expense pressures in 2009/10 only, and will not be available for capital expenditure;

f **consult** the Minister of Health on the draft Cabinet paper at your meeting with him on Tuesday 10 November; and

*Agree/disagree.*

g **sign** the attached paper for Cabinet Expenditure Control Committee and the Cab 100.

*Agree/disagree.*

Claire Douglas
**Manager, Health**
**for Secretary to the Treasury**

Hon Bill English
**Minister of Finance**

# **Treasury Report:** Health Budget 2010 State of Play

## Budget 2010 Operating Allocation for Vote Health

1. On 2 November Cabinet agreed a $300 million indicative operating allocation for Health.

2. Consistent with earlier Cabinet decisions on the Budget process, the terms of reference for the detailed review of Vote Health baselines commissioned by Cabinet state:

   - *"All costs that will impact on the Crown's Operating Balance need to be managed within the value of existing annual baselines and the allocation"*

     That is: Everything "counts" – Baseline plus $300 million is the total funding available for all Health operating pressures, initiatives and risks – including DHB deficits.

   - *"The indicative allocation is the maximum for average annual net increases in operating baselines within the 4-year forecast period for Budget 2010, and the upper limit for net baseline increases beyond the 4-year forecast period."*

     That is: "No bow waves" – the Health budget package cannot increase costs in out-years by more than $300m per year. Many Health initiatives have rising cost profiles over time.

## Process and Timing for Signalling Next Year's Funding for DHBs

3. The terms of reference for the detailed review of Vote Health baselines also noted (amongst other matters) the following implications and issues for Vote Health:

   - *"The Health review should focus on the trade-offs and options to ensure that the pressures of DHB funding and deficits, and any new initiatives can be managed with the funding available to Vote Health in 2010, and how this can be sustained under a lower funding growth path for the foreseeable future…*

   - *The key budget priority in Vote Health will be DHB funding and deficits. Decisions about funding increases for DHBs need to be informed by analysis on the adjustments DHBs can reasonably take to manage pressures and about what change can be achieved to provide bankable gains for Budget 2010.*

   - *Before any new funding or savings from reprioritisation are applied to other pressures or new initiatives, this review should describe a strategy to ensure that the overall operating impact of DHB funding (FFT and Demo, less any "efficiency adjusters") and DHB deficits will be contained within the amount of funding available to Vote Health. This may involve a mix of up-front DHB funding increases and an appropriation to manage DHB deficits. It will also require a mix of pressure and flexibility for DHBs to operate within their available funding."*

4. We understand that the Minister of Health is considering how and when to signal to DHBs their likely funding increase in Budget 2010. We understand he may wish to provide an early signal to DHBs during November to allow maximum lead time for DHB planning. This would be followed by formal notices to each DHB in December, outlining the funding with which they should develop their budgets and District Annual Plans for 2010/11.

5. To date, the Ministry's communications to the DHBs have been framed around "scenarios" for possible Health allocations – but no specific signals have been given about the size of the health allocation or what proportion of this will be passed on to DHBs as "FFT/DEMO" funding increases.

6. DHB funding increases will be the largest component not only of Vote Health but probably of the whole 2010 Budget. As decisions on DHB funding are taken, they therefore constrain the Government's options both within Vote Health and for the budget as a whole.

7. In our view, the following should be met before DHBs are told their likely funding change in Budget 2010:

   a. Cabinet has finalised the 2010 Budget allocations;

   b. A firm number is available for the Health baseline savings achievable in 2010/11 to fund new initiatives, pressures and risks in Vote Health;

   *c. [information deleted in order to enable the Crown to negotiate without disadvantage or prejudice]*

   d. Decisions are made on how DHB funding increases will be allocated (for example: whether the population based funding system is the right way to allocate funding increases if the "efficiency adjuster" reduction from full "FFT and Demo" needed to manage within Health's budget constraint is very large, or whether other approaches such as a targeted capability funding round would be preferable).

8. We recommend that you discuss with the Minister of Health what options and issues he faces in considering if and when to give DHBs an early indication of their Budget 2010 funding. We consider that any funding signal should first be agreed by Cabinet (or at least by Budget Ministers), following completion of the work on DHB funding strategy that will be included in the Minister of Health's detailed review of baselines due 30 November.

## Savings, Reprioritisation and Underspends for Budget 2010

9. On 2 November, Cabinet agreed to the following approach to savings:

   *"The general rule for savings is that they can be retained in a Vote to manage pressures and achieve Ministerial priorities. However, there are two refinements to this rule:.*

   - *If a saving is generated by reducing or stopping a major programme or activity, it requires Cabinet approval. Cabinet will determine the proportion of the saving to be retained within the Vote and that to be returned to the centre."*

     In Health, for example, this may include any savings from reducing services that are subject to specific government policy commitments, *[deleted – confidentiality of advice]*

   - *"Where a saving has been generated by efficiency improvements or where a Vote Minister has actively decided to reduce or stop a programme or activity, the saving can be retained in the Vote. Where active management decisions to stop programmes or activities have not been taken, such as underspends from reduced volume or demand, these savings are to be returned to the centre."*

10. Underspends in Ministry-managed Health appropriations that can be achieved through active management decisions or policy choices should be identifiable in Health's Baseline Alignment Proposal for Budget 2010 (due with Budget Ministers by 8 March) and included in the March Baseline Update. At the least, they should be in the year-end forecasts included in the Budget.

11. Standard budget management processes can be used to retain forecast underspends in Vote Health:

- joint Ministers may approve expense and capital transfers (between years within the same appropriation) or fiscally neutral adjustments (between appropriations in the same year) – Cabinet agreed revised guidelines for changes to baselines in September [CO(09)6 refers] or
- Cabinet can approve other changes in appropriations before the pre-Budget moratorium.

12. Where underspends in Ministry-managed baselines are not identified in the Budget's year-end forecasts or earlier, these will generally be "windfalls" rather than the result of active management and policy choices. Under the approach agreed by Cabinet, these should be returned to the centre.

***Allowing Health to Retain Any Unforecast 2009/10 DHB Deficit Underspends for 2010/11 DHB Deficit Contingencies***

13. A difficulty for Health is the treatment of any unforecast year-end underspend in the appropriated contingency to fund DHB deficits. If DHB deficits are smaller than budgeted, this will generally be due to active management and efficiencies by DHBs. The Ministry cannot forecast DHB deficits perfectly for the Budget forecasts (though improvements in forecasting can always be sought).

14. Treating unforecast underspends in the DHB deficit contingency as "windfalls" to be returned to the centre may create perverse incentives. It would reduce the Minister's and DHBs' incentive to manage down costs over the rest of 2009/10 to help DHBs manage with a lower funding increase for 2010/11.

15. We recommend that you agree to allow the Minister of Health to retain any underspend in appropriated DHB deficit contingencies in 2009/10. As this would be a one-off saving, it should be applied to time-limited operating expenditure risks in 2010/11 – in particular, increasing next year's contingency for managing DHB deficit risks.

16. We recommend that operating underspends should not be used to fund any increase in Health's capital budget. The level of capital investment in health should depend on the relative priority Ministers assign to health capital projects relative to all other capital pressures across government, rather than depending on past years' operating underspends.

## Establishing a 2009/10 Contingency Equal to Health's 2008/09 Underspends

17. On 2 August 2009, you met with the Minister of Health, to discuss underspends, capital, and between-budget spending arrangements in Vote Health. You then wrote to him on 10 August to confirm the decisions taken at the meeting and inform him of your decisions on some matters you did not have time to discuss.

18. You agreed to recommend that Cabinet make 2008/09 Vote Health underspends of $92.646 million available as a tagged central contingency to assist in managing specific pressures in 2009/10.

19. This contingency will be additional to the (oversubscribed) Budget 2009 general contingency. As Health's 2008/09 underspends have already been reflected in the Crown's accounts, any spending from this contingency will reduce the Crown's operating balance and increase debt.

20. The attached Cabinet Expenditure Control Committee paper seeks agreement to establish the contingency, and outlines how it will operate.

21. Your 10 August letter outlined the following rules for the contingency:

    a. The contingency is to manage previously identified pressures, not new initiatives

    b. The contingency will only be available if other sources such as Vote Health risk reserves and reprioritisaiton opportunities have been exhausted

    c. Funding requests require justification and option analysis as for new funding bids

    d. The tagged contingency will expire on 1 February 2010.

22. We provided a draft of Cabinet paper to the Ministry of Health for consultation in August. In mid-October the Ministry informed us that the Minister of Health was concerned the rules for accessing the contingency could be too restrictive and that he may write to or speak with you about this. We understand that no letter about this has been received by your office.

23. The rules proposed for the contingency in the attached Cabinet paper are somewhat less restrictive than those set out in your letter of 10 August. We think these changes will address the Minister of Health's potential concerns:

    a. As a full review of Health baselines is to be conducted for Budget 2010, a lighter test is proposed for accessing the contingency. This requires any unspent risk reserves and any known underspends or savings (in the current financial year only) to be used before seeking contingency funding, but it does not require an additional reprioritisation exercise;

    b. The contingency will expire on the date that March Baseline Update (MBU) submissions are due to you (mid-March), rather than on 1 February. This allows the Minister of Health more time to finalise any contingency funding requests alongside any proposals for other changes to baselines for MBU. The standard 1 February deadline for tagged contingencies funded from the general budget contingency aims to let Cabinet prioritise remaining risks and pressures against remaining contingency funds as the financial year-end approaches. Since the proposed Health contingency is not funded from Budget 2009's general contingency and will not be consolidated back into it, this deadline need not apply.

24. The Minister of Health may wish to have access to the contingency for capital expenditure also. We have limited the contingency to operating expenditure only, in line with your views stated at the 2 October meeting, and given the need for improved Health capital management.

## Capital

25. On the basis of CAM information DHB investment intentions over the next 10 years exceed $3 billion and would require more than $2 billion from the centre. This clearly is unaffordable.

26. The new MRG process and work on capital prioritisation and service planning is underway. The more capital decisions can be brought into the new processes the better. The minimum necessary proposals prepared under old information and requirements should be approved at Budget 2010. This will lead to a larger Budget 2011, as the requirement for capital solutions will not go away. The new MRG capital committee will be operational in time to provide some advice for Budget 2010.

### Current capital process and changes underway

27. To date, the health capital investment process has run relatively independently of the main Budget process. DHBs develop proposals for consideration and assessment by the National Capital Committee and officials and Joint Ministers approve all projects that

are greater than $10 million, require debt or equity funding from the centre or represent a strategic investment. All health sector projects are funded from the health capital envelope which is topped up each year during the Budget based on business cases that will be submitted throughout the following year.

28. There is a three stage project development and approval process for Health capital proposals: the strategic stage which provides a high level concept design, stage 2 business case, and final approval. Ministers jointly approve the last two stages. The stage 2 business case approval is the most important stage as final approval projects are fully developed and further change is costly. The full value of an approved project is counted against the envelope at the time of approval, regardless of the timing of spending on the project.

    Key issues with the capital process that has been running to date include:

    - Lack of a medium/long term perspective. Proposals have tended to be considered and funded when they are ready, giving first movers an advantage rather than the highest priorities over time.
    - Definition of "affordability" allowed spending on capital to run ahead of both depreciation and plausible future operational funding.
    - Limited consideration of regional service planning.
    - Limited options analysis required and tested with a general lack of business case rigour.

29. The decisions to set up the NHB were taken to improve overall planning and decisions making in the health sector. These decisions included replacing the NCC with a NHB capital committee, headed by Murray Horn. This is expected to consolidate the service and capital planning work, improve national and regional planning and drive improvements more quickly.

30. A number of parallel work streams are also underway within the Treasury, Ministry of Health and CHFA to improve the quality of health capital decision-making. These work streams include:

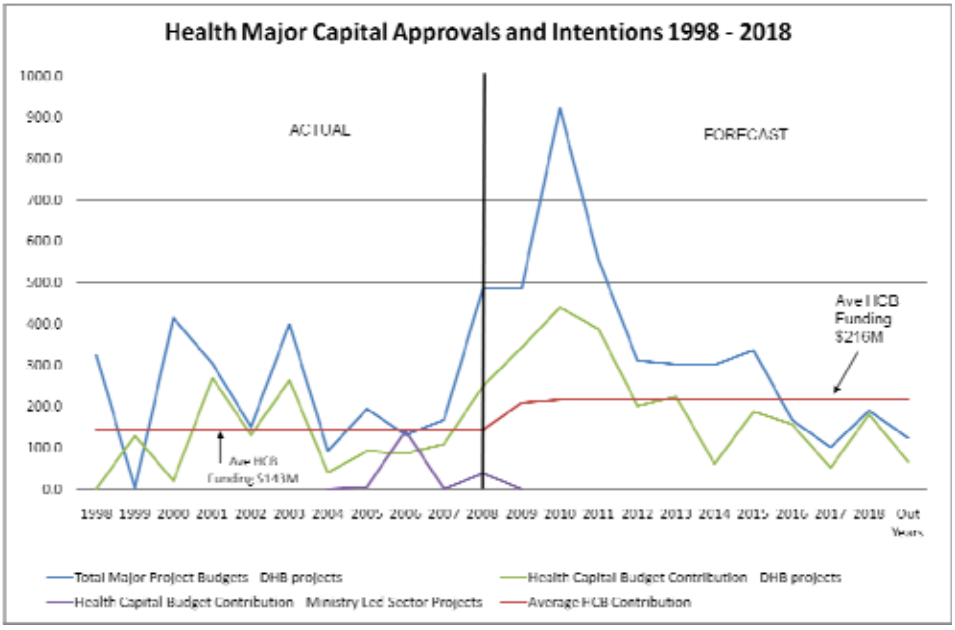
    - CAM: DHBs and the Ministry of Health are currently at the core CAM standard.
    - Long-term service planning: getting greater integration of capital proposals as solutions to service problems rather than replacement of individual buildings and better regional and national service planning, as a foundation for capital planning.
    - Affordability modelling: getting a more rigorous definition of affordability (both confining the revenue stream considered in defining affordability to revenue associated with the asset, and more realistic revenue forecasts).
    - Capital process changes: including improving the overall standards of business cases and options analysis, updating the Health capital investment guidelines, and bringing a greater time dimension to planning.

31. Taken together, these changes will allow more robust prioritisation of health projects and improve the quality of investment planning and decisions over time.

**CAM and DHB intentions**

32. DHBs have signalled intentions to invest more than $3.5 billion of capital over the next 10 years requiring more than $2 billion new funding from the Budget1.

[1] Projects that will require Ministerial approval. Does not include Baseline capital intentions for which DHBs are responsible and which do not require contributions from the HCE.




33. These capital intentions represent a bottom-up and DHB-centric view of investment decisions over the next 10 years. They have not been tempered by a top down view of what is affordable to the Crown and operating affordability assumptions have not been tested. The following capital intentions are likely to come up over the next 5 years:

- *[deleted – confidentiality of advice]*
- *[deleted – confidentiality of advice]*
- *[deleted – confidentiality of advice]*
- *[deleted – confidentiality of advice]*
- *[deleted – confidentiality of advice]*

34. Many of these projects represent a pressure where some change and/or investment will be required. At the same time, it is clear that investment of the level outlined above is unaffordable to both DHBs and the Crown. Investment advice and decisions in future will need to be supported by:

- Affordability: investments must be affordable from a DHB, regional and the Crown perspective
- Service planning: investments must fit with national and regional service planning
- Options: evidence-backed options on the type of investment needed and appropriate for different areas (i.e. may not want to replace a small secondary hospital with exactly the same services in areas such as West Coast)
- Evidence on the flexibility around when investment is required

35. Advising on improving the overall capital process is a key task for the new NHB capital committee.

**Health Capital Envelope update**

36. $203 million remains in the Health Capital envelope un-tagged to projects. In Budget 2009, Cabinet approved a top up to the Health capital envelope of $2 million. $32 million

of this has been allocated to fund the first stage development at Middlemore Hospital. No further decisions have been taken against this funding due to the business case preparation and analysis process. Annex 1 provides further details on capital proposals.

**Capital funding and Budget 2010**

37. Ongoing investment will be required in health capital to maintain and develop health infrastructure to sustainably and efficiently deliver health services in the long-run.

38. In the short run there is flexibility around the health capital allocation. There is a strong case to defer as many capital decisions as possible. The more decisions can be made using new processes and information, the better the likely outcome. The more can be deferred, the less new money can be allocated in Budget 2010. The new NHB capital committee will be able to advise on "must do" projects in 2010. A 2010 health capital budget allocation of between zero and $100 million is possible. Given the pressures, a large direct fiscal saving from deferring capital projects is not expected, as capital solutions to the presenting issues will have to proceed in some form later. The lower the 2010 allocation, the larger the 2011 allocation will have to be. The benefits of deferral are mostly from the service consequences of better decisions.

39. Thus the 2010 budget capital allocation for health should be set between zero and $100m, taking into account other Crown capital pressures and advice from the NHB capital committee.

**Other capital issues**

*Funding capital from operating underspends*

40. In the past, health operating underspends have been used to "top up" the health capital envelope. The amount of capital allocated to health should be set explicitly, rather than as a by-product of the management of operating spending. This is also consistent with a more methodical approach to financing health capital.

41. Thus capital should be funded on its merits, not from underspends.

*Private finance/PPPs*

42. Private financing proposals to date focus on efforts at accessing private credit to escape the disciplines of the health capital envelope (e.g. Wairarapa). As the in-substance economic impact of private credit is the same as Crown debt but at a higher cost, this approach should be avoided.

43. *[information deleted in order to maintain the effective conduct of public affairs through the free and frank expression of opinions].*

44. *[information deleted in order to maintain the effective conduct of public affairs through the free and frank expression of opinions].*

*Elective Theatres*

45. Elective theatre proposals pose a particular challenge. With a strategic-stage price tag of $75m just in Auckland, they are a material charge on health capital. PPPs (or similar) have limited potential for reducing the cost of elective theatres, which is driven mostly by the cost of the facilities. The overall cost of electives policy is dominated by the cost of services, rather than buildings.

46. The wish to progress elective theatres is an important driver of the Minister of Health's concern with the level of capital funding. However, even with a larger health capital envelope, elective theatres may not compare well with other priorities in a more rigorous capital process, although given population pressures elective theatres in Auckland in the near future are likely.

47. Overall, in the context of tight budgets, persisting with extensive elective theatre construction has high costs. The best approach is to allow elective theatre proposals to be developed and prioritised on an equal footing with other capital proposals. The NHB is fully aware of the government's commitment to electives.

Appendix 1

*[information deleted in order to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials].*