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Office of the Minister of Health

Cabinet Business Committee

Implications of Vote Health's Four-Year Budget Plan

Proposal

1. This paper outlines the key components of Vote Health's proposed Four-Year Budget Plan and, in particular, the strategies put in place to manage potential risks identified for the forecast period.

Executive Summary

2. Vote Health has been allocated $420 million of new funding for Budget 2011. Living within this funding will require a range of productivity and efficiency gains ($194 million) from DHBs and the Ministry.**[2]**

The new initiatives complete manifesto commitments and increases in coverage or quality of prioritised services (refer paragraph 16).

3. Risks to managing Vote Health include:

   i. Public confidence in size of the Vote Allocation

[6]

   iv. Partial delivery of estimated productivity and cost reduction improvements from Ministerial Review Group (MRG) changes

   v. Partial delivery of DHB and Ministry of Health efficiency gains

   vi. Failure to achieve the deficit improvement track

[6]

4. A range of management strategies to reduce the probability of these risks materialising are in place. **[6]**

5. These management strategies are expected to ensure that risks are managed within the Vote Allocation, with two exceptions. First, the ability to respond to public concerns about the level of the allocation is difficult to manage within the allocation (since the allocation itself is the issue). **[2],[6]**

[2]

Background

7. Budget Ministers met to consider the Four-Year Budget Plans from across the public service on 15 December 2010 and invited me to report back to Cabinet to discuss:

   i. The choices made in preparing the Budget 2011 package, and

   ii. Strategies for managing risks and pressures in the sector **[6]**

8. Cabinet agreed on 26 October 2010 to allocate $420 million of ongoing funding to Vote Health in Budget 2011, including at least $350 million allocated to DHBs.[1]

9. The Expenditure Control Committee met on 14 September 2010 to discuss managing pressures in Vote Health over the medium term. The discussion focused on Vote Health's strategies to manage controllable and uncontrollable demand, such as, the challenges of the rising prevalence of chronic disease and population ageing. Vote Health is committed to responding to these challenges through smart investments and system performance improvements to manage expenditure.[2] The Vote Health Four-Year Budget Plan is consistent with this approach.

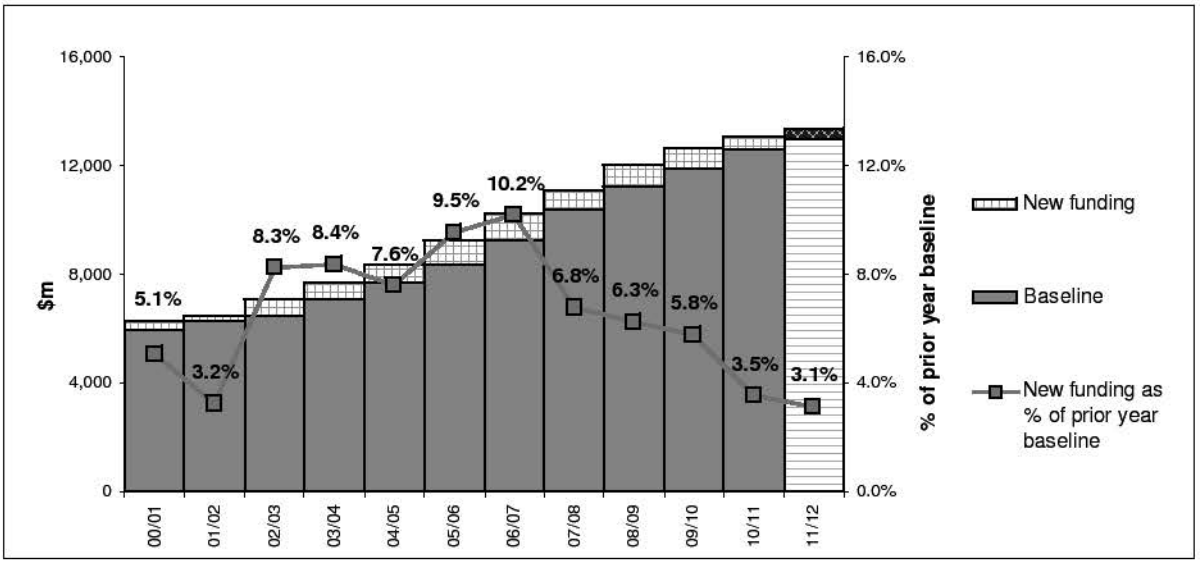
10. The outlook for the current year is on track. Vote Health received a 3.5% increase in Budget 2010. DHBs are conforming to their agreed District Annual Plans, and managing to the deficit reduction track. The MRG recommendations have been implemented and are beginning to deliver savings.

Budget 2011 Overview

11. The health and disability system faces ongoing fiscal and demographic challenges. These challenges require ongoing performance and value-for-money improvements in order to ensure the maintenance of high quality and efficient services that improve health and independence outcomes of New Zealanders, while supporting the fiscal objective to slow the rate of growth of health funding.

12. The 2011 Vote Health Four-Year Budget Plan builds on recent approaches to lower the funding growth path. The proposed 3.1% increase at a Vote level equals 2001/02 as the most challenging increase in recent times (see Figure 1, below). That year, DHB deficits blew out to $286.7 million in the face of such constrained funding and other issues. Strong financial discipline will be needed to avoid repeating this poor performance.

Figure 1: Increases in Vote Health funding as a percentage of previous year expenditure



13. The slower funding growth path requires a number of policy choices to minimise the impact on health outcomes both now and in the future. Vote Health has continued to invest in areas of strategic importance to improve health outcomes including continuing to deliver on health targets,[3] building a sustainable clinical workforce, and ensuring safe and effective services for older people. The financial focus is on the efficiency and productivity of existing services and the of the cost of reduction of back office services. The central budget policy choice is to exhaust all current opportunities for improving efficiency and productivity in the health sector before considering reducing health service coverage or volumes. This places greater emphasis on robust planning, risk management, accountability and monitoring – all of which are functions that have been improved with the establishment of the National Health Board. **[2]**

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[1] CAB Min (10) 38/11

[2] ECC Min (10) 15/1

[3] The health targets are based on Elective surgery volumes, emergency room waiting times, access to radiation treatment and immunisation coverage)

[2]

14. Already, there is a high level of public and political interest on whether Vote Health is maintaining per capita service coverage (i.e funding that keeps up with inflation and population change) and whether the volume of health services valued by New Zealanders is at risk. **[3]**

    This is because the sector shifts funding across services as efficiencies are identified and to match government priorities. The $350 million of additional funding for DHBs is central to this task.

15. A summary of Vote Health's proposed Four-Year Budget Plan is outlined in Table 1 below. The key strategies for operating within this budget are:

    Tight cost containment

    i. Ministry-managed NDE (health services managed by the Ministry of Health rather than DHBs) is receiving an increase of 2.33% to maintain service coverage. New funding is being targeted to where the funding is needed most. DHBs are receiving an increase of 3.5%. To manage within this, DHBs' key operating expectations include limiting personnel cost increases to 2.7%, contracted services to 2.8%, and clinical supplies to 2%.

    Efficiency, productivity and service improvement gains

    ii. To live within the expected funding path, efficiency, productivity and service improvement gains relative to the estimated funding required for inflation and population change are required for both Ministry and DHB managed services (totaling $57 million for Ministry-managed NDE and $144 million for DHBs in 2011/12). Cumulative gains of $359 million in 2012/13, $527 million in 2013/14 and $699 million in 2014/15 will be needed in outyears.

    iii. Also required is better service integration to improve effectiveness and efficiency, including shifting services into community settings (such as Integrated Family Health Centers) and enhanced national, regional and local service planning and delivery. **[2]**

    Reprioritisation of lower value spending

    vi. For Budget 2011, $91 million of funding (highest outyear) from Ministry-managed NDE (3.4% of baseline) has been reprioritised as part of the ongoing value-for-money program. Savings identified represent eliminating duplication, increasing provider efficiency through contracting changes, reducing investment in areas that do not align with Government priorities, and reducing investment in infrastructure and capacity where long term impacts are manageable. Further detail is provided in Annex One.

    New Initiatives

    vii. Investment is planned in Government priorities and Manifesto commitments, including improving access to subsidised medicines ($20 million), increasing the number of Well Child visits ($5.33 million), boosting subsidised medical student places ($17 million in the highest outyear) and voluntary bonding ($1 million).

    viii. Also, new investment is proposed for mental health ($10 million), aged care (dementia) services ($10 million) and elective surgery ($17 million)[4].

    ix. Smaller targeted investments (totaling $12.5 million in 2011/12) will also be made in Oral Health, reducing Rheumatic Fever, Sexual Health, Drug and Alcohol Treatment, and establishment costs for new Crown entities in response to the MRG recommendations.

    x. **[2]**

[4] With additional investment in volumes from DHBs

Risk Management

xi. **[6]**

Table 1: Vote Health Budget 2011 Overview (highest outyear)

All figures $millions. Table does not show Ministry DE			
Current Baseline	**DHB NDE** 10,095	**Ministry NDE** 2,733	**TOTAL** 12,828
Funding Required:			
Indicative cost pressures	457	120	577
Deficit improvement	37		37
[6]			
Ministerial priorities (new initiatives)		92	92
Total cost pressures, risk reserve and Ministerial priorities:	494	222	716
Less new funding allocation in 2011/12	350	70[6]	420
Remaining pressures to be managed	144	152	296
Actions to manage pressures:			
Additional efficiency gains	69	57	126
Productivity gains from MRG changes	75		75
Reprioritisation		91	91
Total Actions	144	148	292
Funding balance[7]	0	(4)	(4)

Managing risks to achieving Budget 2011 expectations

16. Table 2 summarises the risks to achieving the Budget 2011 strategy over the next four years and the strategies to manage them. Risks have been rated as Red, Amber or Green depending on the likelihood that, if materialised, they can be managed within the budget parameters. Green indicates that the risk is being thoroughly managed. Amber indicates a risk that is expected to be manageable within the Vote. Red indicates a risk that is not expected to be manageable within the Vote.

Table 2: Overview of Risks

Risk	Red/ Amber/ Green Rating	Management strategy
[3],[2]		
[6]		
[6]		
4. MRG Recommendations *Partial delivery of estimated productivity and cost reduction improvements*	**A**	Newly established MRG entities deliver their 2011 business plans in March NHB review will ensure actions are in place to deliver required cost savings and that regional service planning is proceeding The NHB will then continue to monitor performance against these plans. The NHB will also ensure that gains are not counted twice by DHBs and MRG entities

[5] Refer to paragraph 40 for a discussion of the sleepover case risk

[6] Includes sector-wide Risk Reserve, which is held in Ministry NDE

[7] Outyear deficit is driven by the increasing cost of the Boosting Medical Places Initiative. The peak is in 2022/23

5. Efficiency *Partial delivery of DHB and Ministry of Health efficiency gains*	**A**	DHBs have agreed that they can manage within the expectations in Budget 2011 though 2011/12 will be a tighter year than 2010/11. DHB annual plans will be provided in March. Once agreed, the Monitoring and Intervention Framework provides scope to work with a board to improve performance The Ministry of Health's efficiency gains are in clearly identified and assessed areas. They have been agreed internally and are now being translated into baselines
6. Deficits *Failure to live to the deficit improvement track*	**A**	As above, Monitoring and Intervention Framework provides scope to work with a board to improve performance If they do not meet expectations. The deficit risk is likely to be a consequence of inability to manage risks 1 to 4 Expectations of achieving the deficit track have been, and will continue to be, clearly communicated to DHBs. Despite an improving deficit track, strong oversight will still be needed
[6]		

Vote Allocation Risk (risk 1)

[3]

[2]

[6]

[6]

[6]

Achieving the required productivity and efficiency gains (risks 3 to 6)

33. The Four-Year Budget Plan details how Vote Heath will live within an increase of $420 million. Vote Health is required to make ongoing efficiency and productivity gains of $194 million to achieve Budget 2011 expectations. This is in the context of the most challenging parameters for of health spending in a decade (refer to figure 1 on page 2).

34. A range of efficiency and productivity initiatives are being progressed. Ministry-managed NDE will have tight cost control and contract management. The National Health Board (NHB) has been established to monitor and support DHBs to achieve efficiency and productivity targets. DHBs will submit their District Annual Plans (DAPs) in March 2011, detailing how they intend to live within their allocation of funding ($350 million across all twenty DHBs) and the agreed deficit improvement track.

35. DAPs that do not comply with Government expectations will be returned for improvement and resubmission. The NHB, through the Monitoring and Intervention Framework (MIF), also has a range of options available to engage with DHBs throughout the year. The NHB monitors DHB financial data monthly, and can increase the level of monitoring should concerning triggers be identified through five stages from standard monitoring to direct governance action (including removal of the board).

36. DHBs are also engaged in a Hospital Productivity & Quality program which includes achieving gains through better contracting, better use of wards and emergency rooms, and shifts to primary care.

37. DHBs also will be supported by two newly established entities: Health Benefits Ltd (HBL) and the Health Quality & Safety Commission (HQSC). HBL has been established to provide shared administrative and support functions in order to improve quality and reduce waste. It is supported by additional Ministerial powers to direct planning and regional collaboration amongst DHBs. It has already identified $33.5 million of savings in 2010/11 and is due to provide its business plan for 2011/12 in March 2011. **[2]**

38. The HQSC has been established to investigate and disseminate instances of best practice to the clinical practice community. The incidence of adverse medical events and their costs will be reduced through the culmination of a large number of marginal quality improvements. **[2]**

39. The key consideration will be ensuring, through robust monitoring and analysis of the business plans that the entities supply, that the efficiency and productivity gains cumulate across agencies.

[6]

[6]

Consultation

43. The Treasury and the State Services Commission were consulted in the development of this Cabinet paper. The Department of Prime Minister and Cabinet were provided with a copy of the paper prior to going to Cabinet. Treasury wishes to make the following comment on the paper:

Treasury Comment for inclusion in Draft CBC paper on Health Budget Issues for OSOC

[2]

[2]

Ministers should note that:

i. When it was agreed last October, Health's $420m budget allocation was 37.4% of a planned $1.122 billion operating allowance. With the operating allowance now reduced to $800m-$900m, Health's current allocation is 46.7% to 52.5% of new operating spending for Budget 2011.

ii. Spending increases at or above "expectations" of demographic and inflation/wages/ technology adjustments are not necessary to maintain and improve current services and quality if the productivity and efficiency improvements described in this paper are delivered. These improvements are achievable, but no amount of improvement within current baselines can help to meet expectations focused on the amount of *new* money added to the health budget each year, rather than on service delivery and performance.

[2]

[6]

[2]

Financial Implications

48. Final decision on the Vote Health Four year Budget Plan will be made by Budget Ministers on 28 February 2011 and incorporated into the Budget Cabinet Paper in April 2011.

Legislative Implications and Regulatory Impact Analysis

49. There are no legislative or regulatory impact implications arising from this paper.

Human Rights and Gender Implications and Disability Perspective

50. There are no human rights, gender or disability implications arising from this paper.

Recommendations

51. I recommend that the Cabinet Business Committee:

a. **note** that Vote Health's allocation of $420 million is the largest increase of all votes in Budget 2011, but has risks and pressures greater than the allocation

b. **note** that an addition $91 million from within Ministry-managed funding will be reprioritised and remaining pressures will be met by initiatives which contain costs and enhance productivity and efficiency across the vote consistent with Expenditure Control Committee discussions in September 2010

c. **note** that additional funding will be targeted to high priority areas such as maintaining front-line services and delivering on manifesto commitments and Government priorities

d. **note** that seven types of risks to the 2011 Budget Strategy have been identified and there are strategies in place to manage the risks to:

[6]

iii. successfully realising the savings from the MRG recommendations, and

iv. the flow-on impact to achieving the DHB deficit reduction track

e. **note** that a number of mitigation strategies have been identified should achievement of the DHB deficit track be compromised

f. **[6]**

g.

h.

i.

j. **[2]**

k.

l. **note** that Budget Ministers are meeting on the evening of 28 February 2011 to consider resubmitted Four-Year Budget Plans and issues from this paper will be considered.

Hon Tony Ryall

Minister of Health

Date: