Reference: 20150507

7 March 2016

Thank you for your Official Information Act request, received on 3 December 2015. You initially requested the following:

- *"- Copies of all presentations, briefings, reports, and aide memoires that discuss the social sector budget including pressures for 2016/17 since June 2015*
- *Copies of all presentations, briefings, reports, and aide memoires that discuss Vote Health since June 2015 including it as part of the social sector spending*
- *Copies of all presentations, briefings, reports, and aide memoires that discuss pressures in Vote Health since June 2015*
- *Copies of all presentations, briefings, reports and aide memoires that discuss the funding review and/or changes as a result, of Vote Health since June 2015".*

Subsequently you submitted a related request on 16 December 2015. Following discussion with Treasury officials, you agreed to combine the two requests into one as follows:

- *"Copies of all presentations, briefings, reports, and aide memoires that discuss the social sector budget including pressures for 2016/17 since June 2015*
- *Copies of all presentations, briefings, reports, and aide memoires that discuss pressures in Vote Health since June 2015, its inclusion as part of social sector spending, and early funding signals for Vote Health (including DHBs) in relation to Budget 16*
- *Copies of all presentations, briefings, reports and aide memoires that discuss the Ministry of Health-led funding review and/or changes as a result, of Vote Health since June 2015*
- *A description of the process for social sector budget bids for 2016/17 and the role Treasury is playing in this process, the role of deputy CEs in the process, is there an appointed board with Treasury that will be examining budget bids and/or spending priorities in context of social investment?*

Where information is withheld, I request you provide the title and date of the communication/document withheld, the reason for refusal and the grounds in support of that reason as required by section 19(a)(i) and (ii) of the Official Information Act."

On 19 January 2016 we extended the time limit for deciding on your request by an additional 30 working days.

Information Being Released

Please find enclosed the following documents:

Item	Date	Document Description	Decision
1.	1 June 2015	Letter to Murray Horn: Health Funding Review	Release in part
2.	14 August 2015	Health Strategy Review 2015	Release in part
3.	8 October 2015	Aide Memoire: Health Strategy: consultation draft	Release in part
4.	19 October 2015	Presentation: The Economic and Fiscal Context for Health	Release in part

I have decided to release the documents listed above, subject to information being withheld under the following sections of the Official Information Act, as applicable:

- personal contact details of officials, under section 9(2)(a) – to protect the privacy of natural persons, including deceased people, and

- advice still under consideration, section 9(2)(f)(iv) – to maintain the current constitutional conventions protecting the confidentiality of advice tendered by Ministers and officials.

Please note that in the documents, any reference to the Health Strategy Review is referring to the DRAFT Review. The Strategy is not yet finalised and specific decisions have yet to be made by Cabinet.

In response to your final question, please refer to the following and item 5 in the below table:

The Treasury assesses and advises Ministers on initiatives submitted by agencies. These assessments are informed by the initiative template, a CBA and a CBAx assessment along with any other relevant contextual documents such as the Four-year Plan.

The Treasury provides advice to Ministers on what it would recommend as a social sector package, informed by the assessments above and alignment with priorities. This is refined over a number of engagements with Ministers.
The Treasury does not have a deputy Chief Executive, so there is no role – we are unable to comment on the role of other agency deputy Chief Executives in the Budget process.

There is no appointed board but for Budget 2016 specific social sector initiatives were presented to the Social Investment Panel (this Panel is made up of range of people including NGO representatives and departmental science advisers). The Panel's recommendations will be provided to Ministers

Information Publicly Available

The following information is also relevant to your request and is publicly available on the Treasury website:

Item	Date	Document Description	Website
5.	22 October 2015	CBAx Tool User Guidance	http://www.treasury.govt.nz/publications/guidance/planning/costbenefitanalysis/cbax

Accordingly, I am declining your request for the document listed in the above table under section 18(d) of the Official Information Act – the information requested is or will soon be publicly available.

Information to be Withheld

There are additional documents covered by your request that I have decided to withhold under section 9(2)(f)(iv) of the Official Information Act – to maintain the current constitutional conventions protecting the confidentiality of advice tendered by Ministers and officials. Titles and dates of these documents are listed below, as you requested.

Item	Date	Document Description	Decision
6.	3 July 2015	Bringing Vote Health into the social sector Budget process	Withhold in full under s9(2)(f)(iv)
7.	24 July 2015	Aide Memoire: Meeting with Minister Bennett on Vote Health	Withhold in full under s9(2)(f)(iv)
8.	30 July 2015	Joint Report: Vote Health and Budget 16	Withhold in full under s9(2)(f)(iv)
9.	10 August 2015	Treasury Report: Social Investment Panel for Budget 2016	Withhold in full under s9(2)(f)(iv)
10.	9 September 2015	Aide Memoire: Budget 16: Cost Pressures	Withhold in full under s9(2)(f)(iv)
11.	20 November 2015	Aide Memoire: Managing baselines: update	Withhold in full under s9(2)(f)(iv)
12.	26 November 2015	Treasury Report: Managing Baselines: Cabinet paper	Withhold in full under s9(2)(f)(iv)
13.	4 December 2015	Aide Memoire: Bilateral meetings on B16 cost pressures	Withhold in full under s9(2)(f)(iv)

In making my decision, I have considered the public interest considerations in section 9(1) of the Official Information Act.

Please note that this letter (with your personal details removed) and enclosed documents may be published on the Treasury website.

This fully covers the information you requested. You have the right to ask the Ombudsman to investigate and review my decision.

Yours sincerely

Ben McBride
Manager, Health

Information for Release 20150507

IN-CONFIDENCE

1 June 2015

Dear Murray

Treasury comments on Health Funding Review

Thank you for providing us with a draft of your report to comment. We have also appreciated the opportunity to talk with you as you were preparing the report.

We have provided general comments on the paper, with more detailed comments focused on the core elements of your model: "four buckets, many funds".

General comments on the paper overall

Overall, the paper is ambitious, proposing fundamental changes to the way the health system is funded and organised. It is also likely to be significantly more expensive than the current system, at least in the short term – e.g. from the proposal of a rehabilitation fund (and other funds), which is essentially an expansion of ACC to cover illness, to duplication and overhead from having competing bidders. The cost and practical implications of many of the proposals (of which the paper is largely silent) may limit its value to Sue Suckling's capability and capacity review and the Ministry's development of the health strategy, but would make a useful contribution to the Social Sector Board's consideration of cross cutting social sector issues.

We agree with the high-level problem definition: (i) lack of transparency about results; (ii) concerns about sustainability; and (ii) inequality. We also agree with the proposal to base accountability on results and shift to a "tight-loose-tight" model (where provider capacity allows).

We also support the intent of moving away from a provider dominated towards a more patient centric system; however this seems incongruous with the significantly increased centralisation that would result from the proposals in the paper.

The paper is quite long and discursive. It would benefit from a good executive summary and specific recommendations. With a number of proposals throughout the paper, it would be useful to provide a high level sense of how you would prioritise amongst (and sequence activities to implement) them. It would also be useful to link recommendations to relevant literature and evidence, to supplement experience from ACC and electives.

Capacity and capability at all levels of the system (including the Ministry) would be critical to making this sort of model work. It will be important to understand how this paper links to Sue

Suckling's work, as well as the wider health strategy. We think it would be challenging to implement this sort of model given current capabilities.

The overall model: "four buckets, many funds"

The model relies heavily on clarity about results (what we want, how we will achieve it, how we will measure it). We support a focus on results, but we are not confident that the necessary infrastructure is currently in place, and we are less optimistic that it will emerge of its own accord under the proposed model. A robust results framework does seem to us like a precondition - the paper is overly dismissive of this point (p20) given limited and narrow NHB monitoring over the last 5 years. Furthermore, we do not think that either the Ministry's existing indicators or the Treasury's monitoring framework is sufficient. Similar questions arise about Ministry capacity regarding "bidder qualification" and "plan assessment".

It would be useful to have a fuller discussion of the literature / evidence regarding payment-by-results in the health sector. Whilst intuitively sympathetic, we are mindful of the comments of the IPIF expert advisory group on this point. Our own reading of the literature suggests that evidence of effectiveness is mixed, and that performance monitoring / reporting (including feedback loops for clinicians) are also important. In addition the comment about officials "developing options" to make up service shortfalls when milestones are missed seems important (and hard).

The criticisms of capitation in general, and PBFF in particular, seem overstated. It might be worth quantifying the extent to which the various PBFF adjusters (along with the minima and maxima) actually move funding away from a pure PBFF distribution. Our understanding is that the impact is generally quite modest, with the biggest issue being the impact of the minima on the funding position of two or three slow/no growth DHBs. In addition, while the PBFF is used to determine a DHB's funding, no monitoring is carried out to determine whether DHBs have allocated funding to those population groups.

Is there any evidence about the impact of contract length on investment? How do we know that longer contracts would lead to self development by providers, rather than to status quo with longer contracts? Is there no theoretical basis for central investments in "provider development" (e.g. to mitigate the hold-up problem)?

On the specific buckets

Core services: The ideas about IDF clearing house and central contracts for clinicians look interesting. It would be useful to better understand the current drivers of IDFs and to look at the evidence of public willingness to travel for faster services (we understand this has been tried in the past). Also, for primary care, the proposal to reduce the capitated subsidy (increase the general level of co-payments) in order to fund targeted support and access incentives also seem worth exploring.

The paper highlights the fact that relatively inflexible operating costs for slow / no growth DHBs gives them limited headroom to invest in primary or community care. This seems like a

key challenge to rebalancing the sector. It is not clear what the strategy is to deal with this issue under the proposed model. Does it just involve waiting until it is demonstrably impossible to maintain quality services or facilities need replacing? That might result in a sub-optimal distribution of services over time (based largely on the most recent investments), with risks to patient care in the meantime. An alternative scenario to services being gradually decommissioned as they become untenable, is one of service or facility failure followed by a backlash and a funding injection.

Government priorities: We agree that there is value in making these expenditure decisions explicit - although we are not convinced that this bucket should necessarily grow in relative importance over time. It would be worth addressing directly the question of tradeoffs between these priorities and overall health outcomes, and mechanisms to make those tradeoffs transparent to the public.

Health investment fund and social investment funds: These two funds would be central to the change envisaged under the proposed model. For the social investment fund, in particular, there are similarities with some of the existing cross-agency "social investment" work being co-ordinated by the Social Sector Board. If you have not done so already, it would be worth discussing these proposals with the Board before finalising the paper. More detailed comments follow:

- The timing of savings is important. If fiscal savings are for the long term, this makes top-slicing problematic in the short term. This means fiscal costs, with tradeoffs against other priorities.

- The paper is optimistic that will a wide range of providers will be ready to compete for funding from the social investment bucket. This may not be justified in the short term. Experience from the Budget 2015 RFI process was that there were few well developed proposals linked to results that could be funded and implemented.

- At a practical level, we think the paper overstates the level of insight that actuarial modelling gives ACC about its fundamental cost drivers or how to control them, as reflected in its performance. In general, the report needs a more critical understanding of ACC: ACC has conceded that it does not know why rehabilitation performance has declined, and it does not know why claims are increasing. Contrary to the statement in para 8, ACC has acknowledged that there is considerable scope for improvement in the outcomes it gets from elective surgery (as noted in recent Financial Conditions Reports, and which the elective services pathway programme is trying to address). ACC's accounts (workers, earners, etc) have been criticised by employers for constraining ACC's approach to rehabilitation, as has its bulk funding of DHBs (by ACC, who is looking to contract with DHBs directly).

- More broadly, as you know, we are not convinced that long-term fiscal savings will always be the correct conceptual starting point for "investment" initiatives, although it may be relevant for specific areas of spend (e.g. employment programmes in welfare,

rehabilitation in ACC). This is particularly important if the intention is to grow these buckets over time relative to the core services bucket: broader measures capturing health and social (as well as fiscal) outcomes would become increasingly important.

- As the paper acknowledges, a key issue will be how to implement this model in an information poor environment. The "generic approach" to resolve this assumes clarity about target populations and results, but these issues are at the heart of the problem. In other words, does the generic approach solve the information problem or describe it?

- On the specific issue of treatment injury: for many providers, the Crown will be the ultimate funder of these services anyway. In that context, to what extent would levies for treatment injury actually change incentives for providers / practitioners? This is another area where more detailed discussion, including of the international experience regarding treatment injury, might be useful. Our understanding (confirmed with ACC) is that there is little to no evidence that financial incentives reduce the incidence of adverse events, but there is evidence that they contribute to an increase in the practice of defensive medicine and discouragement of an open learning environment.

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THE TREASURY
Kaitohutohu Kaupapa Rawa

Treasury Report: Health Strategy Review 2015

Date:	14 August 2015	Report No:	T2015/1902
		File Number:	SH-1-6

Action Sought

	Action Sought	Deadline
Minister of Finance (Hon Bill English)	**Read** prior to your meeting with Hon Coleman and Murray Horn.	Meeting on 18 August.
Associate Minister of Finance (Hon Steven Joyce)	None. For information.	None.
Associate Minister of Finance (Hon Paula Bennett)	None. For information.	None.

Contact for Telephone Discussion (if required)

Name	Position	Telephone		1st Contact
John Marney	Principal Advisor, Health	04 917 6151 (wk)		✓
Ben McBride	Manager, Health	04 917 6184 (wk)	*Withheld under s9(2)(a)*	

Actions for the Minister's Office Staff (if required)

Return the signed report to Treasury.

Enclosure: No.

Treasury Report: Health Strategy Review 2015

Executive Summary

You are meeting Hon Coleman and Murray Horn next week to discuss Murray's funding review. This was one of two independent reports commissioned as part of the process of updating the Health Strategy, the other being the capacity and capability review led by Sue Suckling. This note provides you with an overview of these reports and the draft Strategy. We also provide some talking points for the meeting (see appendix).

Murray Horn's report recommended a number of changes intended to shift the health system towards a contestable funding model, improve planning processes and encourage an investment-style focus on longer-term value. We do not think it provides a blueprint which could be implemented across the sector quickly, but there are some useful ideas that can be considered *Withheld under s9(2)(f)(iv)*

The report by Sue Suckling et al focuses mainly on governance and leadership in the health sector. It emphasises a collaborative, managed approach, which is somewhat at odds with the essentially competitive philosophy underpinning the funding review.

The Health Strategy itself (which is still subject to revision) includes ideas from both these reports. It is ambitious in terms of the scope and scale of the issues discussed, although there are relatively few concrete proposals, making it difficult to form a view about whether it will translate into a meaningful programme of change for the sector. One discernible theme is the consolidation of functions within the Ministry of Health. We think this may contribute to a lack of challenge within the sector. *Withheld under s9(2)(f)(iv)*

Recommended Action

We recommend that you note the contents of this report and discuss with Hon Coleman and Murray Horn:

- the extent to which Hon Coleman has brought the sector with him in developing the new Strategy, and risks around the four-week consultation window;
- Murray Horn's perspective on the social investment agenda, and challenges facing the health sector more generally;

- how much change Hon Coleman wants to see in the sector, and which essential reforms he wants to focus on first; and
- *Withheld under s9(2)(f)(iv)*

Ben McBride
Manager, Health

Hon Bill English
Minister of Finance

Hon Steven Joyce
Associate Minister of Finance

Hon Paula Bennett
Associate Minister of Finance

Treasury Report: Health Strategy Review 2015

Purpose of Report

1. This note briefs you on the progress of the Health Strategy refresh and the two supporting reviews (funding, and capacity and capability), in advance of your meeting with the Hon Coleman and Murray Horn on 18 August. Suggested talking point for that meeting are appended. Note that the Minister of Health will shortly seek Cabinet's approval to release the draft strategy for public consultation.

Summary of the reviews and draft Strategy

Funding review (Murray Horn)

2. Murray Horn's report sets out a series of recommendations intended to move the system from a funding model based around provider costs to once that rewards providers for delivering value. He notes that existing planning processes are largely an administrative exercise and not well connected to the delivery of results (value) for consumers. To address this, the report proposes a more contestable funding environment for providers, including District Health Boards (DHBs). Murray is sceptical about the ability of funders to correctly specify in advance the types of activities, service models, and performance indicators needed to deliver improved health services. Instead, these would be developed by providers and specified in the plans submitted to secure funding. For plans that were approved, some funding would remain contingent on the achievement of milestones.

3. His report also recommends the creation of four separate funding pools:

   - A social investment pool for initiatives with benefits that are largely produced and/or captured by the wider social sector – seeking to align with your stated ambitions in this area. The fund would be funded by top-slicing social sector Votes. Non-injury rehabilitation services and mental health services are suggested as possible candidates.
   - A health investment pool for initiatives that benefit individuals and improve the long-term sustainability of the health system. Treatment injury and long-term conditions are suggested.
   - A government priorities pool, to make funding for these available but transparent.
   - A foundation services pool. This is the residual and would account for the lion's share of funding. The review puts forward a number of suggestions to get more value from this spend, These include: a clearer definition and monitoring of results (including completion of the IPIF); a clearing house for inter-district flows to reduce costs and make better use of existing capital stock; national employment contracts for specialist clinicians; and reforms to primary care funding to improve access and refocus subsidies on low-income and high-need clients.

4. Although the report sets out a "generic model" for introducing investment-style concepts to the health system, we think a lot of detailed policy work would be needed to give these ideas traction. The proposals to introduce contestability to provider (and particularly DHB) funding are interesting but not something that we think could be implemented quickly across the system as a whole. *Withheld under s9(2)(f)(iv)*

Withheld under s9(2)(f)(iv) This is not inconsistent with Murray Horn's advice, which envisages the investment pools operating initially at the margins of the system.

Capacity and capability review (Sue Suckling et al)

5. The authors of this report identify the main issue across the system as being variability in capability and a general lack of strong governance, leadership and technical managerial skill. In contrast to the more competitive arrangements suggested by Murray Horn, they favour a collaborative operating model for the health system under the overall leadership of the Ministry of Health.

6. One key theme in the report involves strengthening the Ministry's hand and consolidating the authority of the Director General. Specific recommendations include:

   - putting various Ministerial Review Group (MRG) entities (the National Health Board, the National Health Committee, the National Health IT Board and Health Workforce New Zealand) under the Director General rather than the Minister.

   - giving the Director General a role in influencing the performance-related compensation of DHB Chief Executives.

   - reducing the number of elected members on DHB boards, with appointed majorities.

7. Another (somewhat related) theme is the need to increase collaboration in the sector, with less fragmentation and duplication. The report recommends that the Ministry leads (funds) the sharing of best practice and the roll-out of service and technological innovation. It also recommends that that National Health IT Board implements a national eHealth record and sets minimum standards. The report suggests increased investment in collaborative leadership development and proposes various cross-sectoral pilot projects in Northland and Auckland.

8. The report also recommends rebalancing the health system away from secondary/hospital care. Proposals include addressing financial incentives to use secondary rather than primary care, eliminating legislative restrictions to scopes of practice, and increasing the stability of funding for NGO providers.

The Health Strategy

9. The Health Strategy itself is still being regularly redrafted. The most recent cut included proposals from both the funding and the capability and capacity reviews, although it could not be described as a synthesis of the two. Neither the Strategy nor the accompanying draft Cabinet Paper systematically analyse the detailed recommendations emerging from those reviews, so it is not always clear which have been accepted and which definitively rejected.

10. The Strategy sets out seven areas of focus. The discussion is mostly quite high level, setting out the direction of travel for the next ten years, rather than a detailed action plan. The seven focus areas are:

    - Living well in health communities. The discussion refers to measures to tackle obesity and increase integration.

    - A good start for families and whanau. This section references stronger community links, coordination, better use of data, and measures to improve workforce capability.

- Partnering with people. Proposals include better information for patients and their families, new service models to improve access, a shift towards primary and community services.

- Working together in a high-trust, high performing system. The main proposals here are the introduction of a new "health investment fund" (from Murray Horn's report), better and more transparent information , and an outcomes-based accountability and performance management framework.

- Building leaders and capability for the future. This section discusses leadership at management and board levels and capacity planning. There is a proposal to look at regulatory and legislative settings to create a more flexible workforce (from Sue Suckling's report).

- Fostering and spreading innovation and quality improvement. The to-do list here includes creating new ways of sharing information and changing performance management systems to put quality and safety alongside other dimensions of system performance.

- Best use of technology and information. There will be an updated eHealth strategy (per Sue Suckling's report), better analysis of existing data, and more information sharing.

Discussion

11. The Health Strategy is pitched at a high level. This is understandable, but it does make it difficult to form a clear view about how the medium-term strategic direction for the sector is likely to crystallise in practice. We understand that Minister Coleman wanted a road map of implementable 5 year actions. It is doubtful whether the Strategy really provides this. Much of the content is fairly anodyne. The key points from our perspective are set out below.

Timing for consultation

12. The proposed timeframe for consultation is only four weeks. There is some risk of a negative reaction from this sector to this very short window, which is not really necessary and may restrict the scope for substantive engagement. The Minister of Health considers the risk to be partly offset by extensive engagement to date. On the other hand, expectations in the sector have been raised, and we have encountered some frustration about the limited opportunities to engage with the reviews by Murray Horn and Sue Suckling.

Centralisation of control

13. The new Strategy would strengthen the role of the ministry of Health vis-a-vis the sector, as a way of managing the system. Specific proposals include disbanding the National Health Board and the National Health Committee as independent advisors to the Minister of Health. These changes are consistent with the recommendations of the capacity and capability review. It is not clear at this stage what will happen to the National Health IT Board, Health Workforce New Zealand, or whether the proposal to give the Director General discretion over the performance related pay of DHB chief executives will also be adopted.

14. The specifics of the post-MRG institutional landscape reflected the preferences and working style of the previous Minister of Health. It is not surprising that the new Minister wishes to make changes, and we think changes at the centre along the lines

proposed will limit the level of disruption for the sector as a whole. However, the following points are worth noting:

- In our post-election advice, we noted that New Zealand's light touch regulatory regime, and the location of administrative, monitoring and policy functions within a single Ministry, created conflicts of interest and contributed to a lack of contestability and challenge within the system, with weak incentives to identify, highlight and address areas of concern. The proposed changes will not address this.

- We also noted that commissioning and longer-term planning functions were underpowered, and that there was a case for greater operational autonomy in this area. Again, it is not clear the consolidation of relevant functions within the Ministry of Health will address this.

- Replacing independent advisory committees with bodies that report to the Director General may weaken incentives for experienced people to accept these roles and restrict the Minister's access to contestable advice.

- While a strong and effective Ministry of Health is important, there are some effective DHBs that should be appropriately enabled to make the changes needed to improve the health system and meet the challenges it faces, as well as advancing your social investment agenda. Again, this was a theme in our post-election briefing, which recommended greater levels of autonomy for successful DHBs, with performance management by the Ministry focusing on outcomes.

Withheld under s9(2)(f)(iv)

Performance management and accountability

18. Our post-election briefing emphasised the need for a stronger performance management framework in the health sector, focused on outcomes and supported by robust accountability arrangements. The Health Strategy takes up these themes,

which is encouraging; but it is light on detail. We understand that a decision has been made to abandon the integrated performance incentive framework (IPIF), which was only introduced last year. We are not sure why this decision was made, or whether there has been any robust analysis of the shortcomings of the IPIF. So at this stage, it is difficult to know whether the new arrangements will be more effective. There certainly seems to be some risk that a lot of time and effort is wasted repeating work that has already been done, without making real progress towards a robust outcomes framework. A number of individual DHBs are already ahead of the Ministry of Health in this regard, having developed and implemented their own frameworks in the absence of leadership from the centre.

Rebalancing the system and reducing inequalities

19. The strategy refers to the need to address inequities in health outcomes and rebalance the system towards primary and community settings and long-term conditions. We agree with the sentiment, although we are not sure what specifically is proposed to make progress in these areas. This has proved challenging in the past, particularly in low-growth DHBs with a high proportion of fixed costs in their secondary system. Murray Horn's report suggested recycling some capitated funding towards low-income and higher-need groups. We have already discussed with you (in general terms) the possibility of changes to the Very Low Cost Access scheme. You may want to raise this with Hon Coleman.

Implementation strategy

20. The Strategy sets out a large number of (high level) actions. These cannot all be implemented properly at once. The Strategy has little to say about the relative priority of these changes, or about sequencing and dependencies. This will need to be properly worked out if the Ministry intends to translate the Strategy into an effective change programme. We suggest that the Ministry report back on their implementation plans following their consultation with the sector.

Capital

21. The Strategy makes no mention of capital pressures facing the sector despite significant demand for additional Crown capital over the coming decade, and the fact capital investments lock in operating model for a long time. We are also unsure what is proposed in relation to the Capital Investment Committee, which we think has made an effective contribution over the last five years.

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Appendix

Talking points for meeting with Hon Coleman and Murray Horn

- The funding review looks at some of the issues government is currently grappling with and makes a useful contribution to our thinking - specifically on:
  - working across sectors,
  - increasing the focus on long-term value, and
  - increasing contestability between providers for funding.
- *Withheld under s9(2)(f)(iv)*
- The funding review identifies some problems with DHB / provider planning processes:
  - it is primarily, an administrative / compliance activity unrelated to the day-to-day business, and
  - it focuses mainly on cost rather than value.

  How will the Health Strategy address these issues? Is there any mileage in the idea of some contestable funding for DHBs, for example?
- The Strategy proposes a number of changes to post-MRG institutions. What actions are planned under the new arrangements to improve planning, prioritisation, and management or risk? Does Hon Coleman have any concerns about his access to advice from outside the Ministry?
- The Strategy raises some familiar themes – rebalancing toward primary / community settings and addressing health inequalities. These are important issues but it has been hard to make progress on them in the past. What are the game changers in the Strategy?
- The funding review discussed possible options for re-targeting primary care funding towards low-income, high-need groups, to address health inequalities. What's the plan here? How about a baseline review of the VLCA scheme?
- The funding review also recommends clearer definition of results and completion of the sector performance framework as levers for delivering value. How will these issues be progressed under a refreshed Health Strategy?
- The Strategy is inevitably broad in scope and pitched at a high level. What is the level of ambition for change. What are the priority areas for action? *Withheld under s9(2)(f)(iv)*

IN-CONFIDENCE

THE TREASURY
Kaitohutohu Kaupapa Rawa

Reference: T2015/2367 SH-1-6

Date: 8 October 2015

To: Minister of Finance (Hon Bill English)

Associate Minister of Finance (Hon Steven Joyce)

Associate Minister of Finance (Hon Paula Bennett)

Deadline: For SOC on 14 October 2015.

Aide Memoire: Health Strategy: consultation draft

The Minister of Health will be bringing a paper to SOC on 14 October seeking agreement to release draft Health Strategy documents for public consultation. Advance copies were circulated to Ministers' offices at the end of last week, although we expect a few (relatively minor) changes in the versions that go to SOC.

The discussion in the Strategy documents is organised under five broad themes (more on these below). The main document focuses on the high-level narrative and long-term (10-year) goals. Medium-term (five-year) objectives and 20 specific action points are set out in a separate Roadmap.

Overall, we think these documents cover the right ground and create an opportunity for positive change in the sector. There is quite a lot of alignment with the Treasury's post-election briefing on health, particularly around the need for stronger performance management and a greater focus on outcomes for high-need populations. We recommend that you support the release of the Strategy documents for public consultation. The window for responses is still quite tight (six weeks, from 26 October to 4 December), but not unreasonable.

There are references throughout the documents to the hot-button social sector policy issues: analytics, segmentation, investment, outcomes, and cross-sector engagement. While the narrative is plausible, the underlying analysis is currently pretty light. The extent to which these ideas will really gain traction, within the Ministry and across the sector as a whole, remains an open question at this stage.

No real structural changes are proposed, apart from some consolidation of advisory functions within the Ministry of Health. Some ideas have been incorporated from Murray Horn's funding review and Sue Suckling's review of capability and capacity. The Productivity Commission's recent report, *More effective social services*, is also referenced, although its proposal for "District Health and Social Boards" has not been

picked up. Although the level of ambition in the Strategy is generally quite modest, delivering the vision articulated will nevertheless require a step-change in capability of the Ministry of Health, including in relation to financial and non-financial oversight of the system and the management and analysis of data.

The documents do not make specific spending commitments. We expect the accompanying Cabinet paper to note that implementation will require continued investment across a range of issues covering social sector, core health services, and health infrastructure, with the Strategy informing Vote Health bids in Budget 2016 and beyond. This seems reasonable and does not pre-empt Budget decisions.

Proposed actions are set out the Roadmap document. We comment on these below following what we understand to be the numbering in the final document (this differs slightly from the numbering in documents circulated last week).

Theme 1. People powered.

Customer-focused health care, including self management, tailored services, and better information.

The overall direction seems sensible, although not particularly new. The short-term actions are quite limited, namely a focus on communication technologies (action 1) and some showcasing of people-led service design exemplars (action 2).

Theme 2. Closer to home.

Integrated health and social services; and better management of long-term conditions and high-need populations.

We agree that these are priority issues for the sector. There is a proposal to engage with DHBs on regional service configuration (action 3). This could result in quite significant service changes, although it all depends on the detail. Regional service plans have been around for a while without having had much impact.

An outcomes framework to measure success in managing long-term conditions and obesity (action 5) is an attractive concept, but will require a sustained effort to implement successfully. As far as we know, thinking here is at an early stage. The Ministry also intends to remove workforce barriers (action 4), and to continue to collaborate across government on social investment (action 6).

Theme 3. Value and high performance.

Outcomes-focused performance management and an investment focus.

Actions include the introduction of new performance-management and outcomes frameworks (actions 7 to 9). This is consistent with our previous advice and we support the intent. The level of ambition, and the commitment to deliver real change, is

currently unclear. Previous performance management initiatives (including the PHO performance programme and its replacement, IPIF) have not had much impact.

Various funding changes are proposed (action 10), including the reform of VLCA and some centralisation of capital and IT project expenditure. There is a reference to improved commissioning (per the Productivity Commission's report), although we are not aware of any detailed thinking to support this.

A new health investment approach is proposed (action 11) to target high-need priority populations and/or improve system sustainability. Again, thinking here is at an early stage. *Withheld under s9(2)(f)(iv)*

There are some specific proposals on quality and safety (action 12). We are supportive of these although, as noted in our post-election briefing, we see a case for going further in terms of strengthening monitoring and assurance arrangements in the sector.

Theme 4. One team.

System leadership and accountability arrangements.

The discussion here is primarily about strengthening the role and capability of the Ministry of Health as system leader, and improving the governance of DHBs (actions 13 and 14). There is also a proposal to consolidate various advisory committees into a single advisory structure reporting to the Director General (action 15). Other proposals include talent management and leadership programmes (action 16) and annual forums (action 17).

We agree that it is important to improve DHB governance, given the central role these organisations play within the health system. This was a major theme in Sue Suckling's report, although it was the proposal to reduce the number of elected Board members that attracted most attention (this has not been included in the draft Strategy).

We also agree that a stronger, more effective Ministry of Health, acting as system leader, is important. Work on the Strategy to date has mostly been driven out of the Director General's office and we are doubtful that the Ministry at large currently has the capability needed to execute the proposed changes successfully. Building this capability should be a priority for the Director General. As we have noted previously, there are some risks in centralising too many functions in the Ministry of Health before it has demonstrated the capacity to deliver effectively and in the absence of other checks and balances in the system (such as an independent monitor).

Theme 5. Smart system.

Data and analytics.

The main concrete action here is the design and roll-out of a national electronic health record (action 19). There is also a general statement about improving the quality and analysis of data (action 18), and some detailed proposals concerning research and medical devices (action 20).

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THE TREASURY
Kaitohutohu Kaupapa Rawa

A contribution that counts 1840-2015

The Economic and Fiscal Context for Health

Health Sector Finance Workshop, Hamilton, 19 October

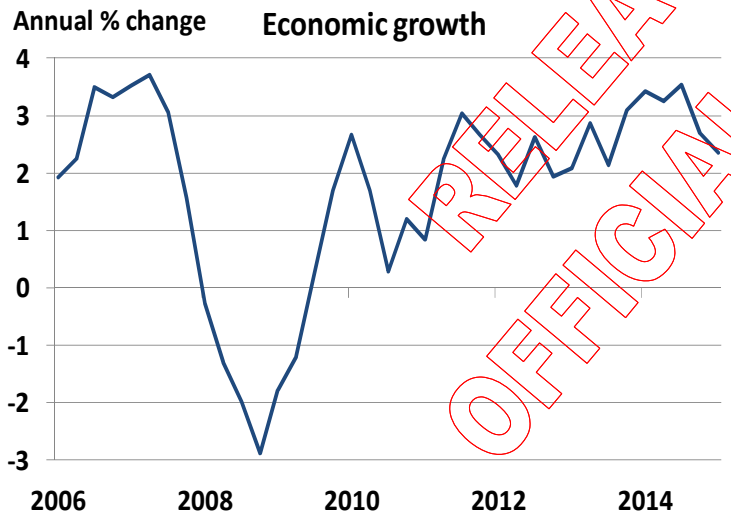
Susie Krieble, Analyst, New Zealand Treasury

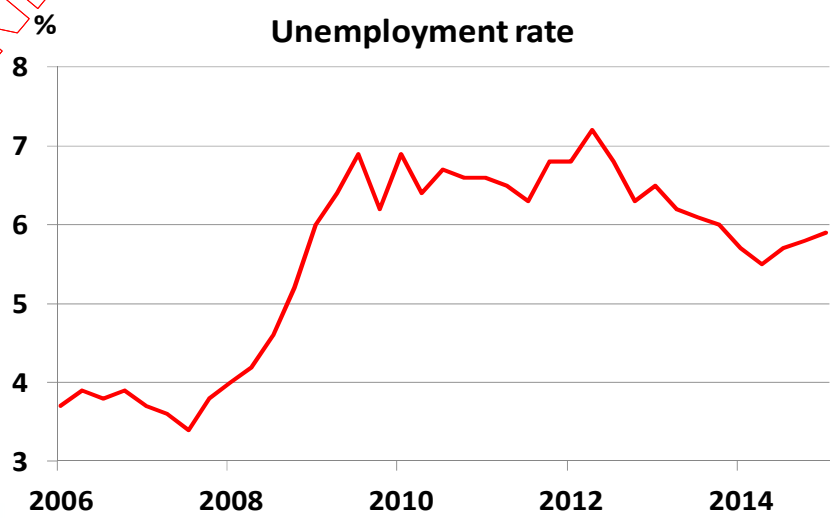
The Economic and Fiscal Context for Health

- Part One: The Economy
- Part Two: Government's Fiscal Strategy and Budget 2015
- Part Three: Treasury's Role in the Health Sector

The Economy

- Risks are increasing to real GDP
- Dairy prices have fallen sharply
- Unemployment rate and demand for labour



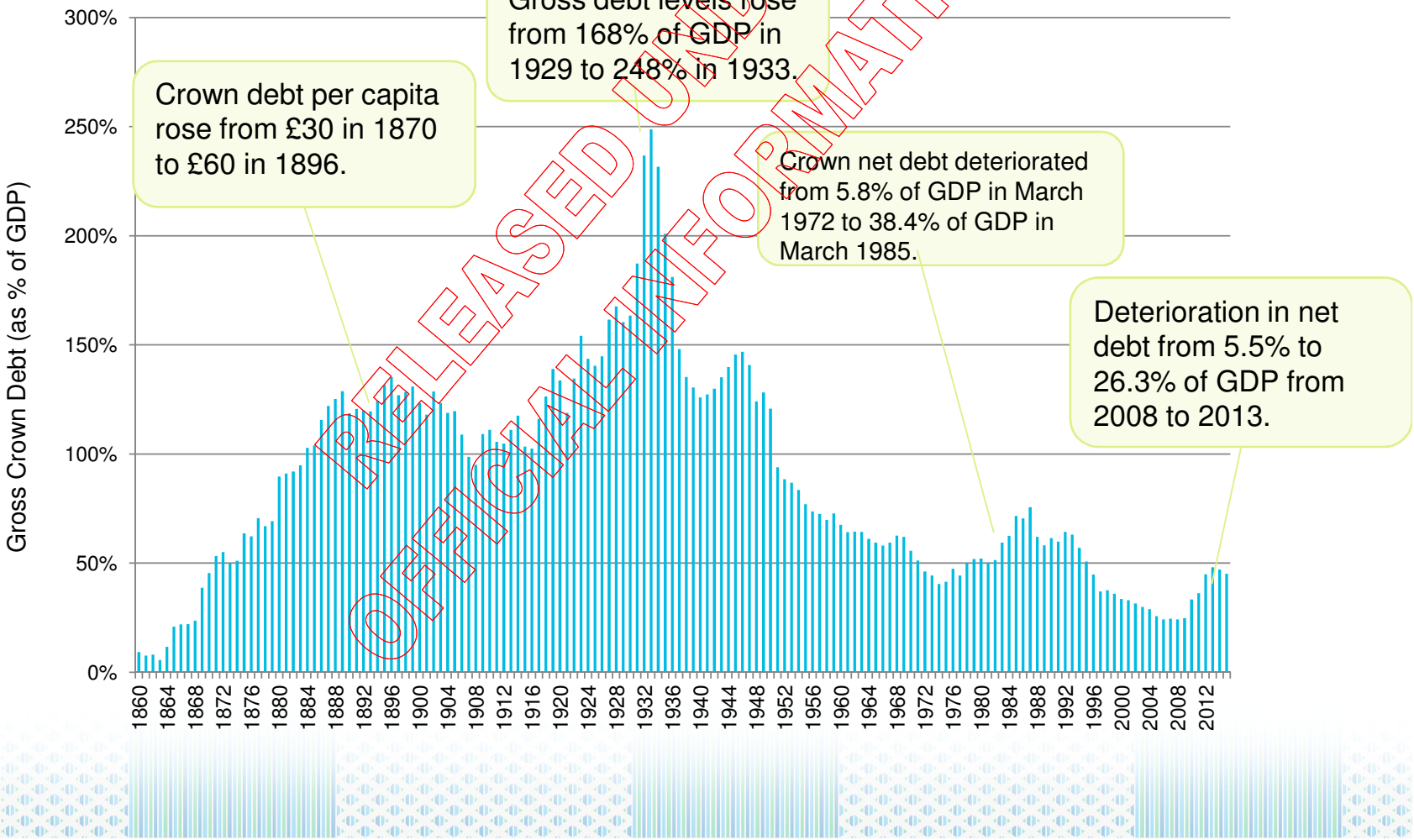


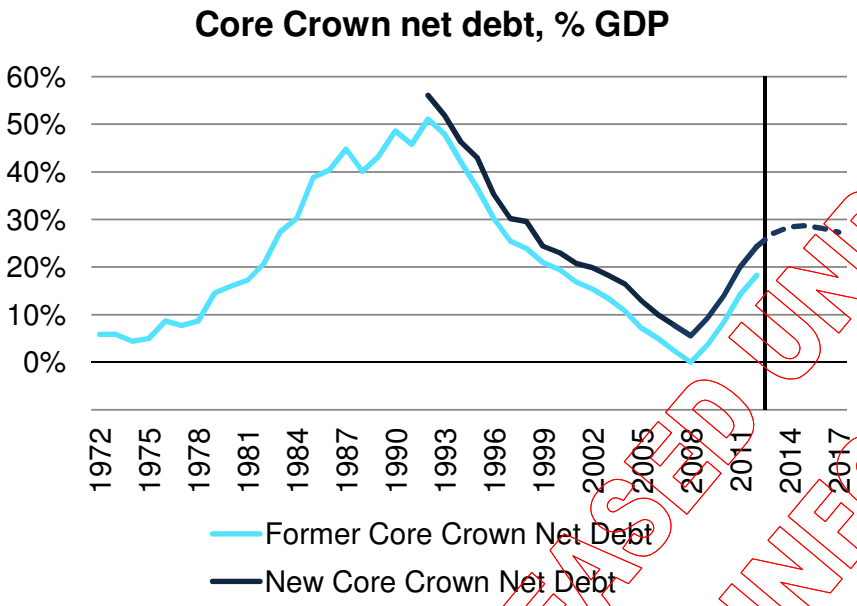
The Economy

- Net migration
- House prices trends
- Returns to commodity exporters
- Spare capacity in economy
- Official Cash Rate to 2.75%
- Exchange rate

- *Monthly Economic Indicators*

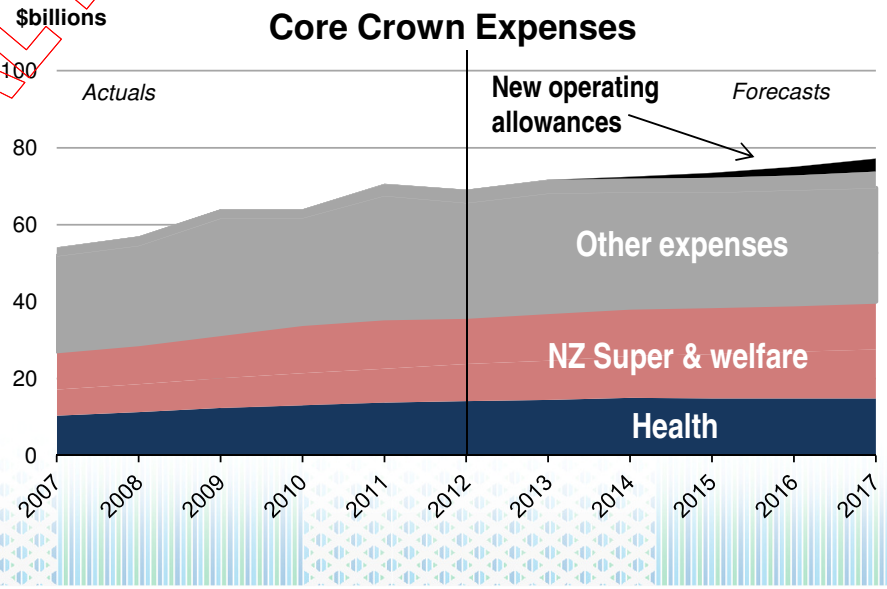
Historical New Zealand





... and fiscal restraint is expected to continue.

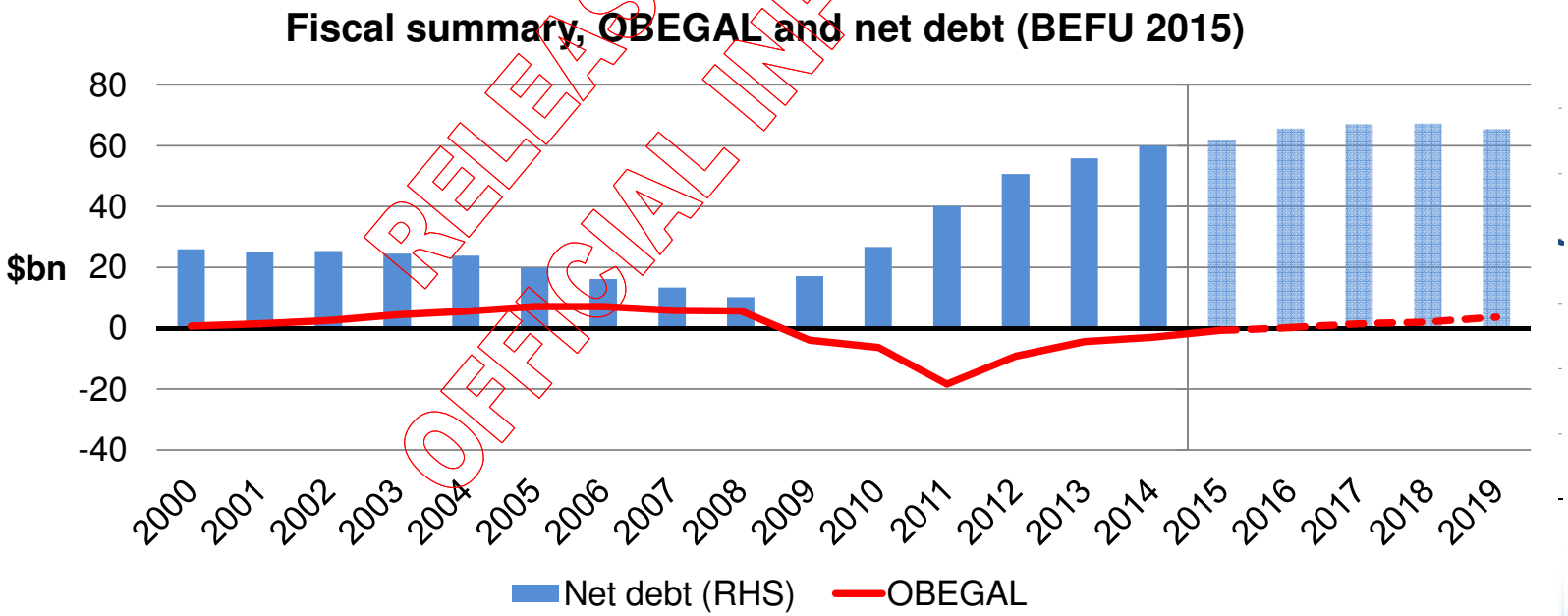
Paying down debt built up since the financial crisis means small increases in new spending.



Fiscal Strategy Outlined with Budget 2015

Key fiscal strategy objectives from the Government's 2015 Fiscal Strategy Report:

- Returning to OBEGAL surplus (operating balance before gains and losses)
- Greater focus on debt and returning net core Crown debt to 20% by 2020
- Further reducing ACC levies and, from 2017, reducing income taxes

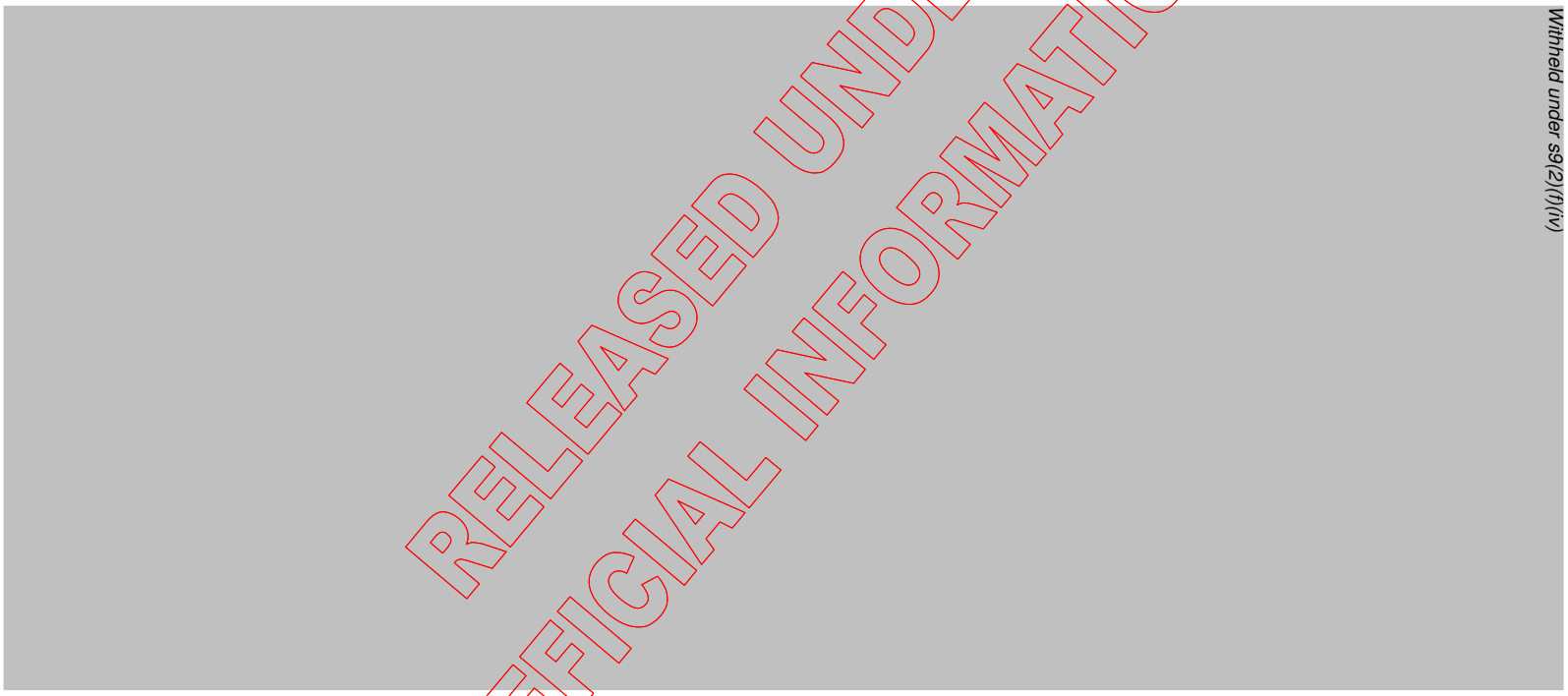


Inputs to Outcomes

Ministers wanted to shake up the Budget process in 2015

- Social Sector
- Business Growth Agenda (BGA)
- Other

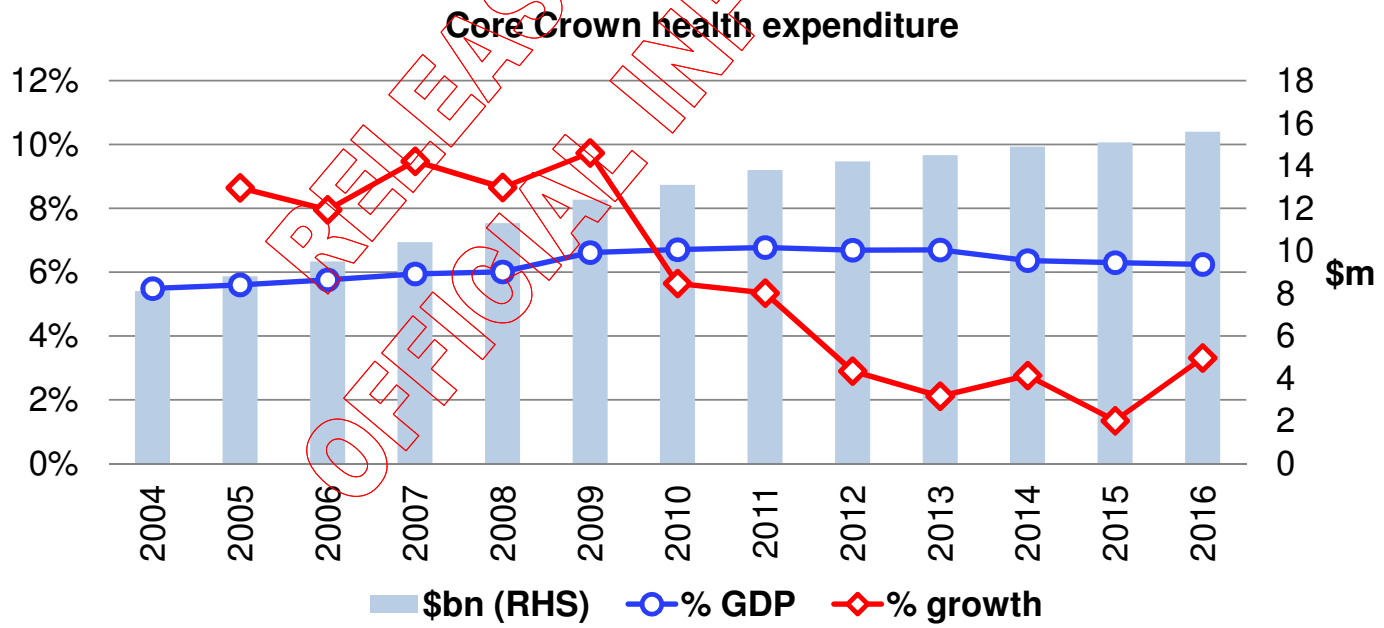
Inputs to Outcomes



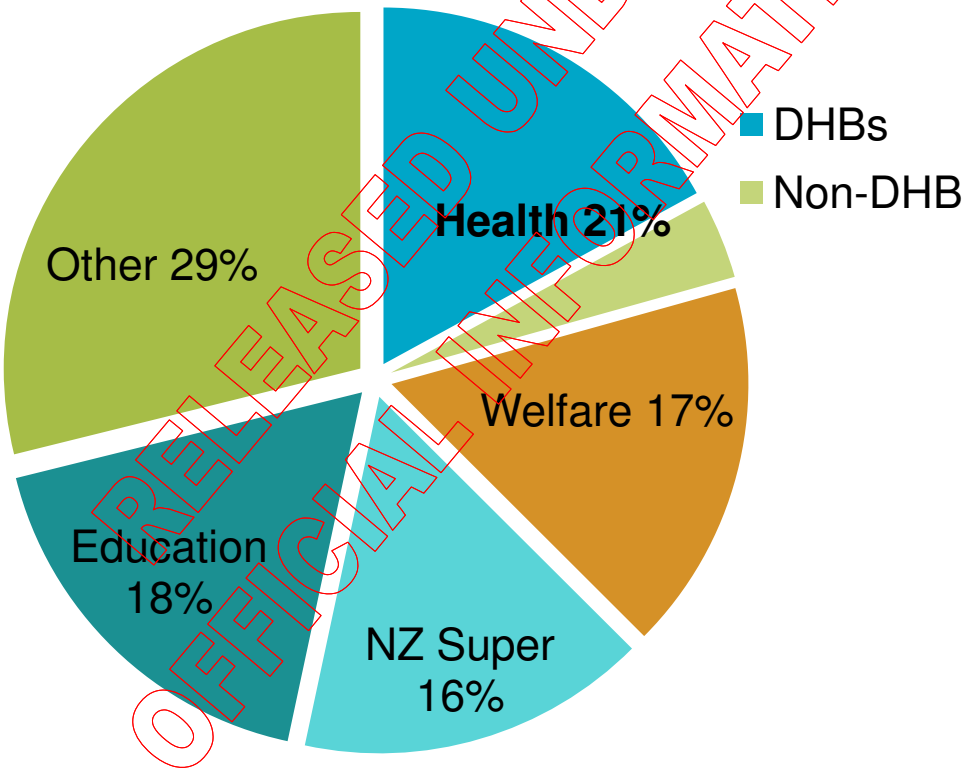
Withheld under s9(2)(f)(iv)

Vote Health

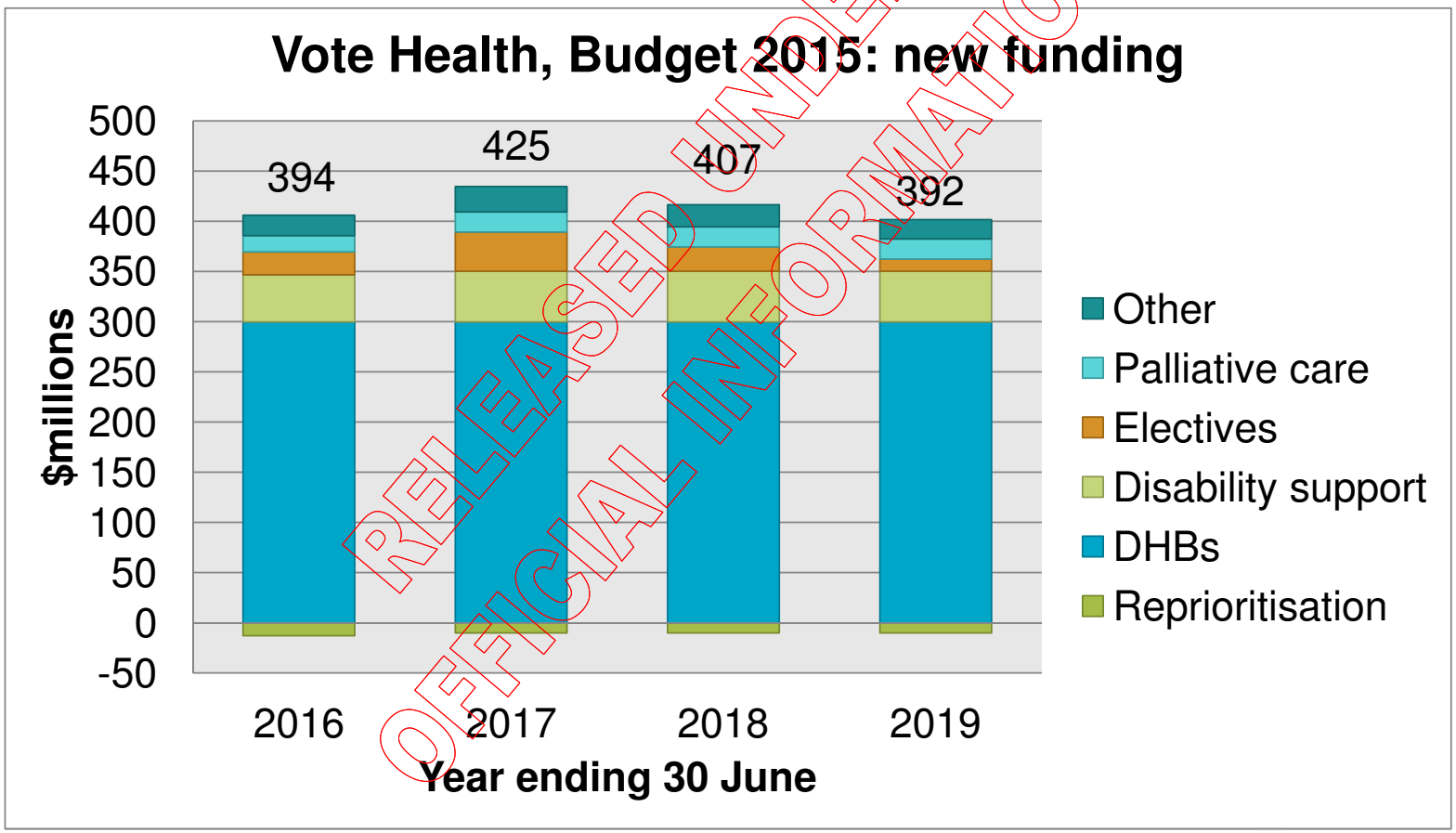
- Health spending has continued to increase in nominal terms, although the rate of growth has slowed
- Now declining slightly as a proportion of GDP as economic growth picks up



Core Crown expenses, 2015 (forecast)



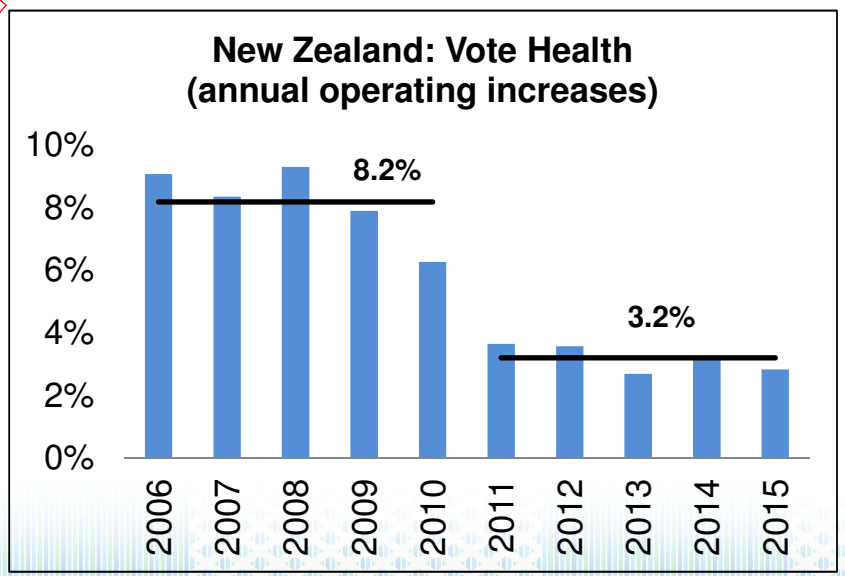
Vote Health 2015



Vote Health 2015

Many cost pressures facing the health sector, as well as top-up funding for other programmes

- Additional $1.7b over four years
- Total health investment $15.9b in 2015/16
- Hospices and palliative care ($76.1m)
- Elective surgery ($98m)



Budget 2016 Strategy Overview

The Government's programme and priorities:

- responsibly managing the Government's finances
- building a more productive and competitive economy
- delivering better public services within tight financial constraints, and
- rebuilding Christchurch

Withheld under s9(2)(f)(iv)

Role of Treasury

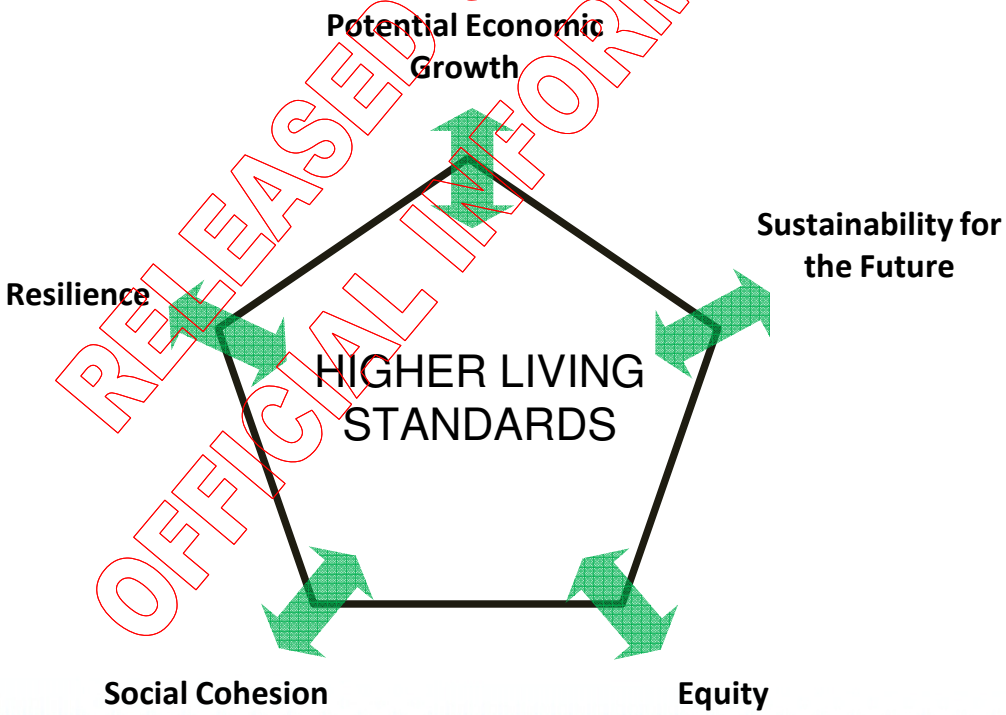
- Lead advisor on economic, financial and regulatory policy.
- Vision: higher living standards for New Zealanders.
- Three key outcomes:
  - Improved economic performance
  - Macroeconomic stability and sustainability
  - An effective and efficient state sector

Treasury's health team

- Small team (also covers ACC)
- Work programme

The Living Standards Framework

In considering changes to the health system, we need to think about the impacts in terms of multiple dimensions.



Focus for Budget 2016

- Fiscal constraint remains
- Focus on targeting vulnerable groups
- Emphasis on testing bids against evidence and data
- Much greater focus on working across government
- Reprioritisation and best use of existing baselines

In Conclusion

- Economy is on the up, but going slower than previously forecast
- Health – a key role to play in an inclusive and prosperous New Zealand
- We want to continue the discussions with the sector on the health system
- The context of fiscal constraint will continue
- Need to keep up the focus on results

THANK YOU

THE TREASURY
Kaitohutohu Kaupapa Rawa

A contribution that counts 1840-2015