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Vote Health

Four-year Budget Plan

9 February 2011

Submitted by:

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Director General of Health

Section 1: Overview

1. This four-year budget plan describes how the Ministry of Health (the Ministry) will address priorities for the health sector for the period for 2012/13 through 2015/16, while continuing to deliver significant reductions in real cost.

2. The plan reflects the Ministry's dual commitments to improve the health, wellbeing and independence of New Zealanders, and improve the quality and sustainability of services.

3. What the public expects of the health system needs to be balanced with what the country is able to afford. At the same time, services should be of high quality and should support the wellbeing of all New Zealanders. A simple trade-off is not necessary. The interplay between the two allows better value and better quality to be achieved.

4. This plan is based on a funding allocation of $350 million for 2012/13 and indicative for outyears as agreed by Cabinet (CAB Min 11 43/3 refers). It presents a balanced budget for 2012/13 and an action plan for how the Ministry will address funding gaps in outyears.

5. This paper will:

    - outline the priorities for health over the next four years (Section 2)
    - detail the cost pressures facing health in that period (Section 3)
    - show how we will address the challenge of bending the cost curve down while continuing to maintain or improve health outcomes and meet service coverage expectations, including the levers we have at our disposal as a health ministry (Section 4)
    - outline the health sector's capital intentions (Section 5)
    - discuss the further options that may be necessary to continue to manage within available funding (Section 6)
    - outline the Ministry's departmental intentions (Appendix 1)
    - provide a list of DHB identified capital projects (Appendix 2)
    - detail plans for new initiatives and reprioritisations (Appendix 3).

The health sector is performing well

6. The health system is sound and is achieving excellent results for New Zealanders, including the following achievements for the Government's Health Targets for 2010/11.[1]

    - 145,353 elective surgical discharges were delivered against a target of 140,063 (four percent more than planned).

[1] Ministry of Health. 2011. Annual Report for the year ended 30 June 2011 .

- 91.6 percent of patients were admitted, discharged, or transferred from an emergency department within six hours (a continued increase moving toward a target of 95 percent).
- 99.95 percent of patients ready for treatment received radiation within four weeks of first specialist radiation oncology assessment (six months after the target timeframe was reduced from six weeks)
- Immunisation coverage for two-year-olds reached 90 percent for the first time.
- 85 percent of hospitalised smokers were offered advice and help to quit (good progress against a target of 90 percent).

7. The public is satisfied with, and expresses a high degree of trust in our health services and workforce.[2] In 2009, New Zealand had the second highest percentage of adults reporting to be in good health of all OECD countries.[3] New Zealanders' health expectancy increased 2.7 years for males to 67.4 years and for females by 1.7 years to 69.2 years between 1996 and 2006. Life expectancy has also increased by 7.6 years over the last two decades – more than in comparable nations.[3]

8. New Zealand total health expenditure per capita (public and private contributions combined for 2009) is less than the OECD average while delivering comparable results in many areas and significant improvements in others, such as reducing waiting times for elective surgery while maintaining access to services.[3]

9. The system's cost effectiveness is demonstrated by its outputs and outcomes continuing to improve, with reducing increases in new funding in recent years. DHBs in particular have continued to do more with less in increasing outputs and delivering new initiatives while reducing their net deficits by $139 million over the last three years from $155 million in 2008/09, down to $16 million in 2010/11.

10. We have avoided major service failure and the loss of public confidence that has typified some previous fiscal tightening in the sector. We have successfully managed unexpected events such as the Canterbury earthquake and the 2009 swine flu pandemic. A long-term view has also been maintained, with investments in immunisation and lifestyle choices (such as smoking cessation) which will lead to lasting benefits well outside the forecast period.

11. System improvements have been achieved, in part, through strengthening the institutions and governance arrangements within the sector, and through better specification and monitoring. Clinical involvement has also been essential in improving models of care and developing workforce capability.

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[2] New Zealand patients report high levels of access to a doctor or nurse, as need arose (Commonwealth Fund International Health Survey, 2010). In the Kiwis Count Survey, 69 percent reported satisfaction with overall health service

[3] Health at a Glance 2011, OECD indicators

Actions and priorities

12. We intend a mixture of actions to further improve the health of the New Zealand public and the overall health system. A number of these improvements will be made without the specific investment of additional funds.[4] In the immediate future, we need to take action in the following key areas.

    - Increase the number of elective operations by an average of 4,000 a year and ensure all patients wait no-longer than four months for elective surgery – by the end of 2014.
    - Ensure patients needing a specialist appointment are seen within no more than four months – by 2014.
    - Expand the Voluntary Bonding Scheme to include more health professionals and hard-to-staff regions as needed.
    - Provide a comprehensive after-hours telephone advice service with access to nurses, GPs and pharmacists.
    - Work with primary care networks to provide free after-hours GP visits to children under six.
    - Provide a $12 million rheumatic fever programme targeting vulnerable communities.
    - Drive clinical integration across the health sector promoting efficient structures, strong workforce and leadership, and effective planning.
    - Further develop and support primary care to:
        - effectively contribute to the management of acute demand, keeping pressure off hospital emergency departments
        - improve immunisation rates
        - identify and better manage cardiovascular disease and diabetes
        - continue to help New Zealanders quit smoking.
    - Improve the health of older people by providing better quality care and protecting those who are vulnerable.
    - Improve access, remove barriers, and reduce transaction costs, with particular focus on cancer services, cardiac services, and elective surgery.
    - Support Whānau Ora.
    - Develop resilient and responsive mental health and addiction services.
    - Maintain a strong and ongoing focus on living within our means.
    - Respond appropriately to the Christchurch earthquake.

13. We also need to respond to health challenges, including: improving how we respond to different parts of the population (such as the rising number of people entering older age with multiple long-term health conditions, and health outcomes for Māori and Pacific peoples), managing non-communicable diseases, and responding to mental health issues.

14. We believe that significant gains can be made. In particular, achieving even average performance for people with the worst health outcomes and those services that are the least efficient offers substantial benefits.

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[4] For example, improvements in health targets are being made without the need for new money to be invested.

We face substantial pressure

15. The health sector faces estimated cost and volume pressure in excess of $690 million in 2012/13, and of over $2.6 billion over the four years outlined in this plan (refer Table A). This includes cost and demographic pressures and other funding pressures that need to be met, such as Kiwi Saver, and the cost of meeting new priorities and challenges to the health of New Zealanders.

16. In the forthcoming year, we will need to reprioritise spending to deliver new initiatives and achieve efficiency gains and tight cost containment while managing within available funding. More substantive progress is required in the years after 2012/13 as cost savings targets compound. This progress will be achieved by a combination of effective implementation of existing initiatives and rolling reviews of current services (further discussed in Section 4).

17. Sound management and clear expectations should enable continued service improvements and judicial investment in some new initiatives. An ongoing additional investment of at least $350 million per annum will be required to cover the volume pressures caused by the country's growing and aging population which cannot be mitigated by service improvements, and to partly meet cost pressures due to inflation and technology impacts.

18. This plan does not introduce changes in entitlement or eligibility or disruptive changes to service delivery. Other options are described in Section 6.

19. The following table shows the amount of efficiency savings and reprioritisation required to manage within an Operating Allocation of $350 million:

A. Pressures facing the health sector with $350 million on-going Operating Allowance	$(million)			
	2012/13	**2013/14**	**2014/15**	**2015/16**
Cost Pressures & New Initiatives				
Demographic	*168.000*	*333.567*	*512.493*	*706.524*
FFT	*317.000*	*627.433*	*964.507*	*1,332.476*
Kiwi Saver	*45.000*	*67.000*	*67.000*	*67.000*
Deficit Reduction	*30.000*	*30.000*	*30.000*	*30.000*
Total DHB Pressures	***560.000***	***1,058.000***	***1,574.000***	***2,136.000***
Ministry Demographic & FFT Pressures	*121.000*	*235.000*	*358.000*	*492.000*
Departmental efficiency & superannuation funding reduction	*11.200*	*11.184*	*11.184*	*11.184*
Total Pressures	***692.200***	***1,304.184***	***1,943.184***	***2,639.184***
New Initiatives	*33.957*	*114.779*	*194.204*	*274.519*
Total Pressures & New Initiatives	***726.157***	***1,418.963***	***2,137.388***	***2,913.703***
Less $350 million Operating Allowance	*(350.000)*	*(700.000)*	*(1,050.000)*	*(1,400.000)*
Required Efficiency &/or Re-prioritisation	***376.157***	***718.963***	***1,087.388***	***1,513.703***

Source of Funds from efficiency & reprioritisation - Cumulative

[10]				
DHB Efficiency Gains Including HBL	*190.000*	*318.000*	*464.000*	*656.000*
Total DHB	***240.000***	***418.000***	***614.000***	***856.000***
DE Savings	*11.200*	11.184	11.184	11.184
Ministry NDE Efficiency Gains	*79.928*	159.856	239.784	399.640
Reprioritisation	*22.335*	129.923	222.420	246.879
Total Ministry	***136.157***	***300.963***	***473.388***	***657.703***
Other	-	-	-	-
Total Funds	***376.157***	***718.963***	***1,087.388***	***1,513.703***

Source of Funds from efficiency & reprioritisation - Annual

Total DHB	***240.000***	***178.000***	***196.000***	***242.000***
Total Ministry	***136.157***	***164.806***	***172.425***	***184.315***
Total Funds	***376.157***	***342.806***	***368.425***	***426.315***

Summary of Changes

Table B provides information on the Ministry's operating position.

B. Budget 2012 Operating Allowance	**Impact $m increase/(decrease)**					
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**Total**
Available Funding						
Budget 2012 Operating Allowance	-	*350.000*	*350.000*	*350.000*	*350.000*	*1,400.000*
Amount reprioritised [**section 4**]	*111.112*	*22.335*	*17.268*	*20.768*	*21.768*	*193.251*
Total Available Funding	***111.112***	***372.335***	***367.268***	***370.768***	***371.768***	***1,593.251***
Cost Pressures & New Initiatives						
District Health Board (DHB) Cost & Demographic pressures **[section 3]**	-	*320.000*	*320.000*	*320.000*	*320.000*	*1,280.000*
Ministry Managed Cost Pressures **[section 3]**	-	*41.072*	*43.345*	*44.545*	*46.830*	*175.792*
New Initiatives	-	*33.957*	*34.779*	*34.204*	*34.519*	*137.459*
Total Cost Pressures & Priorities	**-**	***395.029***	***398.124***	***398.749***	***401.349***	***1,593.251***
Funding - Surplus/(Deficit)	***111.112***	***(22.694)***	***(30.856)***	***(27.981)***	***(29.581)***	**-**

Tables 1, 2, 3, 4 and **5** outline the Vote and proposed changes (in the format requested by Treasury).

1. Operating changes sought	**Impact $m increase/(decrease)**				
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Current Baseline	***13,496.759***	***13,427.240***	***13,344.842***	***13,347.498***	***13,347.498***
Cost pressures resulting from existing policies/settings **[section 3]**	-	*361.072*	*724.417*	*1,088.962*	*1,455.792*
Cost of new/increased activities [**section 4**]	-	*33.957*	*114.779*	*194.204*	*274.519*
Departmental Efficiency savings	-	*(11.200)*	*(11.184)*	*(11.184)*	*(11.184)*
Amount reprioritised [**section 4**]	*(111.112)*	*(22.335)*	*(17.268)*	*(20.768)*	*(21.768)*
Net impact	***(111.112)***	***361.494***	***810.744***	***1,251.214***	***1,697.359***
New baseline	***13,385.647***	***13,788.734***	***14,155.586***	***14,598.712***	***15,044.857***

2. Capital investments being considered for new funding in Budget 2012 **[appendix two]**	**Impact $m increase/(decrease)**				
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16 & Outyears**
[10]					

3. Capital investments likely to require new funding in future Budgets **[appendix two]**	**Total impact across years $m increase/(decrease)**		
	Budget 2013	**Budget 2014**	**Budget 2015**
Various refer appendix two	[6]		

4. Baseline capital expenditure	**Impact $m increase/(decrease)**				
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Departmental					
Baseline funding available for departmental capital expenditure **[section 5, table 5, row e]**	*32.701*	*31.739*	*31.314*	*35.889*	*40.464*
Investments funded from departmental capital expenditure **[section 5, table 5, row f]**	*20.507*	*20.000*	*15.000*	*15.000*	*15.000*
Non-departmental					
[6]					

5. Departmental capital expenditure	**Impact $m increase/(decrease)**				
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**
a. Opening baseline funding available	14.225	12.194	11.739	16.314	20.889
b. Depreciation funding (1:51:1, 199)	18.417	19.500	19.500	19.500	19.500
c. Sale of assets (1:52:0, 1999)	0.059	0.045	0.075	0.075	0.075
d. Other (please specify)	-	-	-	-	-
e. Total baseline funding available (a+b+c+d)	**32.701**	**31.739**	**31.314**	**35.889**	**40.464**
f. Capital investments funded from baselines	20.507	20.000	15.000	15.000	15.000
g. Closing baseline funding available (e-f)	**12.194**	**11.739**	**16.314**	**20.889**	**25.464**

Section 2: Priorities

20. For the sector to continue delivering results and controlling its funding path, it is essential that the health sector has the right tools and processes; that the people and organisations within the sector are brought together; and that patients are placed at the centre of the system, with their health and wellbeing the overall focus of the endeavour. We use the term "clinical integration" to describe the confluence of these concepts.

21. Clinical integration is the principal means of improving our ability to address complex health needs and protect good health and wellbeing, particularly in older age. Integrated approaches to care and service delivery put the patient at the centre of decisions. It can also contribute to the seamless transfer of patients through the different parts of health system, and can be accompanied by moving services to locations that are convenient to the patient.

22. Efficient organisational structures, strong workforce, effective regional planning, information sharing, sector leadership, and innovation are all features of a clinically integrated health sector, and are crucial to the long-term financial sustainability of the health sector.

23. With the goal of achieving Better, Sooner, More Convenient health and disability services, the Ministry intends to drive clinical integration across the health sector, with particular focus on the following areas.

    - Further developing **primary care** as the accessible and affordable first point of contact for health services for all New Zealanders. Delivering more services within local communities improves access to services while reducing pressure on a range of hospital based services. Through work at a primary care level, we also expect to see:

        - effective management of acute demand with inappropriate use of **hospital emergency departments** minimised

        - parents supported and informed so the **immunisation** of children occurs on time, and so that those who are initially missed are caught-up wherever possible

        - those at risk of **cardiovascular disease or diabetes** identified and helped to self-manage that risk or their condition(s)

        - better help to quit provided to those who smoke **tobacco**.

    - Improving the **health of older people** by building better quality care that provides choice and information, involves them in care decisions, provides protection for those who are vulnerable, and is integrated around older people to improve their quality of life – whether at home or otherwise. The number of older people is increasing, and it is important that the impact of that increase is properly met.

- Improving access, removing barriers and reducing transaction costs so that organisational structures and professional practices do not stop or delay patients from getting the services they need. Through focus in this area, we expect to see improvements in:

    - people getting timely access to quality **cancer** services that make the best use of available resources

    - reduced wait times for **cardiac services**, with improved prioritisation and selection of patients for cardiac surgery

    - **elective surgery**, with more people receiving surgery after shorter waits

    - reduced waiting times for **first specialist appointments (FSAs)**.

- Making use of the opportunities afforded by **Whānau Ora** to improve services delivery and build mature providers that support the needs of local communities and support outcome focused relationships.

- Developing resilient and responsive services that function well for people with **mental health and addiction** problems. These services need to be integrated, recovery focused, to intervene early for the best results, and to support self-management by and for the patient.

- Ensuring a strong and ongoing focus on maximising value from the constrained resources available, while ensuring ongoing clinical and system sustainability. **Living within our means** remains a key message and priority for the sector.

- Responding appropriately to the **Christchurch earthquake** to ensure that both current needs and emerging longer-term challenges are met.

24. Real benefits will be delivered through action on these priorities. Continued delivery on the Health Targets will be an indicator of Health's achievements against these priorities.

25. The Government wants to improve the health, wellbeing, and independence of New Zealanders, as well as improving the quality and sustainability of services. We expect to see smarter purchasing, improved prioritisation, and better aligned service and capacity planning as a result of action on these intentions, with resulting service, economic, and health benefits. Specific improvements include:

    - increasing the number of elective operations by at least 4,000 a year and ensuring all patients wait no-longer than four months for elective surgery by the end of 2014
    - ensuring patients needing a specialist appointment are seen within no more than four months by 2014
    - expanding the voluntary Bonding Scheme to include more health professionals and hard-to-staff regions as needed

- providing a comprehensive after-hours telephone advice service with access to nurses, GPs, and pharmacists
- working with primary care networks to provide free after-hours GP visits to children under six
- providing a $12 million rheumatic fever programme targeting vulnerable communities.

Section 3: Cost Pressures

26. The health sector faces ongoing cost pressures. The three main drivers are; price or input pressure, volume or output pressure, and other factors. Each has different causes and responses. This table outlines the proposed funding to address the cost pressures facing health (as per Table 1 in Section 1).

	Cost pressures resulting from existing policies/settings	**$ (millions)**				
Ref	**Description**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
	DHB Demographic	-	163.611	163.611	163.611	163.611
	DHBs Contribution to Cost Pressures	-	156.389	156.389	156.389	156.389
	Total DHBs		**320.000**	**320.000**	**320.000**	**320.000**
1	National Screening Services	-	2.452	2.983	3.512	4.044
2	Disability Support Services	-	30.914	32.509	34.027	35.626
3	Child Youth & Family Services - PlunketLine & WellChild Services	-	1.600	1.640	1.681	1.723
4	Emergency Services	-	2.775	2.799	1.826	1.850
5	National Maternity Services	-	3.331	3.414	3.499	3.587
	Total Ministry NDE	**-**	**41.072**	**43.345**	**44.545**	**46.830**
Total Budget 2012		**-**	**361.072**	**363.345**	**364.545**	**366.830**

	Budget 2013			361.072	361.072	361.072
	Budget 2014				363.345	363.345
	Budget 2015					364.545
Total Forecast Period		**-**	**361.072**	**724.417**	**1,088.962**	**1,455.792**

Price pressure

27. Price pressures arise from specific causes, such as wage or pharmaceutical costs, or from general inflation. Price pressure has historically been managed through the forecast funding track (FFT) adjustor, which allows for cost inflation, technology advances and an efficiency adjustment. FFT has been used in various forms in the health sector for the last 15 years and is a top-down estimate of the net cost required to sustain services at current levels. DHBs are often required to deliver some additional government priorities within this funding allowance.

28. For the past three years, an efficiency adjustor has been applied and met with DHBs receiving a contribution to cost pressures only. The efficiency adjustment applied to DHBs was about 0.6 percent of the year's total operating expense in 2009/10, 1.8 percent in 2010/11, and 1.6 percent in 2011/12. This is an efficiency gain.

29. The Ministry funds a significant amount of health services directly. FFT and demographic pressure is calculated on total funding to give a top-down view of the cost and volume pressures, but the Ministry also undertakes a bottom-up process of assessing pressures which are then scrutinised to ensure equity and robustness. In the current year the FFT and demographic calculation was $121 million. The Ministry has however

managed through a process of budget discipline to limit expected cost pressures to $41 million, resulting in an $80 million efficiency gain relative to the estimate of full cost and volume pressures.

30. A continuation of efficiency gains will be necessary and is assumed over the next four years. The average overall efficiency gain required to manage within forecast Vote health baseline funding over the next four years is 2.3 percent per annum – which lowers to an overall average of 2.0 percent per annum after factoring in forecast gains from effective management of wage pressures. Achieving this level of efficiency gains will ensure that there is no impact on service levels, which are assumed to grow in accord with demographic pressures.

31. **Wage pressures:** The health workforce is expensive to train and we compete for staff in an international market. In the medium term, the world-wide market for health professionals will grow significantly as emerging economies demand better health services and populations age in developed countries (eg, Australia, United Kingdom). The health and disability system is particularly labour intensive - two thirds of health expenditure is on workforce, with a one percent wage increase across the health sector costing about $64 million per annum. This means that the outcome of wage negotiations has a significant effect on the sustainability of the health system.

32. Clinical workforce sustainability is important in ensuring delivery of a safe high quality level of services. This can be achieved through strategic negotiating to achieve improved terms and conditions of employment that are:

    - financially affordable and sustainable
    - comparable across the State sector labour market
    - supportive of attracting and retaining a workforce able to meet the needs of the public health sector.

33. Clear guidelines are laid down for state sector employment negotiations through the Government Expectations for Pay and Employment Conditions in the State Sector (the Expectations). In addition, DHBs have a National Employment Relations Strategy which is approved by the Chief Executives and which includes bargaining parameters for the current year and workforce initiatives locally, regionally and nationally. These are also generally followed by Crown entities such as the New Zealand Blood Service.

34. DHBs have a statutory requirement to consult with the Ministry of Health on all local, regional and national bargaining strategies. All bargaining strategies must consider and be consistent with the Expectations and must cover elements including:

    - the environment in which the negotiations will take place
    - how the employment agreement links to and supports the DHBs' service and workforce plans
    - cost implications for the implementation of the strategy.

Key messages also include:

- better, smarter service delivery
- management within existing resources and sustainability in the future
- support for agency business objectives in the short and medium term
- fairness to employees
- a productivity focus.

35. Effective bargaining of Multi-Employer Collective Agreements (MECAs) to constrain DHB workforce wages has contained the annualised ongoing cost of settlement over the 2010/11 year at 1.77 percent. In the 2011/12 year, it has been contained at 1.5 percent for 85 percent of the health workforce. A number of settlements in the 2011 year have achieved two-year terms and so bargaining will not resume until 2013 or in some cases 2014 (and in one case 2015). Future forecast ranges for wage settlements are detailed as follows:

- [10]

- [10]

- [10]

- [10]

[10]

36. As the economy recovers, greater wage increases will likely be expected. There will be fewer perceived constraints and a general expectation that having "tightened their belts" when things were difficult, there should now be wage increases made to reflect this. Such a rebound in wages costs would push the cost curve back up, and we are endeavouring to manage this risk through effective bargaining, Health Workforce New Zealand engaging with the sector to address non-wage issues such as training and staffing hard-to-staff areas, and through continuing to manage expectations.

37. **Pharmaceuticals:** are a major cost to DHBs at around $1.1 billion per annum for cancer and community pharmaceuticals and dispensing fees. PHARMAC has been highly successful in assisting DHBs to manage drug costs and is an internationally regarded model. Dispensing costs however are growing at an average rate of nine percent per annum, which is in excess of DHB's funding.

[10]

Decisions are expected to be made by 1 May 2012, when the current Pharmacy Services Agreement is due to expire.

38. **Third party suppliers:** Almost $7 billion of health services are provided by NGOs or private sector entities (such as GP services, rest homes and ambulance services). In many areas there are limited options for supply although we have been effective in holding down costs in these areas over an extended period. Tendering is used wherever possible.

39. **Health Benefits Limited:** DHBs will be obliged to make up the difference with their local or regional plans in the event they cannot agree specific savings initiatives in the short term through Health Benefits Ltd.

40. **Other input costs:** Decisions on the funding of KiwiSaver and superannuation will increase DHB costs by $45 million in 2012/13 and $67 million in the out years. Also, insurance costs have risen by an estimated $10 million per annum as a result of the Canterbury earthquake.

41. **Deficit reduction:** DHBs are required to operate with lower deficits than in previous years. This is a cost pressure. DHBs have been very successful in reducing deficits in recent years and the net outturn in 2010/11 was only $16 million. This success included two boards achieving an end of year result $28 million better than budget. The planned net deficit reduction for 2012/13 is $30 million.

Volume pressure

42. Volume growth is driven by population growth and changing demographic mix from an ageing population and spikes in birth rates.

43. We project population growth will add ten percent to service demand over the next decade, and the aging of New Zealand's population will add a further seven percent.[5] Expenditure on people over 65 years of age is predicted to grow from 36 percent to 42 percent of the total.[6]

44. While older people tend to consume a higher portion of health services, demographic factors work in other ways. For example there is currently an "age bump" of adolescents where disabled youth cost considerably more once they leave the care of their parents. The incidence of particular chronic conditions is also a significant cost driver. For example, obesity in adults is increasing. The Northern region is already facing high population growth relative to the rest of the country and this is placing services under pressure.

45. Volume pressure has historically been managed through a demographic adjustor. It is intended to continue to apply the demographic adjustor to ensure that increased natural demand doesn't lead to increased waiting times or reduced services.

Other factors

46. Government decisions to expand services beyond cost and volume considerations are an important source of improvements in the health status of New Zealanders. Initiatives to expand services are included as new policy initiatives in Section 4 of this plan.

47. Other drivers of cost include changing public expectations and technological advancements. Clinical expertise is used to make decisions on a high cost treatment pool of $2.5 million which ensures people most likely to benefit from the most expensive treatments (mostly those specialist procedures only available overseas) can access treatment with public funding. The newly reconstructed National Health Committee is tasked with assisting in prioritising new technology developments across the sector.

48. Cost management over the four-year period of this plan includes the requirement for new initiatives to be self-funded, ensuring any new initiatives are funded by reallocating money from areas of relatively low priority. After a decade of relatively strong growth in access, only a very limited number of initiatives are proposed over the forecast period.

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[5] Using Statistics New Zealand projections and assuming that the pattern of demand by age constraints remains constant.

[6] Some experts think that demand could increase more significantly (eg, Professor Des Gorman suggests that demand could double if action is not taken).

Risks

49. The following risks to the health sector also need to be managed:

- **Litigation.** The health sector is subject to litigation; the most fiscally significant relates to family care-givers. We are appealing parts of the High Court's decision that complainants with disabled children have been discriminated against on the prohibited ground of family status. The matter will be heard by the Court of Appeal from 13 February 2012. A decision from this hearing is likely to take 3 to 6 months. Depending on the outcome of this decision, a further appeal may be made or the matter progressed through a Tribunal remedies hearing for a further 6 to 9 months. The decision has significant implications for the health sector. Any possible cost of settlement is not able to be absorbed although the Ministry has provided for the cost of managing the litigation. Funding additional to Vote Health is unlikely to be required for this issue prior to Budget 2013.

  The underlying risk of litigation is not increasing. Good policy design is key to effective management of litigation risk. Government policy in contentious areas such as the Treaty of Waitangi and human rights can lead to an increase in litigation as Parliament's intent is tested in the courts.

- **An unexpected health event.** For example, a pandemic, an earthquake, or a similar scale event (at either a regional or national level). Systems are in place to coordinate the health sector response to such an event. Depending on the nature or scale of the event, it might be necessary to approach Cabinet for additional funding.

- **Performance risk.** There is a general risk that savings won't be achieved (including those sought from Health Benefits Ltd) in the required time frames or that pressure on providers to do more with less leads to unforeseen health consequences. Typically, these would manifest in longer waiting times or deficit increases. Effective monitoring is key to mitigating these risks.

- **Change Management**. Change often creates unforeseen costs or consequences, or takes longer to implement than anticipated. The more extensive proposed changes are, the greater the risk of unforeseen consequences. A number of changes are underway to move people towards being cared for or treated in the community, including changes in primary health care. These are generally being well managed. Additional change, whether un-forecast such as a major health event or planned such as structural reconfiguration, need to be carefully planned and managed.

Other Pressures facing the health sector

50. **Capital pressures.** To meet increased demand from demographic change, DHBs need to increase capacity by expanding facilities or changing them to enable new models of care. Also, capital investment is

needed nationally so that DHBs can continue to manage current demand because a significant proportion of hospital buildings are in poor condition, with this being of particular concern in the Southern region. The Christchurch earthquakes have also exacerbated the situation regarding the condition of many buildings in that district.

51. DHBs have signalled intentions to invest about $6.8 billion over the next ten years towards meeting these pressures. Because of cost growth over the life of the assets, replacing/refurbishing them will cost more than the funding available through depreciation. Furthermore, as DHBs are adding to assets, not just replacing them, full funding through depreciation is not realistic.

52. **Pressures from outside the Health portfolio.** Good management of other determinants that affect health status, such as housing, can assist in improving the overall health and independence of New Zealanders, while pushing down the cost curve for the health sector. Cross-government work on the provision of housing insulation and other social interventions should contribute to meeting this pressure.

Section 4: Proposed Changes for 2012/13 to 2015/16

53. This section describes what the Ministry will do to bend down the cost curve while continuing to enhance the quality of health services. Our intention is to take all opportunities to improve efficiency and productivity in the health sector before considering reducing the level of health services available to New Zealanders.

54. The Ministry will be working with and monitoring the sector to ensure effective financial management, foster improvements in productivity, put in place regional and national planning, and ensure the development of workforce and IT infrastructure is co-ordinated and rationalised across the country[7].

55. Achieving efficiencies and value for money requires the sector to plan and work collaboratively (eg, through sharing back office functions) to deliver both financial and clinical sustainability across the country[7].

56. We have many of the required initiatives already underway. Our strategy is to:

- Deliver Ministry and DHB plans for 2012/13 to achieve the significant savings needed in 2012/13 to live within a $350 million baseline increase
- Deliver required savings targets across the four year period by:
    - continuing to improve sector outcomes, including lowering costs
    - delivering a series of rolling reviews of sector performance aimed at achieving the required savings.

Short term (2012/13)

57. To deliver on a funding path of $350 million in 2012/13:

- **$320 million will be allocated to DHBs for pressures** (demographic volume pressures and contribution to cost pressures) using the majority of the $350 million allocation.

- **$30 million will be allocated to Ministry NDE for pressures** (volume and cost) by only renewing contracts for services deemed as highest priority, and by not passing cost pressures through to all contracting parties. [10]

- **$240 million of Ministry funding will be reprioritised** over the forecast period to fund cost pressures and the cost of new initiatives and increased activities. The 2011/12 underspends are indicative only

[7] Ministry of Health – Statement of Intent 2011-2014

at this time and will be confirmed later in the budget process. (see Appendix 3 for details).

	Reprioritisation	$ (millions)					
Ref	**Description**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**Total**
1	Māori Health - Whanau Ora	-	-0.091	-0.091	-0.091	-0.091	-0.364
2	Crown Health Financing Agency	-	-1.700	-1.700	-1.700	-1.700	-6.800
3	Mental Health Commission	-	-1.116	-1.116	-1.116	-1.116	-4.464
4	Communicable Diseases	-7.440	-5.400	-5.400	-5.400	-5.400	-29.040
5	Public Health protection - Uncontracted Funding	-1.486	-1.526	-1.526	-1.526	-1.526	-7.590
6	Sanitary Works Subsidy Scheme	-16.104	-	-	-	-	-16.104
7	Social Environments	-	-0.568	-0.568	-0.568	-0.568	-2.272
8	Immunisation	-1.150	-1.150	-1.150	-1.150	-1.150	-5.750
9	Emergency Services	-	-0.046	-0.046	-0.046	-0.046	-0.184
10	Stroke foundation Guideline savings	-	-0.139	-0.139	-0.139	-0.139	-0.556
11	Immunisation - Influenza Vaccine	-0.350	-0.350	-0.350	-0.350	-0.350	-1.750
12	Primary Care Services - Long Term conditions	-	-0.460	-0.460	-0.460	-0.460	-1.840
13	Hospital productivity initiative	-	-0.093	-0.093	-0.093	-0.093	-0.372
14	NZ Health Survey	-0.470	-0.145	-	-	-	-0.615
15	Emergency Preparedness - storage reductions	-	-0.075	-0.150	-0.150	-0.150	-0.525
16	National Screening Services	-	-2.550	-2.920	-2.920	-2.920	-11.310
17	Disability Support Services	-	-1.500	-2.500	-3.000	-4.000	-11.000
18	Forecast 2011/12 underspends	-84.112	-5.426	0.941	-2.059	-2.059	-92.715
	Total Non-Departmental Reprioritisation	**-111.112**	**-22.335**	**-17.268**	**-20.768**	**-21.768**	**-193.251**
	Departmental Efficiency Savings	-	-8.900	-8.653	-8.653	-8.653	-34.859
	Removal of SSRS & Kiwisaver Revenue	-	-2.300	-2.531	-2.531	-2.531	-9.893
	Total Departmental Reprioritisation	**-**	**-11.200**	**-11.184**	**-11.184**	**-11.184**	**-44.752**
Total Budget 2012		**-111.112**	**-33.535**	**-28.452**	**-31.952**	**-32.952**	**-238.003**
	Budget 2013	-	-	-	-	-	-
	Budget 2014	-	-	-	-	-	-
	Budget 2015	-	-	-	-	-	-
Total Forecast Period		**-111.112**	**-33.535**	**-28.452**	**-31.952**	**-32.952**	**-238.003**

- **$60 million of new initiatives and increased activities** ($66 million in out-years) as described below (based on known Government intentions) will be funded through service reprioritisation (see Appendix 3 for details).

	Ministry - cost of new initiatives and increased activities	$ (millions)				
Ref	Description	2011/12	2012/13	2013/14	2014/15	2015/06
1	Train 154 GPs i.e. 18 more	-	0.864	1.314	1.764	1.764
2	Electives to increase by 4,000 discharges per annum	-	12.000	12.000	12.000	12.000
3	Diagnostic System Change - Access to diagnostic to support cancer, cardiac and electives	-	4.000	4.000	4.000	4.000
4	National Cardiac Surgical, Acute Coronary Syndrome and Interventional Cardiology Registers.	-	1.750	0.750	0.750	0.750
5	Expanding the demonstrations of the New Model for Supporting Disabled People.	-	2.268	2.815	2.315	1.955
6	Cancer Control - patient pathway co-ordination and other services	-	6.575	6.500	6.000	6.000
7	Expand Voluntary Bonding Scheme	-	1.000	1.000	1.000	1.000
8	Boost telephone advice - new line service	-	1.500	1.500	1.500	1.500
9	Organ Donations	-	1.000	1.000	1.000	1.000
10	Rheumatic Fever	-	3.000	3.000	3.000	3.000
	Youth Mental Services - Other Services	-	-	0.900	0.875	1.550
Total Budget 2012		**-**	**33.957**	**34.779**	**34.204**	**34.519**
	Budget 2013	-	-	80.000	80.000	80.000
	Budget 2014				80.000	80.000
	Budget 2015				-	80.000
Total Forecast Period		**-**	**33.957**	**114.779**	**194.204**	**274.519**

	DHBs - cost of new initiatives and increased activities	$ (millions)				
	Description	2011/12	2012/13	2013/14	2014/15	2015/06
	Free access for under sixes to after-hours primary health care.	-	7.000	7.000	7.000	7.000
	Youth Mental Services - Other Services	-	4.480	5.000	5.000	5.000
	Support smarter home support services	-	3.000	3.000	3.000	3.000
	Cancer Control - patient pathway co-ordination and other services	-	2.000	2.000	2.000	2.000
	Health of Older People/ Mental Health Initiatives - Dementia	-	10.000	10.000	10.000	10.000
	Expanding role of nurses and pharmacist	-	-	3.000	3.000	3.000
Total Forecast Period		**-**	**26.480**	**30.000**	**30.000**	**30.000**

- **DHBs will absorb $240 million of unfunded pressures**, detailed plans on how to deliver these amounts will be included in DHBs' Draft Annual Plans; submitted by them in March 2012.

  DHBs are required to identify their specific plans for achieving their efficiency targets to live within their means. These plans are then scrutinised by the Ministry and Treasury and feedback provided. DHB plans are signed off by the Minister of Health, when they reach an

acceptable stage. Those DHBs that are under performance management are also reviewed by the Minister of Finance. DHBs are required to obtain specific agreement of the Minister of Health on the action to be taken if their plan requires significant service change to implement.

The process is a robust analysis of the reality of the plans, which the Ministry tests and critiques with individual boards. The nature of the discussions on the plans involves discussions with CEOs, Chairs and in some cases the Board. Plans are often revised before they reach an acceptable standard for Ministers' review.

This system has proved effective and delivered over the last three years:

- An increase in deliverables from within baselines
- an overall improvement of the deficit track

- **savings of $60 million are expected to be found by Health Benefits Ltd.** The effective cost management of medical supplies and services used by DHBs is the subject of work by Health Benefits Limited (HBL), which aims to drive down costs by competitive tendering or merging back office functions. Hard savings targets are factored into this budget plan to deliver efficiency gains across the four year period. HBL is accountable for delivering $60 million of cost savings for DHBs in 2012/13. The extent to which this is achievable will not be known until HBL submits its 2012/13 business plan in March. Any savings achieved will enable DHBs to manage within a lower funding path.

- **containing the cost of the two largest DHB cost elements: wages and pharmaceuticals.** This will be done by delivering specific DHB cost reductions in pharmaceuticals and by holding wage settlements to a level below the underlying cost growth in the economy

  PHARMAC will yield savings in 2012/13 of $30 million as a result of a number of items coming off patent, which it is assumed is retained within Vote Health to help meet pressures and new policy initiatives. DHBs will retain the demographic and price increase on the pharmaceutical budget to use against general pressures. PHARMAC will continue to invest $10 million per annum in new drugs where these have a clear cost benefit, albeit benefits that are reflected in health outcomes not hard savings

- **further reduce deficits by $30 million** against plan in 2012/13, with a planned net break-even by 2014/15. This will be achieved by delivering further efficiencies through the DHB planning process.

Medium Term (2013/14 to 2015/16)

58. The strategy for out years is described in terms of three elements; price, volume and other factors.

59. Initiatives to manage **price** are:

- **the health sector purchasing what it needs on more favourable terms** – PHARMAC has been an international exemplar in the purchase of drugs. [6]

improving the efficiency of the lowest performing parts of the health system – The Ministry has a plan to implement a series of reviews across service lines to deliver the efficiencies required for budget 2013 and 2014. The four initial areas to be reviewed are:

- child and maternity services
- mental health (total budget including DHB expenditure)
- public health services
- unplanned services (such as emergency services)

These reviews are key to delivering out-year savings.

Governance of the reviews will be managed by the National Commissioning Board (NCB), which is a sub-committee of the Executive Leadership Team (ELT).

These reviews will be more in-depth than previous reviews and examine the way services are contracted and delivered. Although the reviews are about how we purchase and provide services, each service area will be set a target to identify what changes they would make to achieve a savings target of 10% over four years.

Each service area will have a cross-Ministry group assigned to complete the analysis and review. The NCB will have a standard terms of reference for reviews, and each group will operate under these terms, but will have individual scopes agreed by the Commissioning Board. The overarching terms of reference includes areas such as policy settings, models of care, integration and strategic procurement.

Decisions arising from these reviews would fall into three categories:

1. Ministry operational decisions for changes that are administrative only and do not directly impact patient services

2. decisions given to the Minister of Health for approval for service changes made for consistency or efficiency that may impact on individuals

3. decisions submitted to Cabinet for major service changes impacting individuals and/or constituting a major policy change,

Four of the reviews have already been commissioned and are underway. The Ministry will be consulting Treasury regularly on the progress of the reviews. The initial four reviews are expected to finalise their report to the NCB in time to inform Budget 2013.

- **Improve payment services** – the Ministry operates a payment system on behalf of DHBs. Formal investigation processes currently yield savings through detected irregularities. Savings estimated at $30 million a year can potentially be generated through system improvements; however, these improvements are likely to take several years to implement.

60. Initiatives to manage **volume** are to:

- **increase the level of self care** – The ability of people to live independent lives is an important determinant of health costs. Vulnerable people, including the elderly, disabled and mentally ill, cost the health system considerably more once they enter residential care. Such people do not always require support from qualified medical staff.

  An example of work in this area is the comprehensive clinical assessments that the Ministry is working on with DHBs to support older people. These assessments will help ensure that older people get the care they need so that their health status doesn't deteriorate to the point where residential care is the only option for them. Comparing DHB performance is another tool in this area, allowing DHBs that have higher levels of people in residential care to learn from DHBs that have lower levels.

  Health literacy and access to information from 0800 numbers, on line or via social marketing campaigns can help people look after themselves better and know when to seek help early. The Ministry is reviewing the number of 0800 lines currently in use and believes there are both efficiency gains through rationalisation and potential improvements in effectiveness. At this stage, direct savings are not specified

- **increase hospital productivity** – Greater emphasis is being placed on shortening the gap between diagnosis and treatment, rather than simply measuring the length of waiting lists. Reducing time to treatment helps public confidence and improves health outcomes without increasing the cost of treatment.

- **move people along the health continuum from relatively expensive hospital and specialist care to management in the**

community – moving people into the community includes initiatives to reduce the length of stay in hospital beds and to move people from residential care into their own homes.

- **promote health** – Immunisation will reduce costs and achieve improvements in health status in the longer term. Screening programmes enable early detection and treatment, avoiding more expensive interventions later. Social marketing is an important tool in ensuring immunisation and screening take place, as is advice and referrals from health specialists like general practitioners and pharmacists. Expectations for referrals, such as cardiovascular disease checks, have been introduced and the Health Promotion Agency has recently been created. These will deliver benefits over the forecast period.

- **reduce secondary costs from preventable causes within the health system** – Preventable admissions, readmissions and extended length of hospital stay can be caused by incorrect medication or diagnosis, medical error and secondary infections. The Health Quality and Safety Commission has been in existence for a year and is charged with improving health outcomes through better quality of treatment. The costs are already reflected in health baselines while the benefits are largely unrealised as yet.

61. Initiatives to reduce the impact of **other factors** include:

- **improved governance and clear expectations** – DHBs have been made aware of the approximate value of the savings that may be required $240 million of efficiencies and savings every year for the next four years and have shown an acceptance of the task before them. Formal notification of planning parameters was provided to DHBs in mid-December 2011 (later than normal due to the Election). DHBs will identify savings in their Draft Annual Plans due at the Ministry in early March. DHB savings will come from:

    - efficiencies in internal operations
    - management of wage negotiations
    - demand management
    - regional service integration
    - quality initiatives.

- **improved DHB performance** - The National Health Board (NHB) has a role managing DHB performance on behalf of the Minister of Health. DHB performance is assessed in a range of ways including against health targets; financial and non financial performance and through the monitoring and intervention framework. By regularly engaging with all 20 DHBs, the NHB and the Ministry become aware of emerging issues at an early stage. DHBs are also required to notify the NHB of proposed service changes which might highlight emerging performance issues.

The NHB has been taking a more active role in assisting DHBs to manage their performance; for example, by working with management to implement recommendations arising from the Dunedin Systemic Assessment and with Mid Central regarding access to cardiac services.

The Ministry of Health has a Monitoring and Intervention Framework which comprises three levels of Ministry monitoring and intervention (plus a special category) and two levels of Ministerial intervention. Of the 20 DHBs:

- 13 are on standard monitoring
- one is on Performance watch (Taranaki DHB)
- five are on intensive monitoring
- one is on single event monitoring (Canterbury DHB following the recent earthquakes).

DHBs also will be supported in their task by the Health Quality & Safety Commission, which investigates and disseminates instances of clinical best practice. The incidence of adverse medical events and their costs will be reduced through the culmination of a large number of marginal quality improvements. The Commission's board has identified the reduction of adverse events as capable of yielding a compounding $10 million annual reduction in costs to DHBs.

- [6] The Minister of Health is required to report back to Cabinet on DHB [6] operations in October 2012 (CAB Min (09) 37/13-15 refers). The policy work for this report is underway [6]

- **Reviews and evaluations of Ministerial Review Group (MRG) reforms** - The Ministry will produce reports on some of the changes recommended by the Ministerial Review Group. An example is the report back to Cabinet by July 2013 on changes to the National Health Committee (NHC) including the management of the budget for new services and statutory regulations for the referral of new treatments to the NHC (CAB Min (10) 23/4B refers).

- **effective management of litigation** – The Ministry will continue taking a proactive and pragmatic approach to manage the risks of litigation before proceedings are filed. In the event that proceedings are filed, the Ministry will continue to actively work with Crown Law to ensure that costs are kept reasonable and a commercial approach is taken to the resolution of any litigation.

- **limited new policy initiatives** – By making targeted adjustments to the settings of the health system, we can enhance the way that services work together.

62. Significant changes in services require the approval of the Minister of Health, particular scrutiny is given to those service changes that impact on personal front line services delivered to individuals. DHB draft Annual

Plans that do not comply with Government expectations will be returned for improvement and resubmission.

Section 5: Baseline capital expenditure

Non Departmental Capital: see Appendix 1 for details of departmental capital, including Treasury Table 5, and Appendix 2 for tables containing new non-departmental capital investments for 2012 and non-departmental capital investments likely to require funding in out years.

63. Within current policy settings, there are three key performance improvement strategies identified by the Ministry to address Crown capital funding pressures (for DHB hospital-based services) that arise as a consequence of the impacts of demographic growth/service demand pressures and the need to replace current assets at higher than historic cost. The key performance improvement strategies are to:

    - slow demand growth
    - improve efficiency and productivity within the existing hospital configuration
    - fully utilise the existing network of available assets.

64. These performance improvement strategies are managed and delivered through moderation and central approval processes, and before DHBs can secure access to any material capital funds to implement capital intentions. These processes include: the District Annual Plan (DAPs)/Regional Service Plan (RSP) approval processes, the Capital Investment Committee (CIC) review process for Business Cases along with individual DHB performance improvement work.

65. These strategies are underway to address the Crown's capital funding challenge; and to effectively moderate DHBs' capital intentions. It is indicatively estimated that these strategies could reduce the size of the capital affordability challenge by up to $1.0 billion over a ten year period, and this plan includes an assumption of a $400 million saving relative to DHB Asset Management Plan intentions over the next four years.

66. As part of these three performance improvement strategies the Ministry will also be encouraging DHBs, in conjunction with Treasury's National Infrastructure Unit (NIU), to consider innovative solutions including the use of private operators and private public partnerships (PPPs). The Ministry has started its development of a work programme, in consultation with NIU, to build central and DHB capacity and capability to support PPPs. This includes the use of market soundings for PPP feasibility for all new business cases. Transfers of activity to private operators or to PPPs could potentially add to the $1.0 billion of indicative Crown capital funding savings over the next ten years.

67. In setting budget intentions for this four year plan we have assumed that we can realistically make $400 million of savings over the four years, relative to DHBs' current Asset Management Plans. DHBs requirement for Crown capital for individual projects from their 2011 Asset Management Plans indicatively sum to [10] for these four years. Netting out savings of $400 million as a result of assumed moderation and approval

process and the [10] residual Health budget leaves a capital requirement of [10] . This requirement is also in line with CIC's earlier estimates of a long-run need for $200 million capital funding allocation per annum, to ensure that the level of capital investment is aligned with the delivery of Crown funded service levels. This investment level is affordable from expected revenue growth across Vote Health, and also includes due allowance for the prior two years where limited capital was allocated to Vote Health.

68. Prioritisation by CIC will be made to balance the needs of the growing population in Northern region with the need for replacement of some South Island (and a few Auckland region) facilities. This prioritisation process will be completed by CIC by 30 June 2012 through an assessment of DHB's business cases and strategic assessments for all capital pressures that have been identified as commencing in 2012/13.

69. The phasing of this [10] requirement will depend upon a number of factors still to be worked through, including:

- which projects are seen as being of highest priority
- [10]
- [10]
- which projects might be suitable for private development or PPPs

70. We have tentatively allocated the capital funding as [6]

Part of this could be done as private or PPPs. As an example of prioritisation this would allow the CIC to use the residual health envelope to address the more critical facility refurbishment problems, approve Christchurch redevelopment and commence work on a Northern region capacity increase.

71. Policy development is also currently underway to support the performance improvement strategies outlined above to limit capital funding pressures. This work is focused on the development of an incentives regime that encourages investment in primary and community service providers in order to limit acute demand and more effective management of chronic conditions within primary and community service provider settings; thus limiting the need for additional hospital capacity in the future.

72. We note that if there was no new additional capital available DHBs would be asked to rethink their capital intentions to remain within a zero funding path. In order to ensure realistic plans are developed DHBs will need to know if there will be capital at the end of this period or not as the solutions would be different for a temporary or permanent freeze.

6. **Non-departmental capital expenditure**	**$m increase/(decrease)**				
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**
[10]					
[10]					
[10]					

Section 6: Further options

73. Section four dealt with the specific actions we intend to undertake in order to deliver a lower level of future funding. This section looks at the types of decisions which may be needed in the short term event of an even lower funding path or in the event that a further shock occurs to the wider economy.

74. In the medium term a number of the further options will be the subject of detailed policy work and consideration, as the longer term cost of services will present a bigger challenge to meet growing demands as the population ages.

75. Initiatives to improve productivity are underway, with each one percent yielding in excess of $120 million. At some future point, the scope for further productivity improvement may be such that further measures are needed. The Ministry is not recommending any significant policy changes at this time. Expectations of a lower growth path in funding have been sent to the health sector.

76. There are essentially three ways in which the cost to the Crown can be reduced in the medium to long term:

    - reduce the unit cost of services
    - reduce the demand for services
    - replace public funding with private funding.

Reducing the unit cost of services (savings typically seen in the medium term)

77. This can be achieved through more efficient purchasing of services, involving clinicians in the design of more efficient models of care, and by achieving economies of scale through greater centralisation of some services. Initiatives undertaken or underway in this space include:

    - analysis of the most effective configuration of services at national, regional, and local levels (such as for paediatric oncology and neurosurgery)
    - centralised capital, workforce, and IT planning functions under the direction of the National Health Board
    - forming a single Southern DHB from Otago and Southland DHBs
    - Health Benefits Limited organising shared back office functions for DHBs
    - merging the Health & Disability Commissioner and Mental Health Commission
    - PHARMAC centrally purchasing pharmaceuticals for DHBs
    - re-forming the National Health Committee to improve value for money and fiscal sustainability through advice on the cost effectiveness of new technology and interventions, prioritisation, and disinvestment

- the development of Integrated Family Health Centres (IFHCs), which bring primary health services together
- the recent disbanding of the Crown Health Funding Authority.

78. Further initiatives that could be explored, include:

- [6]

- [10]

- publically reporting on performance indicators to encourage lower performing providers to improve their performance
- investigating and managing unexplained variations in performance and service delivery costs nationally
- [10]

Reducing the demand for services (savings typically seen in the long term)

79. Prevention initiatives and shifting health intervention from relatively more expensive hospital care to earlier care in the community are examples of demand reduction.

80. Further initiatives that could be explored, include:

- further integration of services to promote continuity of care, which reduces the cost of multiple clinical and administrative transactions, while reducing the harm arising from multiple handovers between treating clinicians
- encouraging the development of clinical networks to, similarly, reduce the number of transactions and streamline necessary handovers (to reduce the chance errors)
- introducing new workforce roles (such as the practice assistant in Primary Care) and expanding scopes of practice.

Replacing public funding with private funding (savings typically seen in the medium to long term)

81. This could occur through greater use of contestability, use of private insurance, co-payments or replacing universal coverage of some services with more targeted public provision based on income or health need.

82. Potential initiatives which could be explored, include:

- increasing user costs for items currently free or subsidised (eg, increasing the co-payment for filling prescriptions by $0.50 would reduce DHBs costs by about $10 million)
- restricting free or subsidised services to those with high need or low ability to pay

Making choices

83. Decisions about which options to take need to weigh the potential benefits against the sector's ability to manage any given level and pace of change, and ultimately the impact on service provision and health outcomes. Key enablers to success include:

    - a sound policy base
    - clear expectations
    - clinical leadership
    - a culture of performance across the sector, including: DHBs, NGOs, and key agencies such as Health Benefits Ltd, the Health Quality & Safety Commission, and the National Health Committee
    - mutually supporting initiatives across government.

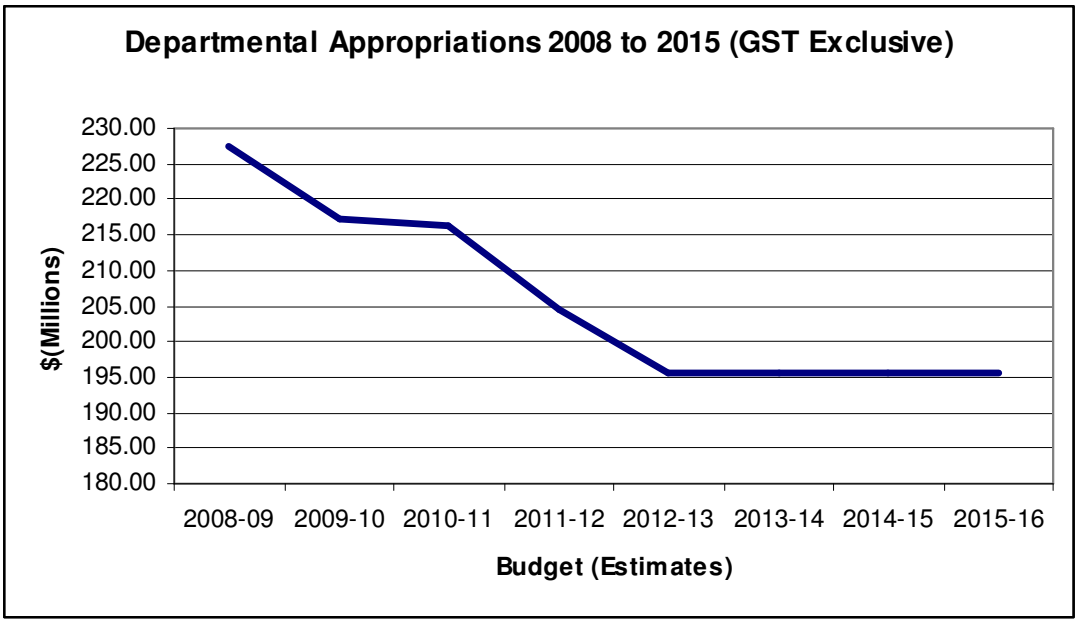
84. Getting all of these factors aligned is a prerequisite for effective delivery of change to a complex system, which is one of the largest parts of the New Zealand economy.

Appendix One: Departmental Four-Year Plan

85. In the main document, information on the Ministry's departmental intentions is aggregated with information on the Ministry's non departmental intentions. This appendix is intended to address this by providing the relevant information for the Ministry's departmental intentions over the next four years.

Direction of change

86. The Ministry's departmental baseline has been significantly reduced in recent years, reducing by $11.3 million (5 percent) between Budget 2009 and Budget 2011. A further reduction is proposed in Budget 2012. In line with Government's drive for improved value for money and the shift of resources to frontline services, it was proposed in Budget 2011 to reduce the Ministry's departmental baseline by $8.9 million (about 4 percent) to $195.690 million from 2012/13. In additional, the State Services Commission will no longer be funding the Ministry's $2.3 million of superannuation costs. The net result is a reduction in funding of $11.2 million, which will be achieved through tight control over travel costs and over the cost of consultants and contractors.



87. Significant investment in departmental capital is planned for 2012/13 and out years ($80 million over four years) to improve the national health systems provided by the Ministry, thereby maintaining sector infrastructure and improving sector connectivity. Capital costs will be funded from the Ministry's depreciation, while operating expenses will be absorbed through efficiency gains. No additional departmental capital is sort, and no departmental capital decisions are required as part of the Budget 2012 process.

Priorities and planned achievements

88. These are the same as those for the wider sector. They are currently articulated in the Statement of Intent and the Ministry's recent Briefing to the Incoming Minister will provide further information on the direction of travel. The Ministry contributes to sector outcomes by setting performance expectations and providing monitoring services. It also provides a range of services directly including payment services, sector IT, and purchase of health services (including clinical training and disability support). We also provide advice to the Minister.

89. The Statement of Intent describes proposed achievements over the coming years. A major series of achievements will be in providing the sector leadership needed to deliver better health services on a reduced sector budget in real terms.

Pressures

90. Around 60 percent of the Ministry's costs are personnel costs. These will continue to increase at around 1.5 percent a year in line with other state sector wages. These will need to be managed through efficiencies elsewhere.

Proposed Changes for 2012/13 to 2015/16

91. Efficiency savings will arise from the Ministry continuing to take up all-of-government contracts lead by the Ministry of Economic Development. These will yield savings of $370,000 in the current year and are forecast to save the Ministry $600,000 in 2012/13.

92. Continued efforts to move the Ministry towards BASS[8] benchmarks will only yield significant savings from 2015 when the existing property leases in Wellington expire and an optimal solution is put in place for the majority of Wellington staff. Current Wellington property costs are $7.5 million per annum and the proposed changes may yield savings of $1 million per annum.

93. Proposed changes to Ministry outputs and costs entail making less use of contracted resource and doing more in-house. Achieving the necessary sector leadership and integration with less resource will require us to improve productivity and capability. Adoption of the proposals to improve policy capability[9] will assist with this.

94. Recently established ELT sub-committees with responsibility to deliver improved outcomes in a number of areas will also be key to success. An example is a committee to review how the Ministry purchases services and the results achieved from these processes. Early projects are underway and are part of the delivery mechanism for future savings described elsewhere in this paper.

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[8] Better Administrative Support Services initiative lead by Treasury.
[9] Treasury circular 2011/11

Departmental capital expenditure

95. As 1 June 2011, the Ministry of Health had capital assets with a net book value (NBV) of $37.37 million (original cost of $106.14 million). The Ministry's main capital investment is in IT hardware and software (NBV $28.7 million, original cost $87.7 million), the majority of which is used to support the Health sector.

96. Departmental capital investments to be funded from baselines from 2012/13 to 2015/16 have recently been the subject of a long term capital plan. The major proposed changes are disinvestment in the National Radiation Laboratory building in Christchurch and continued investment in sector IT systems to improve patient management.

97. We will also be refreshing the payment systems that pay over 100 million transactions a year on behalf of DHBs. Improvements in these systems have to potential to make considerable savings for DHBs (estimated at over $30 million a year) through reduced fraud and mis-payment. They will also mitigate a risk of failure of these systems due to age and enable ease of future change. Changes to the GST rate last year cost almost $1 million and several months to enact, while alterations to cater for the merger of two DHBs will cost over $1 million. Other systems changes to reflect changes in entitlement are also currently expensive and come with system performance risk.

98. All business cases considered by the Ministry are required to address whether the proposed service is to be provided in-house or outsourced. The Ministry makes use of both options, and expects to continue doing so. The option used for any new purchase will depend on appropriateness and cost implications.

5. Departmental capital expenditure	**Impact $m increase/(decrease)**				
	2011/12	**2012/13**	**2013/14**	**2014/15**	**2015/16**
a. Opening baseline funding available[7]	14.225	12.194	11.739	16.314	20.889
b. Depreciation funding	18.417	19.500	19.500	19.500	19.500
c. Sale of assets	0.059	0.045	0.075	0.075	0.075
d. Other (please specify)	-	-	-	-	-
e. Total baseline funding available	**32.701**	**31.739**	**31.314**	**35.889**	**40.464**
f. Capital investments funded from baselines	20.507	20.000	15.000	15.000	15.000
g. Closing baseline funding available	**12.194**	**11.739**	**16.314**	**20.889**	**25.464**

[9]

Appendix Three: Supporting tables

	Reprioritisation	**$ (millions)**					
Ref	**Description**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**Highest Out year**	**Rational and Benefits**
1	Māori Health - Whanau Ora	0.000	-0.091	-0.091	-0.091	-0.091	Savings from review of planned contracts and contracts coming due.
2	Crown Health Funding Agency	0.000	-1.700	-1.700	-1.700	-1.700	Legislation to be passed - target 31/03/12. Implementation being managed through Health Crown Entity Change Project Steering Group.
3	Mental Health Commission	0.000	-1.116	-1.116	-1.116	-1.116	Savings from the dissolution of the Mental Health Commission
4	Communicable Diseases	-7.440	-5.400	-5.400	-5.400	-5.400	Uncommitted funding to respond to communicable disease outbreaks – to be covered by the risk pool in future years
5	Public Health Services – Environmental Health - Uncontracted Funding	-1.486	-1.526	-1.526	-1.526	-1.526	Savings from short-term one-off contracts not required
6	Sanitary Works Subsidy Scheme	-16.104	-	-	-	-	This is a 10 year appropriation and the scheme is scheduled to finish in 2012/13, although there is a possibility that the scheme may go into out-years based on when the final approvals are granted.
7	Social Environments	-	-0.568	-0.568	-0.568	-0.568	The Social Environments funding is invested in services that complement and support healthy Physical Environments.
8	Immunisation - Reduced IT spending	-0.950	-0.950	-0.950	-0.950	-0.950	Savings due to: reduced spending on IT following major upgrade of the National Immunisation Register; lower vaccine prices; and tighter ordering and forecasting of vaccines, resulting in less stock being held.
	Immunisation	-0.200	-0.200	-0.200	-0.200	-0.200	The update of school consent forms is cheaper than anticipated due to lower quotes and not doing additional consumer testing.
	Total Immunisation	**-1.150**	**-1.150**	**-1.150**	**-1.150**	**-1.150**	
9	Emergency Services	-	-0.046	-0.046	-0.046	-0.046	Savings in the organ retrieval budget related to underspend in previous year.
10	Stroke foundation Guideline savings	-	-0.139	-0.139	-0.139	-0.139	Implementation of the Stroke guidelines is costing less than was expected.
11	Immunisation - Influenza Vaccine	-0.350	-0.350	-0.350	-0.350	-0.350	Savings following cheaper vaccine costs following tender process
12	Primary Care Services - Long Term conditions	-	-0.460	-0.460	-0.460	-0.460	Savings from ongoing underspend in long term conditions following devolution of actual budget and costs to DHBs
13	Hospital productivity initiative	-	-0.093	-0.093	-0.093	-0.093	This funding was for the hospital productivity initiative and $93,000 is uncommitted in outyears and available for reprioritisation
14	NZ Health Survey	-0.470	-0.145	-	-	-	Funding for NZ health survey - one off savings in 2011/12 and 2012/13.
15	Emergency Preparedness - storage reductions	-	-0.075	-0.150	-0.150	-0.150	Savings from review of supplies to be stored or maintained. Annual, non-cumulative, saving of $150,000.
16	Cancer Screening Services - Contract renegotiations	-	-0.300	-0.300	-0.300	-0.300	Savings from cheaper contract prices
	National Screening Services (Antenatal Downs)	-	-2.000	-2.000	-2.000	-2.000	Savings from underspend due to lower than forecast expected uptake.
	National Screening Services - uncontracted funding	-	-	-0.370	-0.370	-0.370	Savings from review of planned evaluation programme.
	National Screening Services - reduction in training services	-	-0.100	-0.100	-0.100	-0.100	Maturity of programmes will lead to a reduction in training requirements
	National Screening Services - Medical Radiology Technician funding no longer required training	-	-0.050	-0.050	-0.050	-0.050	This funding is used to recruit Medical Radiology Technicians in providers as part of the BSA Age Extension from 50 to 69 to 45 to 69 yrs. No longer required.
	National Screening Services	-	-0.100	-0.100	-0.100	-0.100	Online resources will lead to a reduction in hard copy printing
	Total National Screening	**-**	**-2.550**	**-2.920**	**-2.920**	**-2.920**	
17	Disability Support Services	-	-0.500	-1.000	-1.000	-1.000	[10]
	Disability Support Services (Day services)	-	-1.000	-1.500	-2.000	-3.000	[10]
	Total Disability Support Services	**-**	**-1.500**	**-2.500**	**-3.000**	**-4.000**	

Appendix Three: Supporting tables

	Reprioritisation	$ (millions)					
Ref	**Description**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**Highest Out year**	**Rational and Benefits**
18	Unutilised FFT/Demo	-	-0.559	-0.559	-0.559	-0.559	DHB Funder arm item
	Unutilised Risk Reserve	-41.712	-3.637-	3.000	-	-	Risk Pool Reduction
	Departmental Underspend	-5.000	-	-	-	-	
	Health workforce training & development	-32.000	-	-	-	-	
	National Mental Health Services	-5.400	-	-	-	-	
	Health Quality and Safety Commission	-	-1.500	-1.500	-1.500	-1.500	Back Office savings and programme revamp.
	Forecast 2011/12 Underspends	**-84.112**	**-5.426**	**-0.941**	**-2.059**	**-2.059**	
	Departmental Efficiency Savings	-	-8.900	-8.653	-8.653	-8.653	
	Removal of SSRS & KiwiSaver Revenue		-2.300	-2.531	-2.531	-2.531	
Total		**-111.112**	**-33.535**	**-28.452**	**-31.952**	**-32.952**	

	Cost of New / Increased Activities	$ (millions)					
Ref	**Description**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**Rational and Benefits**
1	Train 154 GPs i.e. 18 more	-	0.864	1.314	1.764	1.764	Train 154 GPs (18 more).
2	Electives to increase by 4,000 discharges per annum	-	12.000	12.000	12.000	12.000	Electives to increase by 4,000 discharges per annum of which 50 percent to be funded by DHBs leaving balance to be funded by Ministry. This is estimated to cost $15 million per annum. However, there is now an assumption that DHBs will improve productivity which will enable payment of the increased discharges to be made at below national prices.
3	Diagnostic System Change - Access to diagnostic to support cancer, cardiac and electives	-	4.000	4.000	4.000	4.000	Diagnostic System Change re Access to diagnostic to support: cancer, cardiac and electives for CT, MRI, Colonoscopy and Coronary Angioplasty waiting times.
4	National Cardiac Surgical, Acute Coronary Syndrome and Interventional Cardiology Registers.	-	1.750	0.750	0.750	0.750	National Cardiac Surgical, Acute Coronary Syndrome and Interventional Cardiology Registers.
5	Expanding the demonstrations of the New Model for Supporting Disabled People.	-	2.268	2.815	2.315	1.955	Expanding the demonstrations of the Ministry of Health's New Model for Supporting Disabled People. These expansions would occur in three related demonstration projects that all come within the overall new model framework: • the core elements of the new model in Western Bay of Plenty • individualised support in Canterbury, which is a joint initiative of the Ministries of Health and Social Development. This initiative responds to the impact of the Christchurch earthquake on providers and involves significant changes to the way that support is delivered • Choice in Community Living, which is being implemented in Auckland and Waikato, which is an alternative to residential services for people with disabilities.
6	Cancer Control - patient pathway co-ordination and other services	-	6.575	6.500	6.000	6.000	The funding sought assumes that DHBs will re-prioritise some of their existing funding to implement the indicators. Sustainable funding is required for: • patient pathway co-ordination and on-going operation of MDMs to embed well co-ordinated services that track patients and ensure 'blockages' are minimised leading to timely diagnosis and initiation of treatment with multi-disciplinary care • implementation of decision supports tools in primary care • information networks to encourage proactive patient behaviour and support patients to self-manage through the cancer care pathway • contribution funding towards service improvements to optimise existing services.
7	Expand Voluntary Bonding Scheme	-	1.000	1.000	1.000	1.000	Expand Voluntary Bonding Scheme
8	Boost telephone advice - new line service	-	1.500	1.500	1.500	1.500	Boost telephone advice - new line service.
9	Organ Donations	-	1.000	1.000	1.000	1.000	Funding of additional positions to facilitate increased organ donation rates.
10	Rheumatic Fever	-	3.000	3.000	3.000	3.000	
11	Youth Mental Services - Other Services	-	-	0.900	0.875	1.550	Funding for programmes to improve prevention and treatment services for young people with, or at risk of, mental health problems such as depression and anxiety.
Total		**-**	**33.957**	**34.779**	**34.204**	**34.519**	

Appendix Three: Supporting tables

Ref	Funding Pressures	$ (millions) 2011/12	2012/13	2013/14	2015/16	2014/16	Rational and Benefits
1	National Screening Services (Cancer Screening)	-	2.100	2.122	2.144	2.166	There is price pressure because the majority of staff are entitled to MECA rates.
	National Screening Services (Antenatal IV screening)	-	0.028	0.029	0.029	0.030	There is price pressure because the majority of staff are entitled to MECA rates.
	National Screening Services - Antenatal Down and other Conditions Screening	-	0.163	0.667	1.171	1.676	There is price pressure because the majority of staff are entitled to MECA rates. This is a new programme and not fully rolled out, so current uptake is relatively low. Consequently $2 million has been made available for reprioritisation from next year. Uptake is projected to increase as the programme is rolled out.
	National Screening Services - Universal New-born Hearing Screening	-	0.114	0.117	0.120	0.123	There is price pressure because the majority of staff are entitled to MECA rates.
	National Screening Services - New-born Metabolic Screening	-	0.047	0.048	0.048	0.049	There is price pressure because the majority of staff are entitled to MECA rates.
	Total National Screening	**-**	**2.452**	**2.983**	**3.512**	**4.044**	
2	Disability Support Services - Residential Care Community	-	13.577	14.198	14.683	15.185	The ageing of the disability population is resulting in clients presenting with more complex disabilities and technological changes are resulting in better survival rate of premature babies who may require more complex and higher levels of disability support. There are wage pressures and also cost pressures related to KiwiSaver and ACC policy changes. Volume pressures have been building as other funders tighten their access criteria.
	Disability Support Services - Community Care services	-	12.456	13.235	14.065	14.951	Volume growth as care is provided in the community and the disability population ages. More flexible service specifications and clients having more choice and control is also increasing pressure on residential care budgets. There is also wage price pressure.
	Disability Support Services - Environmental Support - Mobility and Sensory	-	4.881	5.076	5.279	5.490	Costs are increasing due to: technological changes, increasing housing modification costs, increasing freight costs, the ageing of the disabled population, and raising the eligibility age limit for children from 8 years to 15 years and under for access to spectacle subsidy.
	Total Disability Support	**-**	**30.914**	**32.509**	**34.027**	**35.626**	
3	Child Youth & Family Services - PlunketLine & WellChild Services	-	1.600	1.640	1.681	1.723	Staff and operational cost pressures and PlunketLine volume pressures - baseline growth is assumed to be 15 percent per annum.
	Total Child & Youth	**-**	**1.600**	**1.640**	**1.681**	**1.723**	
4	Ambulance Services	-	1.775	1.799	1.826	1.850	The Ministry part-funds ambulance services. In the last two years, although the funding baseline has grown in line with DHB funding growth for cost pressures, it hasn't fully compensated for volume growth. Overall demand is increasing, and there are also pressures to fully implement double crewing, which adds significantly to costs of service delivery.
	Emergency Services- Electronic Patient reporting	-	1.000	1.000	-	-	Contribution towards ambulance cost of introducing an electronic patient reporting system.
	Total Emergency Services	**-**	**2.775**	**2.799**	**1.826**	**1.850**	
5	Maternity Services (Section 88)	-	3.331	3.414	3.499	3.587	[10]
	Total Maternity Services	**-**	**3.331**	**3.414**	**3.499**	**3.587**	
Total		**-**	**41.072**	**43.345**	**44.545**	**46.830**	