The Treasury

Budget 2011 Information Release

Release Document

June 2011

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THE TREASURY
Kaitohutohu Kaupapa Rawa

Treasury Report: Vote Health Budget 2011 Package

Date:	22 November 2010	Report No:	T2010/2278

Action Sought

	Action Sought	Deadline
Minister of Finance (Hon Bill English)	**Note** the contents of this report. **Signal** your preferences for the Vote Health 2011 Budget package by answering the questions in this report. **Signal** whether you would like to meet to discuss any of the issues raised.	Friday, 26th November 2010
Associate Minister of Finance (Hon Simon Power)	**Note** the contents of this report	None
Associate Minister of Finance (Hon Steven Joyce)	**Note** the contents of this report	None

Contact for Telephone Discussion (if required)

Name	Position	Telephone	1st Contact
[2]	Analyst, Health	[2]	✓
Chris Bunny	Manager, Health		

Minister of Finance's Office Actions (if required)

None.

Enclosure: **No**

22 November 2010

Treasury Report: Vote Health Budget 2011 Package

Executive Summary

On the first of December, you will receive the Ministry of Health's 4-year budget plan. Before you receive this, we would like to test whether our objectives for Budget 2011 align with your own, and provide you with some first opinion advice on the preparation of the Vote Health budget package.

[2]

Our strategy for Budget 2011 is to move the Vote into a position where it is able to provide Ministers with these options in time for Budget 2012.

There are key trade-offs that can be made between the three aspects of the package that Budget Ministers have the most discretion over – the size of the Vote Health operating allocation, the size of the capital envelope, and the use of underspends. It is important that these three aspects are considered in light of each other.

We recommend that the Vote Health capital envelope receive **[2]**

We also suggest the Minister of Health use 2010/11 underspends as the funding source, to relieve pressure on the central capital allowance.

It is unlikely that a sufficient number of risks will materialise during the 2011/12 year to justify a dedicated Vote Health risk reserve on the basis of risk mitigation alone.**[3]**

If Budget Ministers and Cabinet agree to an allocation, a dedicated risk reserve (as described above) and the retention of underspends on the expectation that all risks, pressures and new initiatives are to be managed within the Vote, then it will be important to make sure this expectation is clarified and made clear during the budget process.

Recommended Action

We recommend that you:

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

b **signal** your preferences for the Vote Health 2011 Budget package by answering the questions in this report; and

c **signal** whether you would like to meet to discuss any of the issues raised.

Yes/No

Chris Bunny
Manager, Health
for Secretary to the Treasury

Hon Bill English
Minister of Finance

Purpose of Report

1. The purpose of this report is to:

    - Test your views on our approach to the Vote Health 2011 Budget package ("the package"); and

    - To provide you with advice on the package ahead of any budget discussions you may have with the Minister of Health, before receiving Vote Health's 4-year budget plan.

2. We will provide you with advice on the initiatives and savings proposals within the package, once we have received the 4-year budget plan in December 2010.

Overall Objectives

3. The objectives we are seeking to achieve as a result of our work on the package are as follows. They are listed here in descending order of priority:

1.	Vote Health Operating Allocation	Vote Health's funding allocation does not exceed its share of the 2010 operating allowance (OA) i.e. is no greater than $430 million ongoing (or less depending on competing priorities).
2.	DHB Allocation	The DHB share of the Vote Health allocation is sufficient to manage pressures (given realistic assumptions about efficiency gains) and maintains an acceptable level of risk regarding service coverage and deficits i.e. is no less than $350 million.
3.	Capital Allocation	**[2]**

[3]

5.	Vote Arrangements	Expectations regarding the fiscal management of Vote Health are clear, well understood and Health's allocation is considered to be a firm allocation i.e. the rules of the game are made clear.
6.	New Initiatives	All new initiatives are good value for money and represent the next best spend in Health and/or are government priorities.
7.	Price and Demographic Adjustors	Price and demographic adjustors are applied to the areas of greatest need in Ministry-managed non-departmental expenditure (NDE) and options are made available for managing pressure.
8.	Savings	Savings are of an appropriate level and minimise risk and reductions in quality or quantity of services i.e. do not unnecessarily compromise high value or core services.

4. The following objectives can be considered in conjunction with, and as tools to achieve, the outcomes described above:

    - Decisions by Budget Ministers are well informed and made at the "right time" i.e. decisions on the health budget package are made in a way that allows Ministers to consider competing priorities both within health and across the state sector as a whole.

- Ministers are given meaningful options, both in regards to the package and re-prioritisation within the base.

- Our relationships with our key stakeholders (yourself, the Ministry of Health, Hon Tony Ryall, and Budget Ministers) remain constructive and conducive to ongoing positive engagement.

- Vote Health budget proposals are subject to the same level of scrutiny as other votes.

- You are prepared and well informed for any informal budget meetings or discussions.

Do these objectives and priority rankings broadly align with your own?

Yes / No

Budget 2012

5. An allocation of $400 to $430 million for Vote Health represents a high proportion of the overall operating allowance, and arguably will not require the Vote to make choices nearly as difficult as the ones currently facing most other votes.

[3]

7. Budget Ministers will therefore need to take significant decisions on systems and policy settings in Budget 2012 to achieve the fiscal strategy. The health sector should be included in these considerations. This will require the Ministry of Health to present Ministers with options to allow Vote Health to manage to a lower allocation. The work needed to develop these options will need to begin now to be ready in time for Budget 2012.

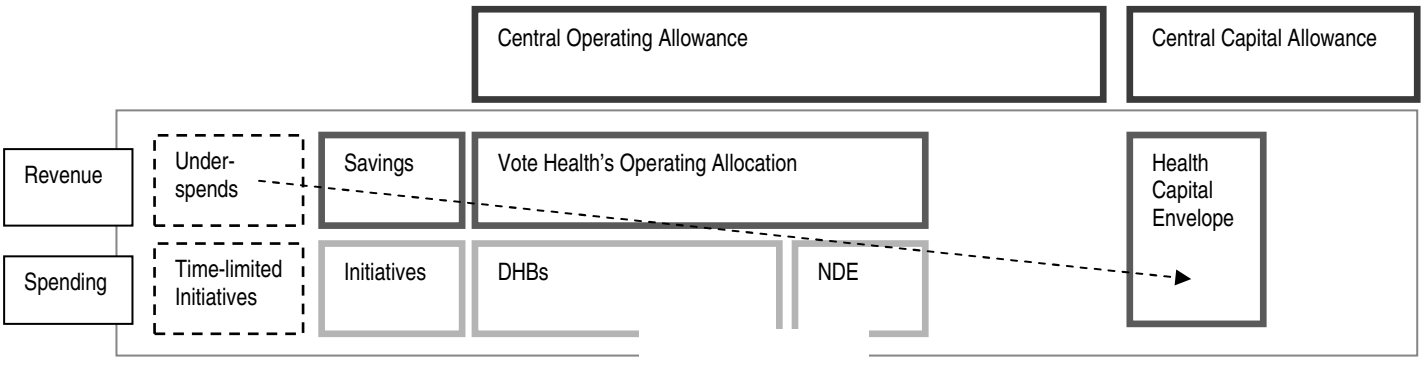
[2]

Are you comfortable with our approach to Budget 2011 and Budget 2012?

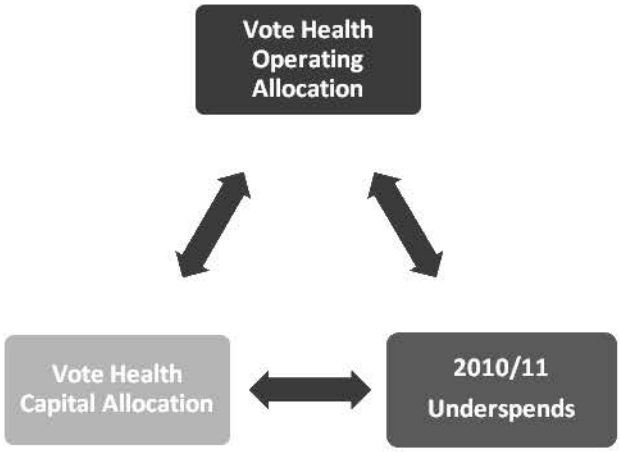
Yes / No

How it fits Together

9. The various aspects of the Vote Health budget package could fit together as follows:



10. There are key trade-offs that can be made between the three aspects of the package that Budget Ministers have the most direct control and discretion over:

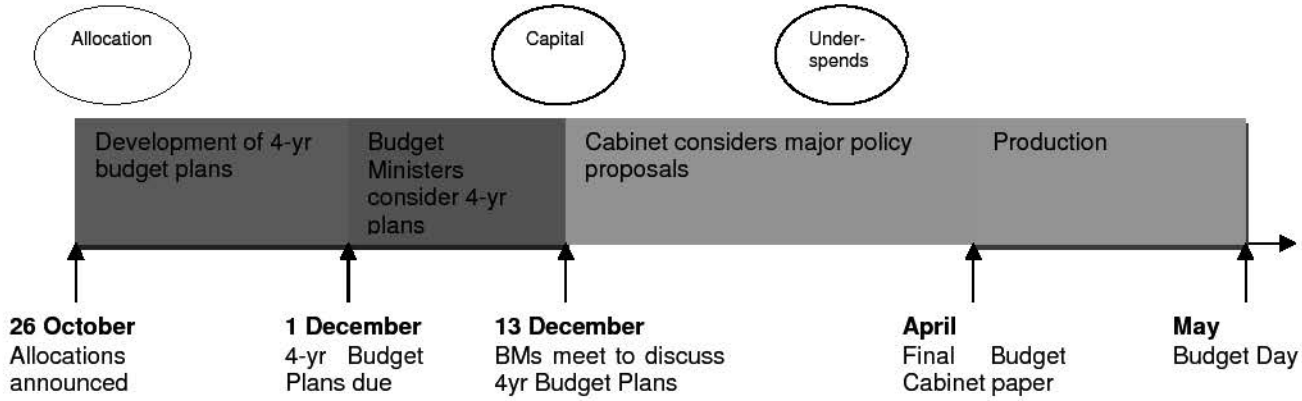


11. Budget Ministers could, for example, agree a higher capital allocation for Vote Health, on the condition that it receives a modest operating allocation and all underspends from 2010/11 are returned to the Crown. Conversely, Budget Ministers could agree to allow Vote Health to retain its 2010/11 underspends for time limited operating initiatives instead of increasing its operating allocation.

12. As underspends are time-limited, they are a good substitute for capital (and using them for operating initiatives often creates future baseline pressure). Budget Ministers could, therefore, allow Vote Health to transfer its 2010/11 underspends to capital, in exchange for a modest or zero capital allocation from the central capital allowance.

13. In order to make these trade-offs, it is important that key decisions on the operating allowance, capital allowance and underspends are made at the right time and in light of wider considerations.

14. The Vote Health operating allocation has already been agreed, but the size of the allocation is likely to be re-litigated throughout the budget process. The Minister of Health will probably request a capital allocation in the 4-year budget plan due in December, and final decisions will be made by Cabinet between March and April. The use of some 2010/11 underspends will also probably be requested in the 4-year budget plan, and further requests to transfer underspends are likely to be submitted in the March Baseline Update or via a Cabinet paper prior to June.



15. Regardless of when each of these aspects of the budget package are first raised, all three should be considered as complementary aspects of the same package and decisions on each should not be made without consideration of the others. It is especially important that the issue of the capital and underspends are considered concurrently, so the option of using the 2010/11 underspends as the funding source for the capital envelope can be considered. We therefore recommend that you do not agree to new operating expenditure commitments funded from 2010/11 underspends before the Health capital allocation is set.

Vote Health Operating Allocation - $420 Million

16. Cabinet has agreed an operating allocation of $420 million for Vote Health. It has also agreed that at least $350 million of this is to go to DHBs for price and demographic pressure.

17. Approximately $50 million is likely to be needed for price and demographic pressure in Ministry-managed non-departmental expenditure. This means that the Minister of Health will have approximately $20 million, in addition to any savings found within the vote, for new initiatives.

	Allocation of $420 million
DHBs	$350 million
Ministry-managed NDE FFT and Demo	$50 million
New initiatives	$20 supplemented by any savings found

18. Last year, Vote Health's allocation of $420 million, plus a relatively modest $46 million in savings, was enough to fund many new initiatives, including a bowel cancer screening pilot, a Maori Health innovation fund, shared services establishment costs, increased funding for medicines, increased medical training places, a primary health care flexible funding pool, increased mental health funding, a dedicated risk reserve of $20 million and an additional $20 million for other risks (none of which has yet been required to manage risks or pressures).

19. It is important that Health's allocation does not continue to increase throughout the budget process. Finalising Health's allocation is important to allow DHBs to start planning for the 2011/12 year and to allow the Ministry of Health to produce a high quality budget plan and package. It also enables the rest of the Health budget process to be focused on the quality of the package, rather than the size of the allocation.

DHB Allocation - $350 Million

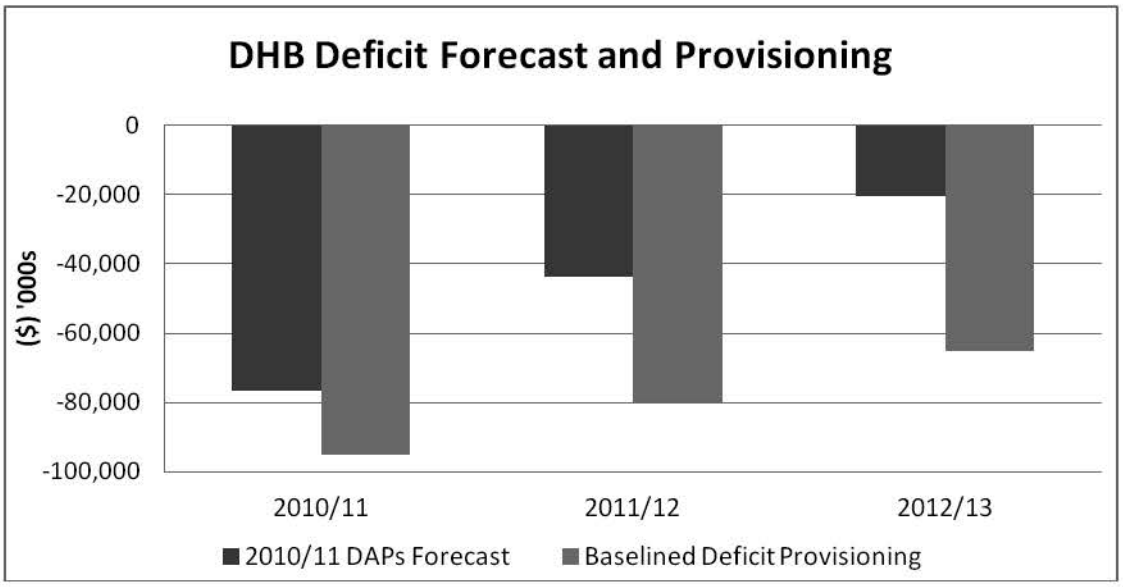
20. Cabinet has agreed that at least $350 million of the $420 million allocation is to go to DHBs for price and demographic pressure.

21. FFT and Demo ($615 million) represents the likely price and demographic pressure facing both DHB and Ministry managed services under business as usual, with no reprioritisation or productivity savings. This level of funding, if received, would imply an increase in price (as per inflation), an increase in quantity (as a result of an increase in the population), an increase in services per head of population (given ageing population) and an increase in quality via a technology adjustor. The Ministry of Health have estimated this at $490 million for DHBs and $125 million for Ministry managed services ($615 million total) for 2010/11.

22. This $615 million figure may be presented as the level of funding required to keep the system "standing still", and therefore may be presented as justification for increasing the level of Vote Health's allocation. However, it is important to keep in mind, first, that this implies no efficiency gains, and secondly that with DHB funding increases to be decided in December, there is no basis for arguing for a FFT and Demo based increase to the Vote as a whole.

23. In the 2010 funding advice letter, DHBs were told to assume, for the purposes of their 2010/11 District Annual Plans, that they will receive the same nominal increase in funding in 2011/11 and outyears, as they received in 2010/11 (i.e. $350 million).

24. Using this assumption, DHBs have forecast/budgeted a decline in their overall deficit position as follows:



25. Therefore, based on DHBs' own plans, $350 million should be enough to ensure the deficit track continues to trend downwards and will not exceed provisioning.

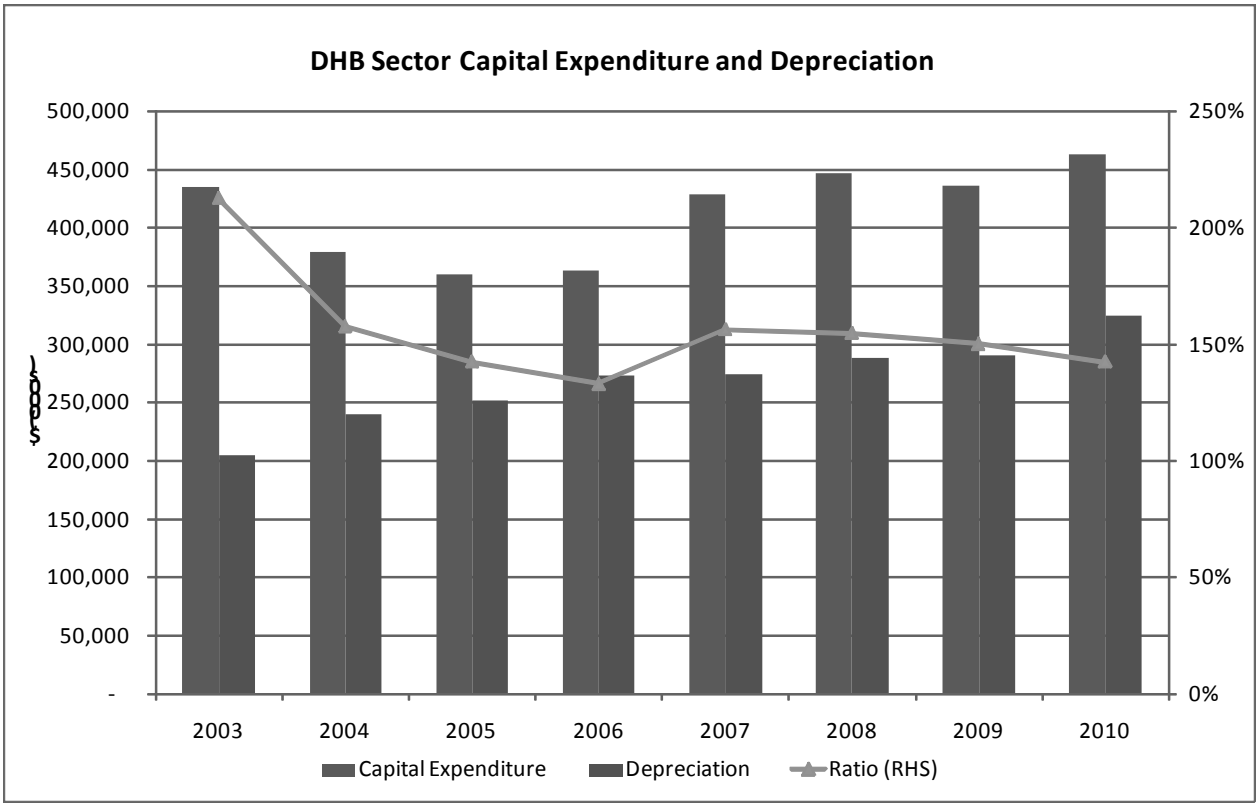
26. This level of funding implies DHBs will need efficiency gains of approximately $140 million or 1.4%, compared to full Forecast Funding Track and Demographic funding (FFT and Demo). The gains from shared services (including Health Benefits Ltd) are estimated to be $40 million in 2011/12, suggesting DHBs will need to find another $100 million. This is twice as much as last year. DHBs' price and demographic pressure should be considered the highest priority item in the health package, and funding should not be allocated to new commitments unless the Ministry of Health can demonstrate deficit risk can be sufficiently managed within the DHBs' allocation. The same test should be applied to any new requirements for DHBs to fund initiatives from their population-based funding.

Vote Health Capital Allocation - [2]

Background

27. Between 2002 and 2010, DHB fixed assets have grown by $2,486 million, or at an annual growth rate of 10.4%. This compares with operating expenditure growth of 11.45% per year over the period between 2002 and 2009.

28. Total capital expenditure was $3,664 million over the same period with depreciation totaling $2,341 million. Average capital expenditure over the eight years was $407 million per year with a range of $352 million (in 2005) to $463 million (in 2010). While capital expenditure has showed no clear trend, depreciation has grown steadily from $192 million to $325 million, averaging 6.8%, as a result of the steady growth in fixed assets.



29. Major capital projects with a total value of $2,339 million were approved over the period from 2000 to 2009, with a Health capital envelope contribution of $1,387 million. The corresponding averages over this ten-year period were $234 million per year in capital projects with $139 million per year funded through Health capital envelope contributions.

30. Using a variety of assumptions (e.g. revenue, labour-capital ratios, the share of internal funding), estimates of the maximum affordable long-run annual health capital envelope contribution come out at around $100-$200 million.

Projects for Consideration

[2]

[2]

Comment

33. The contribution to the Health Capital Envelope in 2010/11 should be informed by the presence of necessary and sound business cases that will be ready for approval in 2011/12, as well as a consideration of DHB incentives:

    - *Necessary?* Hospital capital developments take a long time, so needs have to be anticipated well in advance. The main need currently is a response to population pressure in Auckland.

    - *Sound?* "Sound" includes consistency with long-run service and funding assumptions. The National Health Board acknowledges we do not yet have service planning to support capital planning. Service costing models and business cases are on a learning curve and Ministers have yet to see a substantial sound health business case.

    - *Ready?* Only old pipeline business cases will be ready for approval in 2011/12.

    - *DHB incentives*? DHBs accept the fiscal position, the long-run challenges, and the need for better business cases. There are some examples of good behaviour **[3]** but DHBs are also focused on getting their projects built, which leads to some bad behaviour (e.g. Waitemata have poured four stories of concrete on their Lakeview project, without final approval). There is a case for limiting additional funding until the sector consistently acts in the interests of the wider Crown.

[2]

35. The Ministry of Health is currently forecasting underspends of approximately $80 million in 2010/11. **[2]**

Do you support a capital allocation of between $0 and $100 million for Health?

Yes / No

Do you support using underspends as the funding source of the capital envelope?

Yes / No

Risk Reserve

Recent Use of Vote Health's Risk Reserve

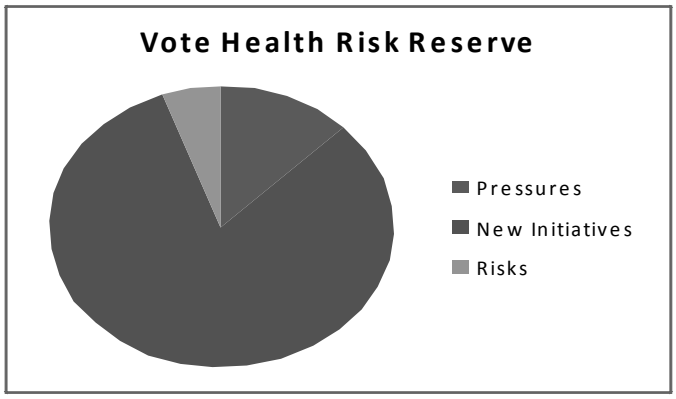
36. Vote Health is unusual in having an appropriated contingency for risks, with joint Ministers having delegated authority to spend from it without reference back to Cabinet. The intent of this has been to allow the Vote to manage genuine risks (e.g. DHB deficits and public health emergencies such as flu epidemics) within the Vote.

37. In 2009/10, the risk reserve was used for the following:

Initiative	**Total Cost**
Electives services funding	$16 million (over two years)
Electives cardiac initiative	$4.2 million
Funding for measles vaccine (expenditure had already been incurred when funding was requested)	$1.5 million
Pandemic funding (expenditure had already been incurred when funding was requested)	$3.315 million
Shared services entity and MRG change costs	$6 million (over two years)
Budget pressures in disability support	$5 million
Tackling methamphetamine action plan	$25.741 million (over four years)

38. The Minister of Health intends to request funding from the risk reserve for the following initiatives in 2010/11:

Initiative	**Total Cost**
Increased surgery volumes	$10 million
Hibiscus Coast Hospice	$0.4 million
Cancer centres	$3.752 million
National youth survey	$0.300 million
PHARMAC medical devices procurement **[2]**	$1.803 million
Disability support pressures	$1 million
Bariatric surgery	$6 million



These items can be categorised as funding to meet price or volume pressures (e.g. disability support), funding for new initiatives (e.g. methamphetamine action plan)/government priorities (e.g. bariatric surgery) or funding to manage unavoidable risk (pandemic funding). As shown by the graph to the left, the majority of risk reserve provisioning over the last two years has been used (or requested) for new initiatives, not for alleviating or managing risk within Vote Health.

[6]

[3]

[3]

Are you comfortable with this approach to a Vote Health risk reserve?

Yes / No

Vote Arrangements

Deficit Provisioning

45. As mentioned earlier, DHB deficit provisioning currently exceeds requirements, and will continue to do so over the next few years. This means there is an outstanding question about what should be done with the excess funding. If nothing is done explicitly, it will turn up as an under spend. Options include:

    - Transferring the funding into future years in case the deficit position deteriorates in the future;
    - Transferring it to up-front funding increases for DHBs to further improve their deficit position and recognise their improved financial management;
    - Re-prioritising the funding into other health priorities or returning it to the centre as a "wind-fall" gain.

46. Which option is best depends on the ability of the DHBs and the Ministry of Health to provide assurance regarding the permanence of the improved forecast for DHBs' financial position. It also depends on to what degree the improvement in the deficit position has been, and will continue to be, the result of active management by the DHB boards. This is an issue that should be addressed in the 4-year budget plan.

Underspends

47. Standard rules enable underspends and savings from reprioritisation to remain available to Vote Health, as long as they are identified and managed appropriately before the year's end. If they are not transferred before the end of the year, they are consolidated into the Crown's year-end accounts, and if they are then "re-appropriated" they reduce the Crown's operating balance and increase debt.

48. As mentioned earlier, we would support allowing the Minister of Health to transfer his 2010/11 underspends to capital. This retains the incentive for the Minister of Health to actively manage savings, and relieves pressure on the central capital allowance. It also avoids the future baseline pressure problems caused by using one-off underspends for operating initiatives.

Expectations

49. If Budget Ministers and Cabinet agree to an allocation, a dedicated risk reserve, the transfer of excess deficit funding and retention of underspends on the expectation that risks, pressures and new initiatives are to be managed within the Vote, then it will be important to ensure this expectation is made clear.

50. Therefore we recommend that during the budget process Budget Ministers clarify these expectations with the Minister of Health by agreeing to the following (or some variant depending on the actual shape of the package agreed):

- that the Minister of Health is to manage risks (including DHB deficit risk) and pressures within Vote Health and will not apply for funding from the between budget contingency unless the following funding sources have been exhausted:
    - The dedicated risk reserve;
    - The $17.4 million in ongoing risk provisioning that was agreed in Budget 2009; and
    - All reprioritisation options within the Vote that do not result in reductions to core or high value services.
- that Vote Health is to apply standard Vote arrangements as laid out in CO(09)6, including applying to transfer un-spent appropriations prior to year end.
- that the Ministry of Health will begin policy work to develop savings options to enable Vote Health to mange to a growth path of less than $420 million from Budget 2012, to ensure Ministers have a full set of options to allow them to meet the fiscal strategy in outyears.

Do you support our approach to Vote Arrangements for Budget 2011?

Yes / No

Next Steps

We will use the preferences you have signalled in this report to inform the preparation of our advice to yourself, Budget Ministers, and Cabinet throughout the rest of the Budget 2011 process.