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Vote Health

Four-year Budget Plan

Version 1

As at 8 December 2010

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Section 1: Overview of Delivering on Government Priorities in Vote Health in Budget 2011 and the medium-term

1. The health and disability system faces significant fiscal and demographic challenges over the coming years which will require ongoing performance and value for money improvements to ensure highest quality, best value services are provided to improve the health and independence outcomes of New Zealanders.

2. Budget 2011 funding allocated to Vote Health represents a slower funding growth path than previous years. This is expected to continue over the next four years, meaning fiscal and demographic challenges will continue to be felt over the medium to long-term. Despite this, the Health sector is committed to developing a sustainable and high performing health and disability system in which resources are moved to the frontline to enhance quality of care and support.

Government Priorities

3. The Government is seeking to improve State sector performance to ensure the value for money of public spending and to address imbalances in the New Zealand economy.

4. For Health, the Government's priorities are to ensure a clinically and financially sustainable health and disability system, a system in which the services New Zealanders expect are delivered to high quality, and in a timely way, and clinical input into decision-making is valued. Given the fiscal environment, this requires improved efficiency, less bureaucracy and moving resources to highest value services across the system.

Achievements to date on Government Priorities

5. The Health sector has made significant progress in moving more resources to valued frontline services including:

    - $78 million reprioritised in Ministry Departmental Expenditure (DE) and Non-Departmental Expenditure (NDE) to valued frontline services and Government priorities over the last two budgets and cost pressures of $57 million carried internally
    - Ministry FTEs reduced from 1675 to 1390 by 1 July 2010, with a commitment to reduce FTEs to 1290 by July 2011 - one of the largest reductions in the state sector
    - DHBs have also committed to manage non-frontline FTEs within an agreed headcount cap
    - District Health Board (DHB) deficits, which were $102 million at 30 June 2010 (and forecast to reach $200 million for that period), are forecast to reduce to $80 million in June 2011
    - Significant improvements in hospital productivity, delivery on health targets and tight employment relations management in 2009/10
    - Better, Sooner, More Convenient primary care is being implemented and savings from management fees and bureaucracy have been made to manage cost growth, including the consolidation of Primary Health Organisations (PHOs) from 81 to 56.

6. Following the report of the Ministerial Reform Group (MRG), the Minister of Health has initiated an improvement programme for the health and disability system that is expected to deliver substantial savings over the next four years.

7. In addition, the Government has significantly increased funding to Vote Health over the last two years ($750 million in Budget 2009 and $512 million in Budget 2010) to ensure valued frontline services continue to be delivered to the public and that health manifesto commitments are progressed including:

    - $790 million to DHBs to maintain per capita service coverage of valued frontline services
    - $121 million to Ministry-managed services such as Disability Support, National Screening, National Electives, National Emergency Services, and Primary Care to maintain per capita service coverage
    - $93 million to DHBs as a supplementary price increase to manage pressures in Budget 2009 and deliver the following manifesto commitments including:

    - Devolving some hospital services to primary care as part of Better, Sooner, More Convenient
    - Respite care for older people and their carers
    - Improve the quality of supervision and nursing in aged residential care
    - Longer post-natal stays in birth facilities
- $30 million for an additional 80 medical student places per annum
- $35 million for other workforce development and training initiatives
- $60 million to Boost Subsidised Medicines (including Herceptin) per annum
- $40 million for mental health initiatives
- $15 million for boosting hospice care
- $30 million for maintaining Maternity and Compulsory Care frontline services.

Delivering on Government Priorities Over the Next Four Years

8. Delivering on Government priorities over the next four years requires building a high-quality, patient-centred health system that ensures all New Zealanders have the same opportunities for good health and one that is able to respond effectively to current and future pressures. This goal is achievable, but it will be tough given the fiscal and demographic challenges facing Vote Health.
9. There is no single answer for addressing these challenges. Of particular importance will be effectively managing controllable and uncontrollable demand, such as the challenge of the rising prevalence of chronic disease and population ageing. Maintaining firm fiscal control is also essential in the face of rising expectations regarding what services the system provides and labour costs. The health and disability system needs to do the right things at the right time, eliminate duplication, and have people with the right knowledge, skills and incentives in the right place to do the job.
10. An improvement programme for the health system has commenced that goes a long way to lifting system performance.
11. Into the future, as outlined in the recent Expenditure Control Committee (ECC) report, the strategic direction is to deliver better, smarter public health services by controlling price pressures while delivering services in the right location, at the right time, at the highest quality, and for the best value. Over the next four years this will be achieved through delivering on the Government's improvement programme and a combination of:
    - Tight cost containment
    - Purchasing/productivity improvement
    - Service reconfiguration
    - Reprioritisation of lower value spending to fund higher priority new initiatives.
12. These methods are expected to enable Vote Health to live within a slower funding growth path while maintaining per capita service coverage of valued frontline services and improve the health and independence outcomes of New Zealanders.

Ministerial Priorities for Budget 2011

13. The Budget 2011 priorities for the health and disability system outlined in this plan are:
    - Delivery on Government Health Targets to improve health and independence outcomes and sector productivity
    - Continuing to deliver better frontline services that improve the health and independence outcomes of New Zealanders
    - Strong financial management across the health and disability system to move resources to frontline services and ensure continuous value for money and productivity improvements

- A sustainable clinical workforce that has a strong leadership role in the health and disability system to facilitate improvements in quality, patient/client outcomes, and productivity
- Safe and effective services for older people to improve their health and well-being through a seamless spectrum of care, enabling them to remain independent and in the community for longer.

14. In addition, further progress will be made on fulfilling costed Government health manifesto commitments. The proposed Budget 2011 package will mean that all costed health manifesto commitments will have been progressed with only the outyear (Budgets 2012 and 2013) commitment of 80 remaining medical places to be funded.

15. Finally, new funding is being provided to a select number of programmes such as health of older people, maternity services, and reducing rheumatic fever.

Delivering Ministerial priorities for 2011/12

16. Top-down estimates of cost pressures (FFT/Demo) for non-departmental expenditure (NDE) services in Budget 2011 currently suggest $577 million of funding is required to address demographic and financial pressures prior to efficiency expectations. Based on Vote Health's Budget 2011 new operating allocation, this implies up to $157 million (1.2 percent) of efficiency savings are required to maintain valued frontline service coverage, and DHBs expected to continue to improve the sector deficit track by $37 million in 2011/12.

17. The Budget 2011 package proposes to focus on maintaining valued frontline service coverage and addressing risks and pressures as far as possible to ensure system sustainability and avoid problems emerging during the year. The funding increases agreed for DHBs, and proposed for health and disability services managed on behalf of the Crown by the Ministry, are aimed at achieving these priorities. The impact on operating funding baselines is provided in Table 1.

18. Given the fiscal environment, a modest new initiatives package ($97 million in 2011 and $93 million at the highest outyear) is proposed. The package will be funded through reprioritisation (see Table 3). This is fiscally prudent and aligned with the priority of ensuring system sustainability.

Table 1: Summary of operating funding impacts over forecast period (Budget 2011 funding impact only)

Operating	**Impact ($Ms)**				
	2010/11	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Current Non-Departmental Expenditure Baseline (Main Estimates)[1]	12,846.564	12,754.483	12,729.824	12,706.666	12,713.012
DHBs allocation to manage cost pressures (demo/price)	-	350.000	350.000	350.000	350.000
Ministry NDE allocation to manage cost pressures (demo/price)	-	60.000	60.000	60.000	60.000
Risk reserve to provision for fiscal risks		10.000	10.000	10.000	10.000
Ministerial priorities (new initiatives) & remaining cost pressures addressed through fiscally neutral reprioritisation	See Table 3.				
New baseline	-	13,174.483	13,149.824	13,126.666	13,133.012

19. The funding requested from the Crown's Capital Allowance to be allocated to Vote Health's Capital Envelope (Table 2) is to provide capital investment to meet population growth pressures, ensure the

[1] Note the figures in this report are based on Vote Health 2010/11 Main estimates.

sustainability of current assets[2] (e.g. publicly owned hospitals), deliver Government priorities (e.g. increased elective theatre capacity), and other delayed capital projects. These investments are intended to ensure the quality of service delivery over the longer-term.

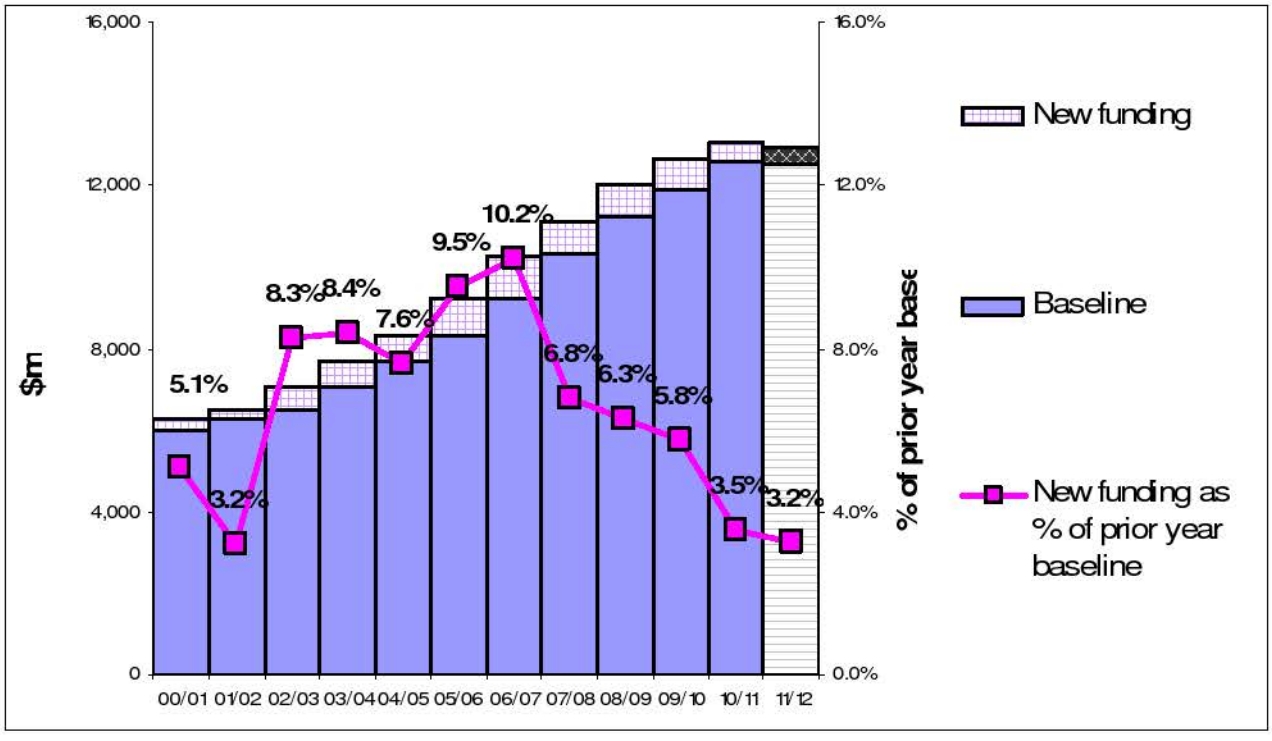
Table 2: Summary of capital funding impacts over forecast period (Budget 2011 funding impact only)

Capital	Impact ($Ms)				
	2010/11	2011/12	2012/13	2013/14	2014/15
Health Capital Envelope allocation sought for Budget 2011	-	220.000	-	-	-
Estimated Health Capital Envelope allocation to be sought in future budgets (as discussed in paragraph 53.)	-	-	229.900	240.246	251.057
Total Capital	-	220.000	N/A	N/A	N/A

Section 2: Vote Pressures and Priorities

20. As discussed in Section 1, Vote Health faces significant immediate fiscal and demographic challenges in Budget 2011. These challenges will continue to be felt over the medium to long-term in the context of a slower funding path for Health as shown in Figure 1 below. The health and disability system has responded well to the significantly tighter financial situation.

Figure 1: Vote Health new operating funding as a percentage of previous years Main Estimates baseline (NDE & DE excluding capital)



21. In-depth reviews of DHB expenditure and Ministry-managed NDE have been undertaken with the involvement of external reviewers to develop options to manage cost pressures and reprioritise spending in Budget 2011. Reviews have focused on the most critical pressures and have been guided by the agreed strategic direction for Health, as outlined in paragraph 11.

22. Paragraphs 27 to 46 provide information on how DHBs and the Ministry, for the services it manages on behalf of the Crown, will work to manage cost pressures within available funding. Summary of reprioritisation proposals for Budget 2011 are outlined in Section 3.

23. Reprioritisation of health spending requires difficult trade-offs to be made. This includes the need to balance demand for frontline services now with the need for preventative services, such as public health and primary care, to lower demand for frontline services in future.

24. In addition, the health system faces fiscal and policy risks that can materialise as cost pressures over the course of a financial year. These risks need to be monitored, and sufficient funding provisioned, to enable timely intervention. A provision of $10 million is proposed to enable Government to respond to fiscal risks that may materialise in 2011/12.

25. As with preceding budgets, a modest package of new initiatives (Annex 2) is proposed for Budget 2011 of $97 million in 2011/12 and $93 million in the highest outyear[3].

26. Table 3 provides the key overview of Health's Budget 2011 package.

Table 3: Summary of Vote Health Budget 2011 operating package

$ Millions	2011/12	2012/13	2013/14	2014/15	Highest Outyear
Available Funding					
Budget 2011 Allocation	420.000	420.000	420.000	420.000	420.000
Reprioritisation (ongoing)	92.920	88.863	90.863	91.463	91.463
One-off savings	22.631	0.638			
Total Available Funding	535.551	509.501	510.863	511.463	511.463
Cost Pressures and Ministerial Priorities					
DHB cost pressures (demo/price)	350.000	350.000	350.000	350.000	350.000
Ministry-managed NDE cost pressures (demo/price)	62.515	62.515	62.515	62.515	62.515
Ministerial priorities	96.857	86.986	87.926	88.709	92.953
Increase to Risk Reserve	10.000	10.000	10.000	10.000	10.000
Total Cost Pressures and Priorities	519.372	509.501	510.441	511.224	515.468
Remaining funding	16.179	0.000	0.422	0.239	**-4.005**

District Health Boards non-departmental expenditure cost pressure management in Budget 2011

27. DHBs manage over $10 billion of Vote Health funding on behalf of the Crown to deliver health and disability support services. In October 2010, Cabinet agreed that $350 million of new funding would be allocated to DHBs from Health's allocation of $420 million in 2011/12 and outyears. Cabinet's agreement is in accord with the outyear funding signal provided to DHBs to inform their 2010/11 District Annual Plans (DAPs). Therefore, DHBs will be held to account for delivering on their 2010/11 DAP outyear financial performance parameters in Budget 2011.

[3] Achieving the Government's manifesto commitment to boosting medical student places requires additional funding outside of the forecast period until all additional places and associated post-graduate placements have reached their peak in 2023/24.

Table 4: Aggregate DHB 2010/11 DAP Financial Forecast and two years out[4]

Aggregate DHBs 2010/11 DAP Financial Forecast - in accord with final templates provided to MoH
Consolidated Financial Performance & KPIs

$millions	Actual 2008/09	Estimate 2009/10	DAP 2010/11	DAP 2011/12	DAP 2012/13	Annual Variance - % 2009/10	2010/11	2011/12	2012/13
Consolidated Financial Performance									
Revenue									
Government & Crown Agency	10,197.7	10,753.5	11,111.3	11,464.9	11,827.8	5.5%	3.3%	3.2%	3.2%
Other Income	368.2	336.7	324.9	326.3	341.3	(8.6%)	(3.5%)	0.4%	4.6%
Total Revenue	10,565.9	11,090.2	11,436.2	11,791.3	12,169.1	5.0%	3.1%	3.1%	3.2%
Expenses									
NGO Provider Payments - primary & community	3,742.2	3,987.5	4,117.3	4,232.3	4,349.5	6.6%	3.3%	2.8%	2.8%
DHB Hospital Provider Costs									
Personnel Costs	4,201.8	4,449.2	4,606.6	4,730.6	4,873.0	5.9%	3.5%	2.7%	3.0%
Outsourced - Personnel	175.3	145.3	109.2	112.4	114.8	(17.1%)	(24.9%)	2.9%	2.1%
Outsourced - Other	271.1	263.4	239.5	248.6	258.2	(2.8%)	(9.1%)	3.8%	3.9%
Clinical Supplies	951.4	991.5	998.8	1,019.1	1,046.5	4.2%	0.7%	2.0%	2.7%
Infrastructure & Non-Clinical Supplies	715.1	671.6	721.9	728.1	737.5	(6.1%)	7.5%	0.9%	1.3%
Capital Costs (Interest Exp, Depreciation, Capital Charge)	542.8	591.2	625.7	665.3	708.9	8.9%	5.8%	6.3%	6.5%
Total DHB Hospital Provider Costs	6,857.4	7,112.2	7,301.8	7,504.1	7,738.9	3.7%	2.7%	2.8%	3.1%
DHB Governance-Arm Costs	121.4	104.8	97.2	98.6	100.9	(13.7%)	(7.3%)	1.5%	2.3%
Total Expenses	10,721.0	11,204.6	11,516.2	11,835.0	12,189.4	4.5%	2.8%	2.8%	3.0%
Net Surplus / (Deficit)	**(155.1)**	**(114.4)**	**(80.1)**	**(43.8)**	**(20.3)**				
KPIs									
DHB Hospital Full-Time-Equivalent (FTE) Staff	53,345	55,023	55,681	55,926	56,290	3.1%	1.2%	0.4%	0.7%
Average Hospital Personnel Cost per FTE Staff ($)	78,766	80,859	82,732	84,586	86,570	2.7%	2.3%	2.2%	2.3%
Total Hospital Personnel Cost Change						5.9%	3.5%	2.7%	3.0%
Effective Total Hospital Personnel Costs (incl outsourcing)	4,377.1	4,594.5	4,715.8	4,843.0	4,987.8	5.0%	2.6%	2.7%	3.0%
Implied DHB Hospital FTE Staff Change (after allowance for outsourcing)						2.3%	0.3%	0.5%	0.6%
Overall Expected Service Level Change - Demographics Volume Increase							1.9%	1.7%	1.6%

28. The funding allocated to DHBs represents a 3.5 percent increase on their 2010/11 baselines. The funding increase is to meet cost pressures arising from demographic growth and population ageing (estimated at 1.75 percent) and a contribution towards price pressures (1.73 percent).

29. Top-down estimates (based on a certain set of assumptions) of DHB cost pressures (FFT/Demo) suggest $457 million of funding is required to manage pressures prior to efficiency gain expectations. Budget 2011 funding allocated to DHBs ($350 million) implies an efficiency gain expectation of approximately 1.1 percent against the top-down estimate of cost pressures of 4.55 percent.

30. To manage within their available funding ($350 million) against top-down estimates of cost pressures and deficit improvement expectations ($457 million plus $37 million equals $494 million), DHBs will need to make efficiency and productivity improvements of approximately $144 million to maintain per capita service coverage and associated volumes while meeting Government Health Targets. Approximately $75 million of these improvements will be delivered through a mix of initiatives in the existing improvement programme for the health sector, for example, Health Benefits Limited (HBL), Health Safety and Quality Commission (HSQC), and central sector services (payment processes).

31. To deliver the remaining $69 million, DHBs have committed to make further efficiency and productivity improvements. The recent in-depth review of DHB expenditure indicated that this level of improvements would be challenging to deliver but feasible. The DHB review identified the following options to deliver the required efficiency and productivity savings, in line with advice to ECC:

    i. *tight cost containment* – to limit the rate of cost growth through proactive management of employment relations settlements, improved/innovative use of a suitably skilled workforce, collective procurement and increased shared services

[4] Note this table shows how DHBs plan to live within their available baseline funding and signalled potential new funding allocation. It shows how they plan to spend their funding across hospital and non-hospital services and DHB governance arm costs but does not show the full extent of underlying pressure as these are expected to be managed through the required efficiency and productivity gains to limit expenditure growth to forecast levels.

ii. *purchasing and productivity improvement* – to deliver services more efficiently and effectively across both non-hospital and hospital providers through increased visibility and accelerated implementation of the sector productivity work programme, reviewing NGO purchasing and pricing arrangements, improved integration between hospital and community services, and better management of demand-driven services

iii. *service reconfiguration* – to support improved national, regional, and local service delivery models (including greater regional co-operation) through reconfiguring and rationalising current service delivery models, implementing new models of care, and improving capital planning.

32. Some of the above options will include changes to models of care and service mix. In some instances, changes to service mix will require reprioritisation of funding from lower value services and contracts to valued frontline services. The expectation communicated to DHBs is that these changes are not to affect the overall service coverage and quality of valued frontline services. This will be monitored by the National Health Board (NHB).

33. The key risks to DHBs realising the required improvements are:

- under-delivery on expected MRG reform savings
- under-delivery on hospital and non-hospital productivity/efficiency improvements
- employment relations negotiations are settled above affordability constraints.

34. Cabinet-agreed MRG reforms are being implemented with thorough analysis of potential savings and plans to realise them. While this work is only partially completed at this time, and further advanced for some reforms than others, indications are that substantial gains are likely to be made. The NHB is working with the new organisations established to ensure that agreed organisation business plans and other initiative savings expectations are delivered. ECC will receive advice on progress on implementing MRG reforms in December 2010.

35. Risks around productivity and efficiency improvements and employment relations settlements are manageable through tight performance management and clear communication of expectations to the sector. DHBs will be required to identify specific productivity improvement initiatives and expected savings across both hospital and non-hospital settings in their 2011/12 District Annual Plans (DAPs), as they were in the 2010/11 DAP round. The NHB will monitor DHB progress against agreed savings targets with early identification and intervention where evidence suggests under-delivery. The hospital productivity programme will also continue to be rolled out.

36. DHBs are required under the New Zealand Public Health and Disability Act 2000 to consult with the Ministry prior to entering into employment relations negotiations. As per Government expectations, the Ministry has advised DHBs that they need to ensure they can afford the full cost of any settlement offer, along with the cost of their existing commitments within their funding package and without recourse to extraordinary government funding. Under the same arrangements in Budget 2009 and 2010, DHBs settled employment relations negotiations within agreed parameters.

37. DHBs were provided with the same level of funding increase in Budget 2010 as is signalled for Budget 2011. Monitoring of DHB financial performance at this stage of the 2010/11 financial year suggests that DHBs will meet agreed financial parameters including their agreed productivity improvement initiatives while delivering on Government Health Targets, as they did in 2009/10.

38. Any unexpected calls on DHB funds may place pressure on DHB forecast deficits and, unmanaged, lead to variance from the agreed deficit improvement track. DHBs will be held to account for meeting their accepted DAP financial performance targets. The NHB will monitor this performance, including active intervention when targets are not being met.

Ministry non-departmental expenditure cost pressure management in Budget 2011

39. The Ministry manages $2.7 billion of services on behalf of the Crown, most of which are frontline services such as disability support, primary maternity services, national elective services, national screening services, and primary care services. Ministry-managed frontline services face the same

pressures as DHB-managed services; a third of Ministry-managed funding is directly contracted with DHBs.

40. As part of the review of Ministry-managed NDE, a prioritisation process was undertaken to identify the most critical pressures within Ministry-managed services and management options including reprioritisation. The majority of Ministry-managed pressures requiring funding in Budget 2011 are frontline care and support services (as outlined below in Table 5).

41. Top-down estimates (based on a certain set of assumptions) of Ministry-managed NDE cost pressures (FFT/Demo) suggest $120 million of funding is required to manage pressures prior to efficiency gain expectations. Following a detailed assessment of feasible efficiency gains, while ensuring financial and service sustainability, Ministry-managed NDE cost pressures have been scaled by $57 million to $63 million. This equates to an efficiency gain expectation of approximately 2.2 percent against the top-down estimate of cost pressures of 4.55 percent (and DHB efficiency gains of 1.1 percent) This is two times higher than the efficiency expectation of 1.1 percent implied for DHBs.

42. The proposed aggregate increase of 2.33 percent ($63 million) to Ministry-managed NDE services is in line with funding increases provided in the last two budgets. The funding increase is to manage population growth and ageing pressures (1.75 percent), and a small contribution (less than for DHBs) towards price pressures (0.65 percent).

43. This will require significant service delivery efficiency gains. These efficiency gains are achievable. New funding will be allocated for price pressures on the basis of financial and service sustainability assessments. As such, funding allocations will vary across services and just over one third of services will receive no increase.

Table 5: Ministry-managed NDE cost pressures ($ millions)

Ref	Service Area	2010/11 Baseline	2011/12	2011/13	2011/14	2011/15	Highest Outyear	Percentage
1	**Disability Support Services**	970.077	32.500	32.500	32.500	32.500	32.500	3.35%
2	**Elective Services**	235.726	5.000	5.000	5.000	5.000	5.000	2.12%
3	**Emergency Management Vaccine write-offs**	0.000	8.000	8.000	8.000	8.000	8.000	N/A
4	**National Emergency Services**	93.892	2.234	2.234	2.234	2.234	2.234	2.38%
5	**National Maternity Services**	129.610	3.240	3.240	3.240	3.240	3.240	2.50%
6	**National Screening Services**	106.257	2.500	2.500	2.500	2.500	2.500	2.35%
7	**Personal Health Services**	Healthline: 12.750	1.148	1.148	1.148	1.148	1.148	9.00%
		Well Child: 41.137	0.823	0.823	0.823	0.823	0.823	2.00%
		PlunketLine: 3.500	0.315	0.315	0.315	0.315	0.315	9.00%
		Chaplaincy: 2.434	0.097	0.097	0.097	0.097	0.097	3.99%
		Sub Total: 59.821	**2.383**	**2.383**	**2.383**	**2.383**	**2.383**	**3.98%**
8	**University of Otago National Poisons Centre**	0.936	0.399	0.399	0.399	0.399	0.399	N/A
9	**Family Violence - Elder Abuse & Neglect**	3.907	0.078	0.078	0.078	0.078	0.078	2.00%
10	**ESR Scientific Services Programme**	10.530	0.527	0.527	0.527	0.527	0.527	5.00%
11	**NZ Health Survey**	4.749	0.416	0.416	0.416	0.416	0.416	8.76%
12	**Very Low Cost Access / Under Sixes**	55.500	3.400	3.400	3.400	3.400	3.400	6.13%
13	**Public Health Units**	61.727	1.838	1.838	1.838	1.838	1.838	3.00%
14	**All other services receiving no increase**	953.000	0.000	0.000	0.000	0.000	0.000	0.00%
TOTAL		**2685.732**	**62.515**	**62.515**	**62.515**	**62.515**	**62.515**	**2.33%**

44. The key risks to realising the Ministry-managed NDE service efficiencies are:
    - **[6]**
    - output delivery in demand-driven services outstripping available funding, particularly in maternity and disability support

    [6]

45.

46. Demand-driven service risks have been mitigated through tighter forecasting, as far as possible given available information. If demand-driven risks do materialise, the Ministry will advise Government of options to manage these risks including accessing the proposed Vote Health risk reserve or changes to policy settings.

Managing 2011/12 fiscal risks over and above those addressed in Budget 2011

47. The health and disability system faces fiscal and policy risks over and above those already discussed for DHB and Ministry-managed NDE services, such as any fiscal implications arising from the Family Caregivers human rights commission case, any risks arising from employment relations settlements **[6]** and volume-driven Ministry-managed NDE service (e.g. maternity). These risks will need to be monitored and managed in 2011/12.

48. It is proposed that $10 million of Vote Health's new operating allocation will be set aside, on top of any residual risk reserve funding that may remain from Budget 2010, as a provision for any fiscal risks that materialise as cost pressures during the 2011/12 year.

49. The strategy for managing known Health fiscal risks during the 2011/12 year is:
    - Addressing as many pressures as far as possible in the Budget 2011 package to manage down possible fiscal risks during the 2011/12 year
    - Reprioritisation of lower value spending, or
    - Use of risk reserve funding.

50. Health is committed to living within its available funding. However, if extraordinary risks emerge that exceed available funding then access to the Crown between-Budget contingency may be required.

51. Given the significant reprioritisation that is proposed to be made in Ministry-managed NDE to balance the Budget 2011 package, and savings that DHBs are required to make to live within available funding, it is likely that any further reprioritisation will require changes to policy settings which will affect service coverage in Ministry-managed services.

Managing cost pressures and Ministerial priorities over the medium-term

52. Vote Health faces considerable fiscal and demographic challenges over the medium-term as shown in the table below. The table assumes that Health receives the same level of funding in each Budget, employment relations are settled within affordability constraints, and that each year productivity and deficit improvements are successful. It shows that significant cumulative performance savings, approximately $1.8 billion over four years, are required to live within this funding growth path before any reprioritisation to fund Government priorities (i.e. new initiatives).

Table 6: Cumulative estimates of operating performance improvement savings required to live within available funding over the medium-term

$ millions GST exclusive		2011/12	2012/13	2013/14	2014/15	Total
Vote Health NDE baseline (2010/11 Main Estimates)	12,828.357	12,774.483	12,749.824	12,701.666	12,707.922	
New funding assumption based on Budget 2011 allocation		420.000	840.000	1,260.000	1,680.000	4,200.000
Pressures						
FFT (price pressure estimate of inflation, labour costs, and technology change at the margin)		354.369	707.489	1,071.509	1,446.657	3,580.025
Demo (annual adjustment to account for demographic pressures including population ageing)		222.272	431.921	635.367	851.981	2,141.542
Deficit improvement (required to reach sector break even)		37.000	60.000	80.000	80.000	257.000
Total cost pressure (FFT, Demo, Deficit Improvement) estimate		613.641	1,199.410	1,786.876	2,378.639	5,978.566
Cumulative performance improvement required to live within Health operating allocation scenario		**-193.641**	**-359.410**	**-526.876**	**-698.639**	**-1,778.566**
Cumulative performance improvement savings as a % of 2010/11 operating expenditure baseline (Row 1)		**-1.5%**	**-2.8%**	**-4.1%**	**-5.4%**	

53. Health has also estimated capital investment funding requirements over the next three years (shown in Table 7) based on demographic growth pressures, affordability constraints, and allowing for a smoother investment track to contribute to financial and service sustainability.

Table 7: Estimate of capital investment requirements over the medium-term ($Ms)

2012/13	2013/14	2014/15 and outyears
229.900	240.246	251.057

54. To deliver the required performance improvement savings and system sustainability, recent progress and improvements, discussed below, need to continue.

55. The establishment of the NHB and other boards (eg, Health Workforce New Zealand) focused on improving national, regional, and district service and capacity planning will aid in ensuring best use of resources. Improvements will also ensure greater DHB collaboration on service and capacity planning (first full regional services plans due 2011/12) and hospital productivity to address upcoming clinical and financial sustainability issues.

56. Technology is a key cost driver in the system primarily through its impact on service expansion. The prioritisation of new technologies and service expansion has been strengthened with a refocused National Health Committee (NHC). The refocused role of the NHC will require advice to be provided on whether any proposed service expansions demonstrate clinical and cost effectiveness and over time, apply the same rigor to existing services.

57. PHARMAC's expanded role in managing hospital medicines and some medical devices[5] will materially contribute to controlling hospital expenditure growth. PHARMAC's expanded role and a refocused NHC will likely have an immediate constraining influence on expenditure growth.

58. Waste and bureaucracy reduction in the system will be assisted by HBL, the Quality and Safety Commission, and consolidation of PHOs.

59. The capital decision-making process is undergoing significant change with the establishment of the NHB and the Capital Investment Committee. The process includes an enhanced method for determining capital investment funding requirements to provide a clear capital investment pathway in which service planning inputs (e.g. labour) can be assessed against the affordability of the proposed capital path to ensure capital decisions are supporting service planning.

[5] Estimated expenditure on medical devices was $770 million in 2008/09, with growth of 20 percent over the previous two years.

[6]

New priorities for Budget 2011

64. Given the fiscal environment, a modest new initiatives package of $97 million in 2011/12 and $93 million at the highest outyear (Table 8) is proposed. With the exception of the Boosting Subsided Medicines initiative ($20 million) to be funded by DHBs, this package will be funded through reprioritisation from Ministry-managed NDE (approximately $70 million at the highest outyear). This is fiscally prudent and aligned with the priority of ensuring system sustainability.

65. The new initiatives package for Budget 2011 progresses outstanding manifesto commitments and supports key priorities for 2011/12.

66. The most significant new priorities are Government manifesto commitments (boosting medical student places, boosting subsidised medicines, additional WellChild visits, and Electives services). Other new priority initiatives total approximately $43 million including health of older people, maternity services, and reducing rheumatic fever. The latter initiative is time-limited and will be funded through underspends. **[6]**

67. Discussions are also under way with Associate Ministers on their priorities for Budget 2011. Approximately $4 million has been identified for reprioritising funding within their portfolios.

Table 8: New priorities for Budget 2011

Ref	Description	2011/12	2012/13	2013/14	2014/15	Highest Outyear
1	**Boosting Medical Places - year 3 of 5**	1.178	3.270	5.412	7.560	17.348
2	**Boosting Subsidised Medicines - year 3 of 3 - to be funded within DHB new funding allocation ($20 m)**	-	-	-	-	-
3	**Additional Well Child visits (scaled)**	5.330	5.330	5.330	5.330	5.330
4	**National Health Committee Innovation Fund**	3.000	3.000	3.000	3.000	3.000
5	**Maternity Quality and Safety Programme**	9.800	9.800	9.800	9.800	9.800
6	**Electives (additional discharges) - Ministry of Health share of Government target of 4000 per annum**	12.000	12.000	12.000	12.000	12.000
7	**Health of Older People (dementia services)**	10.000	10.000	10.000	10.000	10.000
8	**Mental Health Blueprint**	10.000	10.000	10.000	10.000	10.000
9	**Electives (funding to maintain 2009/10 discharge levels which were time limited)**	5.000	5.000	5.000	5.000	5.000
10	**Reducing Rheumatic Fever (time limited)**	0.949	1.099	0.909	0.544	N/A
11	**Oral Health**	1.100	1.100	1.100	1.100	1.100
12	**Voluntary Bonding Scheme additional registrations (time limited)**	1.000	N/A	N/A	N/A	N/A
13	**Health Benefits Limited (fiscally neutral over time via DHB savings)**	5.000	4.000	3.000	2.000	-3.000
14	**Compulsory Drug and Alcohol Treatment**	N/A	0.787	0.775	0.775	0.775
15	**Sexual Health**	2.500	1.600	1.600	1.600	1.600
[6]						
GRAND TOTAL		**96.857**	**86.986**	**87.926**	**88.709**	**92.953**

Capital investment in Budget 2011

68. The Government wants to improve the asset management practices of the State sector. As part of the Government's reforms for the health and disability system a new Capital Investment process overseen by the Capital Investment Committee (CIC) has been instituted.

69. The new capital process will place greater emphasis on the link between health planning and asset management to inform capital investment decisions. Over time the new process will build a national view of Health's current asset base and an enhanced assessment of capital investment options.

70. While the benefits from the new process will accumulate over time, there are immediate capital pressures that require addressing in Budget 2011. Crown capital allocation funding of $220 million is sought in Budget 2011. This level of investment is to ensure the sector's capital infrastructure will enable ongoing quality and safety of service delivery while addressing the demographic challenges facing Vote Health. This has been considered within the parameters of DHB affordability, expectations of economy-wide affordability (longer-term GDP growth assumptions), and no Crown capital funding being allocated to Health in Budget 2010.

71. If the capital funding sought is not agreed at the indicated level, fewer capital projects will be approved. Combined with no capital allocation in Budget 2010, this would exacerbate the risks of insufficient capital investment in the sector impacting upon the quality and safety of service delivery. This may include business cases for urgent investment or cases where patient safety and/or legislative requirements being compromised by inadequate facilities.

72. Ongoing under-investment is unsustainable resulting in more significant levels of capital funding being required in the future. This has macroeconomic and service delivery implications, both for the Health sector, as well as for the Crown.

73. The CIC will scrutinise all business cases that have Crown capital requests and/or also require approval by both the Minister of Health and the Minister of Finance. The CIC's criteria will ensure that projects agreed will integrate with IT, service and workforce planning, as well as support the Government's future direction for the health system.

Section 3: Summary of Reprioritisation Proposals for Budget 2011

74. The proposed package of reprioritisation initiatives for Budget 2011 was developed through the in-depth reviews of DHB and Ministry-managed NDE. Options are based on a value for money assessment of their contribution to the well-being of New Zealanders, Government priorities, and the clinical and financial sustainability of system over the short, medium, and long-term.

75. Reprioritisation within DHB funding will focus on achieving their financial targets and managing pressures and/or risks. Reprioritisation is retained by them (paragraphs 31 and 32).

76. Reprioritisation to fund new initiatives (with the exception of boosting medicines) has been from Ministry-managed NDE. The focus has been to eliminate waste and duplication, make changes to programmes (generally infrastructure and capacity support) and identify one-off savings. Details are provided in Annex Three.

Table 9: High level summary of Budget 2011 reprioritisation package to fund new initiatives

$ millions	2011/12	2012/13	2013/14	2014/15	4 yr Total
Eliminating waste and duplication (includes Departmental Expenditure savings)	23.103	23.478	23.478	23.478	93.537
Changes to programmes generally infrastructure and capacity support	39.817	45.385	47.385	47.985	180.572
Risk reserve	30.000	20.000	20.000	20.000	90.000
One-off savings from lower than expected spending	22.631	0.638	-	-	23.269
Total	115.551	89.501	90.863	91.463	387.378

77. The eliminating duplication and waste component of the package contains no significant policy issues or trade-offs and reflects the priority of sustainable financial management in the health and disability system. Some options will require changes to contracts and who delivers services. To achieve savings, implementation will require active management.

78. Given the fiscal environment, contracted providers should be expected to provide services to the highest quality, for the best value. Budget-holders are expected to extract the maximum value from their funding, with any funding not committed within the immediate future to be moved to valued frontline services and higher priority initiatives.

79. In previous years, many contracted providers have received significant funding increases with little or no explicit expectations of efficiency gains in service delivery. Through the review of Ministry-managed NDE, initiatives to increase the efficiency of some service providers have been identified by an assessment of their ability to continue to provide the same level of service delivery within scaled contract funding. Additionally, initiatives have been identified for improved forecasting and treatment of demand-driven services such as primary care.

80. The changes to programmes (generally infrastructure and capacity support) component of the package will contribute to maintaining valued frontline services and have been assessed as relatively lower value than other programmes in this category. In some cases, these initiatives are about extending the timeframe of capacity building programmes, for example workforce funding, rather than eliminating the

programme. These reprioritisation initiatives have been assessed against available information as able to be feasibly implemented without significant disruption or impact on the provision of valued frontline services or medium-term system sustainability.

81. While the focus is on ongoing savings to support ongoing pressures and new priorities, a number of one-off savings totalling $23 million have been identified. This will smooth out funding requirements in 2011/12 and will be used for addressing time-limited initiatives such as reducing rheumatic fever.

82. The amount from 2010/11 risk reserve will be used to respond to any fiscal risks that materialise as cost pressures during the 2011/12 year.

Section 4: Annexes

84. Attached are the following annexes

ANNEX ONE: Ministry-managed NDE cost pressures

Ref	Service Area	Description	Pressure	2010/11 Baseline	2011/12	Highest Outyear	Percentage
1	**Disability Support Services**	The Government's DSS policy is to support, where appropriate, people with disabilities to live independently in the community. Ministry–managed DSS frontline services, include: home and community support services, community residential care (including young people in residential care), respite care, carer support, supported independent living, clinical services purchased from DHBs, and NASC management. These frontline services face the same cost and volume pressures as DHBs. There are over 30,000 New Zealanders with low to very highly complex disabilities who access some or all of these services per annum. Most providers have received little or no price increases in recent years and been forced to make efficiency gains to meet wage and consumable cost increase. The proposed funding increase for DSS in Budget 2011 is to maintain per capita service coverage and provider sustainability, while moving service delivery closer to home to improve the cost-effectiveness of care. The Ministry considers this a tight but feasible increase for DSS in 2011/12 that will provide for financial and service sustainability. DSS also includes Environmental Support Services (ESS). These provide support services for all age groups so that people with disabilities can reside in the community. Over 41,000 New Zealanders with disabilities access ESS per annum. DSS also provides services for people referred by courts under the Intellectual Disability Compulsory Care and Rehabilitation (IDCC&R) Act. These clients have very high care needs that come with significant associated financial costs. The Ministry has no demand management levers to ameliorate volume pressures in this area. Finally, DSS also includes Assessment, Treatment & Rehabilitation services. These are multidisciplinary response teams for people with extremely complex needs, often following a stroke.	The majority of the funding increase proposed for DSS is to manage volume pressures. DSS faces volume pressures due to significant annual increases in the number of people living with disabilities. This is due to people living to an older age with disabilities than they have previously - meaning that they stay in the system for longer. This not only increases the number of people receiving services, but also increases the degree of complexity of services required, leading to transitions into more costly care. This is cumulative with population growth. The volume pressure would be more significant if not for the ongoing strategy of shifting services into community settings and placing an emphasis on maintaining a client's independence so that they may remain in their own home. Managing these volume pressures in cost-effective ways requires providing appropriate support in the community and assisting caregivers to provide care in their own homes. Targeted investment is being made to address the additional pressures in home and community support services and lower investment into more costly residential care (although still ensuring that services can be accessed in a timely fashion). This strategy has allowed DSS to function within a significantly more constrained funding package in recent years. **[9]** The Ministry has made significant progress over the last few years to live within a slower DSS funding growth path. This has included initiatives to improve the client needs assessment, shifting clients where appropriate from higher cost services to lower cost services, and enhancing purchasing through addressing price and contract variation across providers. The Ministry is continuing with this work including exploring alternative models of needs assessment and coordination, funding and service delivery, and procurement. This ongoing work will inform Budget 2012 decision-making. For ESS, in addition to the same volume pressures as other services, there are significant price pressures arising from technological innovation and increased cost for equipment and modifications. The Ministry advises that the key risks if the proposed funding increase for DSS is scaled down without corresponding improvements in policy settings will be: wait-listing for services; reductions in services for current clients; and the potential exit from services of some providers. If realised, these risks would impact on medium-term financial and service sustainability as client needs may increase at a faster rate resulting in them requiring more costly care sooner than would have otherwise have been the case.	970.077	**32.500**	**32.500**	**3.35%**
2	**Elective Services**	The Ministry manages $235 million of funding for DHB delivered elective services discharges. This is approximately 20% of the total elective surgery delivery nationwide. The funding is paid on a fee for service basis to DHBs upon delivery of elective discharges in order to incentivise DHB performance.	This proposed funding increase for Ministry-managed NDE electives is to provide a purchase price adjustment of 2.12% for the purchase of electives discharges. This price adjustment is based on calculation of Inter-District Flow (IDF) pricing work that informs the 2011/12 DHB Funding and Planning Package. IDF prices are adjusted for estimated increases in the cost of clinical labour and consumables. If a price adjustment is not provided to Ministry-managed electives NDE it is highly unlikely DHBs will be able to maintain 2010/11 elective volume discharges without needing to find further savings/productivity improvements on top of those already identified to enable them to manage within their current deficit track. The ability of DHBs to achieve the same volume of activity with less revenue will impact on achievement of the Government's electives target of an additional 4000 discharges on average per annum However, the Ministry considers that better connectivity between productivity gains and pricing arrangements to ensure cost effective service delivery is crucial in the future. This work can inform Budget 2012 decision-making.	235.726	**5.000**	**5.000**	**2.1%**
3	**Emergency Management Vaccine write-offs**	Write off of vaccine stocks purchased for the global pandemic threat of H5N1 (Avian Flu) and SARS (Severe Acute Respiratory Syndrome).	These potential pandemics did not eventuate. As a result, the stock of vaccines was never used and is now about to exceed the maximum usable age set by Medsafe. The cost of the vaccines has been accrued up to the point the vaccines are used or expire and needs to be accounted for. An alternative option is to approach Medsafe and seek reassessment and potential extension of the expiry date. The prospects of this succeeding have not been assessed, and, even if successful, this would only delay the funding requirement.	0.000	**8.000**	**8.000**	**N/A**

4	**National Emergency Services**	Purchase of national emergency road and air ambulance services, disaster preparedness, primary response in a medical emergency (PRIME) for rural regions and emergency ambulance communication centre services. Emergency Ambulance Communication Centres (EACCs) receive, handle and respond to all 111 calls for Emergency Ambulance Services. EACCs are bulk funded by the Ministry (65%) and ACC (35%) based on calls and activity. EACCs employ both call takers and dispatchers, who have different training requirements and roles.	Pressures arise from forecasts of significant volume increases (4% for ambulances, 5% for EACCs). The demographic adjuster is used as a proxy as services are expected to make efficiency gains to manage increases above this. They also face a 1.5% price pressure for ambulances due to wage pressures and large increases in the cost of consumables (medical supplies, petrol etc). [9]	93.892	**2.234**	**2.234**	**2.4%**
5	**National Maternity Services**	Funding under the Primary Maternity Services Notice 2007 for Lead Maternity Carers (ante and post natal care), primary birthing services, ultrasounds and primary birthing care. Primary Maternity Services are funded on a fee-for-service basis under a Section 88 Notice. Services are entirely demand driven due to prices being fixed under the notice. The Ministry has no direct lever over the volume of services provided and is legally obligated to fund all claims that comply with the notice.	The demand for primary maternity services is forecast to exceed available funding in 2010/11 due to higher than forecast demand (Demo). This will be addressed within available Vote Health funding. In 2011/12, a 3.2% volume pressure is forecast due to a slightly increasing birthrate and a substantial year on year growth in the numbers of ultrasounds per pregnancy. Ultrasound volumes have been steadily increasing over the last five years, however they have grown at an even greater rate in the last year due to a recommendation by the National Screening Unit to conduct a Nucal Translucency scan in the first trimester to detect antenatal Down Syndrome. The Ministry considers that demand for some primary maternity services can be eased in future years through aligning some fee-for-service specifications with international best practice. This requires amendment to the Service Notice which can not be feasibly implemented for Budget 2011. However, the Ministry is progressing work to develop options for managing maternity service pressures in Budget 2012.	129.610	**3.240**	**3.240**	**2.5%**
6	**National Screening Services**	BreastScreen Aotearoa, Cervical Screening and Antenatal & Newborn screening services. Screening services are purchased from DHBs and associated clinical staff costs resulting from employment relations negotiations place additional pressure on service budgets. Screening services are demand driven services with targeted coverage for a defined population. Changes in the size of the defined population (i.e. population growth and ageing) plus ensuring coverage targets are achieved places pressure on service budgets. Within screening programmes technological developments that improve the effectiveness and cost effectiveness of screening can place cost pressure on service budgets (even if they reduce costs in the future elsewhere).	BreastScreen Aotearoa, Cervical Screening and Antenatal & Newborn Screening services all face volume pressures due to population growth and the need to meet higher coverage targets. BreastScreen Aotearoa and Cervical screening services also face volume pressures arising from population ageing as the proportion of people in older age groups that form the defined population for these services increases. Service coverage targets are also lower than optimal for high needs groups such as Maori and Pasifika peoples. All three services are in the main provided by frontline clinical staff primarily employed by DHBs. Clinical workforce costs make up between 60% and 65% of budgets for these services. Industrial relations settlement cost pressures are incorporated into this funding proposal (1.5% adjustment) within Crown and DHB affordability constraints. If the proposed funding is not allocated to these services then per capita service coverage will not be able to be maintained. This will result in some people not being identified with associated medical conditions that may lead to preventable deaths occurring in outyears. Workforce retention and recruitment issues may also arise affecting service sustainability.	106.257	**2.500**	**2.500**	**2.4%**
7	**Personal Health Services**	Includes pressures for HealthLine, Plunket Well Child, PlunketLine and Hospital Chaplaincy. HealthLine is a 24-hour telephone triage service staffed by registered nurses. It provides advice and links patients with appropriate medical services if required. The Plunket Well Child contract covers approximately 85% of Well Child visits nationally. Visits form a comprehensive system of post-natal advice for new mothers and screening and health assessments for babies. PlunketLine is a 24-hour telephone advice service for families, whanau and caregivers to provide support for young families. The Ministry part funds the InterChurch Hospital Chaplaincy (ICHC) service that provides for the spiritual, emotional and pastoral needs of patients, particularly where their illness has presented a major threat or trauma and which may render patients and/or their whanau/family vulnerable.	HealthLine's contract incorporates a 3.4% price increase (paid at a per-call rate) in addition to a forecast volume increase of 6.87%. The Ministry funds this service on a fee-per-call basis. Not providing additional funding to address demand will require reductions in service coverage or hours. Such service reductions will place increased pressure on other telephone advisory and after-hours services, primary care, emergency ambulance services and EDs, with consequential safety implications and costs. This has been scaled back to 9% in total, which equates to 3.4% for price and 5.6% for volumes. If volume increases are higher then there is an equivalent risk of overspend in this line. Plunket Well Child services and PlunketLine both share the same workforce, and therefore face identical price pressures [9]. In addition, PlunketLine forecasts that call volumes may increase by a further 10.2% in 2011/2012. The total increase for PlunketLine has been scaled back to 9% in total, which equates to 2% for price and 7% for volumes. If volume increases are higher then there is an equivalent risk of overspend in this line or reduction of service hours. The contract for Hospital Chaplaincy includes an annual price increase of 4%. This cannot be avoided without amending the contract.	*HealthLine: 12.750*	***1.148***	***1.148***	***9%***
				Well Child: 41.137	***0.823***	***0.823***	***2%***
				PlunketLine 3.500	***0.315***	***0.315***	***9%***
				Chaplaincy: 2.434	***0.097***	***0.097***	***4%***
				Total: 59.821	**2.383**	**2.383**	**4%**

8	**University of Otago National Poisons Centre**	Provides a 24/7 toll-free emergency phone service: 0800 764 766 (0800 POISON) and a TOXINZ website, the only one in New Zealand. This phone service and website has been developed, and is delivered, by the University of Otago. As a result, the University retains the intellectual property rights, preventing the Ministry from shifting providers without developing a new service and database from the ground up.	After no increase for many years, a bottom up costing was undertaken to assess sustainability. The University of Otago has advised that the current funding is not viable, and has not been for a number of years. The latest Otago University budget of salary, operating and department costs shows a total shortfall of over $0.4m. The Ministry needs to fund an increase of $0.399m required to allow the ongoing management of services. [6]	0.936	**0.399**	**0.399**	**N/A**
9	**Family Violence - Elder Abuse & Neglect**	The Ministry currently provides funding to DHBs to deliver prevention programmes for partner and child abuse and neglect. DHBs have been advised to provide additional services to address Elder Abuse & Neglect which has a prevalence of between 2% and 5% in New Zealand	Price and volume pressures have arisen in this service area due to wage growth and changes in volumes as the population ages. A 2% funding increase is below forecast, with additional pressure to be managed through efficiency gains in service delivery by DHBs	3.907	**0.078**	**0.078**	**2%**
10	**ESR Scientific Services Programme**	ESR provides national and international reference laboratory, health intelligence and environmental health services. 56% of the cost of delivering services relates to personnel. ESR has had difficulty in recruiting and retaining the technical experts required to deliver the science programme.	[6]	10.530	**0.527**	**0.527**	**5%**
11	**NZ Health Survey**	The Ministry of Health has a statutory responsibility to monitor the health of the population through the NZ Health Survey. Legislation changes in the past five years have increased the range of indicators required to be monitored. In previous years, individually funded surveys have been used to cover these indicators. These functions have now been added to the redesigned NZ Health Survey	Additional functions increase the cost of delivering the NZ Health Survey. However, this will remove the need for one-off funding to be found to meet the legislative requirement. The one-off surveys have cost substantially more than the proposed increase to the NZ Health Survey price.	4.749	**0.416**	**0.416**	**8.8%**
12	**Very Low Cost Access / Under Sixes**	VLCA is a voluntary scheme to reduce co-payments for high need communities. Under-Sixes is provided to practices that commit each quarter to providing free standard consultations to children under six. It is a voluntary opt in (and opt out) scheme similar to the Very Low Cost Access initiative. For practices enrolled in VLCA the co-payment that they are permitted to charge is capped at $17.00. It increased by $0.50 in Budget 2010.	Inflationary pressures in general practices are partially met by DHB price increases and partly by floating co-payments. However, VLCA enrolled practices do not have the ability to float co-payments to account for this increase due to the co-payment ceiling. Consequently, the subsidy that the Ministry provides must be increased in order to maintain the viability of the scheme. The Minister has agreed to permit the co-payments to increase by an additional $0.50 to pass some of the inflationary pressures onto the users. It is not expected that this will have a significant effect on utilisation as primary care co-payments for non-enrolled practices often exceed $50. Increasing the co-payment ceiling has reduced the pressure by $2.1 million per annum. The current increase proposed has taken account of this adjustment.	55.500	**3.400**	**3.400**	**6.13%**
13	**Public Health Units**	Twelve DHB staffed PHUs are funded by the Ministry to provide nationwide coverage. Core functions include disease prevention and control, health promotion, regulation and enforcement, emergency preparedness and response, population health monitoring, surveillance and analysis. Funding is required to maintain capacity and capability in a context of increased expectations, especially regarding response to communicable disease and environmental emergencies. The recent PHU review has made recommendations to improve effectiveness through regionalisation, but this is not expected to effect the demand for capacity and the capability of staff required.	[6] In addition, there is an expansion of the scope of services in order to accommodate responses to global disease outbreaks and emergency preparedness. This obligation results from the World Health Organisation assessment of pandemic risk in New Zealand. Additional quality drivers include capacity to cover more common small scale outbreaks (such as the recent measles outbreak) and exposure to hazardous materials. This pressure has been scaled back from an initial estimate 3.94% as the Ministry expects efficiencies to be found in service delivery.	61.727	**1.838**	**1.838**	**3%**
14	**All other services receiving no increase**	This funding line denotes the quantity of other services that the Ministry provides which are not seeking funding increases. This includes: promotion and prevention initiatives such as tobacco, mental health, social environments and physical activity; innovation funding and infrastructure development for local services and for workforce; services such as mobile surgical services, oral health policy and cochlear implants.	The Ministry proposes to manage all other service pressures within existing funding through cost containment and efficiency gains. This will be achieved without adjusting current policy and eligibility settings. No reduction of coverage or services is proposed.	953.000	**0.000**	**0.000**	**0%**
TOTAL				**2685.732**	**62.515**	**62.515**	**2.33%**

ANNEX TWO: Ministerial Priorities (New Initiatives)

Ref	Description	2011/12	2012/13	2013/14	2014/15	Highest Outyear	Rationale and Benefits
1	**Boosting Medical Places - year 3 of 5**	1.178	3.270	5.412	7.560	17.348	Manifesto commitment - The third tranche of the Government's commitment to increase the number of fully funded medical student places by 200 over five years. This funding is for an additional 40 places on top of the 80 places funded through Budgets 2009 and 2010.
2	**Boosting Subsidised Medicines - year 3 of 3**	-	-	-	-	-	Manifesto commitment - Increase to the per-capita spending on medicines in order to increase the range of medicines available, as the last year of the manifesto commitment to a three year subsidised medicines plan.
3	**Additional Well Child visits (scaled)**	5.330	5.330	5.330	5.330	5.330	A scaled manifesto commitment - provide up to three free Well Child visits to the 30% of new mothers with the highest level of assessed need in the postnatal period from 4 to 9 weeks.
4	**National Health Committee Innovation Fund**	3.000	3.000	3.000	3.000	3.000	Funding the Cabinet agreement to establish an innovation fund for the National Health Committee to trial, test, and assess new technologies and innovations to gather information around value for money, and efficacy before any possible introduction into the New Zealand health system.
5	**Maternity Quality and Safety Programme**	9.800	9.800	9.800	9.800	9.800	The Maternity Quality Initiative is a comprehensive set of actions designed to improve quality, safety and coordination of maternity services. Funding will be used to implement clinical quality improvement activities across hospital and community based services; revised service specifications for DHB-funded primary, secondary and tertiary maternity services; and revised maternity referral guidelines (including processes for the transfer of care).
6	**Electives (additional discharges) - Ministry of Health share of Government target of 4000 per annum**	12.000	12.000	12.000	12.000	12.000	Manifesto commitment - Funding to meet the health target of increasing access to elective surgery. This funding is to meet the Ministry of Health share of the 4000 per annum elective discharge target.
7	**Health of Older People (dementia services)**	10.000	10.000	10.000	10.000	10.000	New Zealand has approximately 570,000 people over the age of 65 and this number is expected to increase considerably in the next five to ten years (up to 1.09 million by 2031). It is estimated that dementia currently affects 40,700 people, 95% of these being aged 65 and over. There is currently a shortage of dementia beds and services. The costs of dementia services is significantly greater than for rest home aged care services. This funding will facilitate increased incentives to providers to deliver additional services for dementia patients. It is essential that dementia sufferers are supported with quality care within the right environments to ensure safety of the patients and others in the community. As the population of older people increase, the number of older people living with dementia will also to increase.
8	**Mental Health Blueprint**	10.000	10.000	10.000	10.000	10.000	Additional Blueprint funding of $10 million in 2011/12 will fund new mental health and addiction service development that aligns with Government priorities and addresses service gaps in areas of significant unmet need. Te Rau Hinengaro, the New Zealand Mental Health Survey, found that there is low access to health care by people with serious mental health illnesses. The study confirms that considerable unmet need amongst people with serious mental and addiction disorders continues to exist. Lack of diagnosis and/or treatment involves personal distress for affected people and their families as well as wider adverse societal and economic consequences for communities. Priorities for new Blueprint funding in 2011/12 **[6]** new alcohol and drug services to address regional service gaps (subject to internal prioritisation). New services in these areas align with initiatives to reduce offending and victimisation under the Government's 'Addressing the Drivers of Crime' policy.
9	**Electives (funding to maintain 2009/10 discharge levels which were time limited)**	5.000	5.000	5.000	5.000	5.000	Manifesto commitment - Funding to meet the health target of increasing access to elective surgery. This funding is to maintain the elective discharges at 2009/10 levels, which at the time were time limited. This funding ensures that the health targets are met, and that the electives discharges necessary to meet the government's commitment are funded.
10	**Reducing Rheumatic Fever (time limited)**	0.949	1.099	0.909	0.544	NA	Time limited funding to evaluate and coordinate local initiatives to eradicate rheumatic fever. New Zealand is an outlier in the developed world. Funding supports a suite of initiatives targeted at affected communities including roll out and evaluation of local community initiatives by DHBs, national and local coordination of initiatives to ensure sharing and collation of evidence of effective strategies and resources to reduce duplication, and supporting research into new or more effective intervention tools.
11	**Oral Health**	1.100	1.100	1.100	1.100	1.100	Funding to address oral health issues identified in the 2009 New Zealand Oral Health Survey. The bid could comprise any number of a suite of responses including: oral health promotion trials targeting at-risk adults; provision of information for at-risk families and whānau on self-care; oral health resources and information for primary health care providers; more oral health care training for caregivers working in aged-care facilities; better integration of oral care training into older people's caregiver training; conducting a study on older people's oral health issues; and Investigating public-private arrangements for extended use of community oral health facilities and, where practical, mobile dental clinics.

Ref	Description	2011/12	2012/13	2013/14	2014/15	Highest Outyear	Rationale and Benefits
12	**Voluntary Bonding Scheme - additional registrations (time limited)**	1.000	NA	NA	NA	NA	Funding to support additional registrations to the Voluntary Bonding Scheme. This funding is time limited and tied directly to the number of registrations. Voluntary bonding ensures that the health workforce is available to meet the demand of the sector and that New Zealand retains highly skilled workers.
13	**Health Benefits Limited (HBL)**	5.000	4.000	3.000	2.000	-3.000	This is a fiscally neutral initiative - that is based on HBL seeking to move from a fully Crown-funded entity in 2010/11 to self funding over time. The costs in the initial years are fully offset by baseline savings in subsequent years. HBL advice on the sustainable business model is expected with shareholding Ministers in December 2010. HBL has been set up as a shared services agency to reduce duplication and make efficiency savings through the health sector.
14	**Compulsory Drug and Alcohol Treatment**		0.787	0.775	0.775	0.775	This initiative will enable compulsory treatment for people with severe substance dependence in a manner that reflects modern approaches to treatment. This option aims to engage people in treatment when all other options have been exhausted, and also supports affected families. Without compulsory treatment, these people are likely to become progressively worse and require increasingly intensive health and social services. With intervention, many will improve significantly and with good after-care and support are likely to enjoy a much improved quality of life.
15	**Sexual Health**	2.500	1.600	1.600	1.600	1.600	This initiative supports a range of activities in the sexual health area and includes: health education in schools, implementing chlamydia guideline. HIV/Aids education and support, health education for Maori, and additional funding to provide sustainability for the Auckland Sexual Health support services.
16	**[6]**						
	GRAND TOTAL	**96.857**	**86.986**	**87.926**	**88.709**	**92.953**	

ANNEX THREE: Reprioritisation package to fund new initiatives

Ref	Description	2010/11 Baseline	2011/12	2012/13	2013/14	2014/15	Rationale	Impact of Reprioritisation
Efficiency, productivity & eliminating duplication options								
1	**Low impact efficiency gains across the Ministry** - delivery of current service levels with tighter cost containment and management expectations for a range of providers that are assessed as capable of managing within reduced funding. Areas include provider development, public health, tobacco, crown entities and primary care.	107.435	13.103	13.478	13.478	13.478	Funding from Ministry contracted services that have been identified as being able to make greater efficiencies in service delivery without compromising quality or volume. Specific details have been aggregated as no policy changes are required. Individual budgets are only affected by no more than 10 percent.	Nil
2	**Primary Care -** improved forecasting to align funding levels with actual utilisation levels.	167.945	5.000	5.000	5.000	5.000	Each year primary health care has an underspend as a result of conservative forecasting of demand driven services. In particular, difficulties in forecasting arise due to factors such as client up take and PHO performance. Improved forecasting will more accurately forecast demand releasing surplus funding.	Nil
Sub total Efficiency, productivity & eliminating duplication options			**18.103**	**18.478**	**18.478**	**18.478**		
Infrastructure, capacity & prevention options								
3	**Better, Sooner, More Convenient** - funding for the development of capacity and capability to develop business cases for BSMC. Savings available for reprioritisation.	2.000	0.500	0.900	1.400	2.000	Contracts for two programmes are set to expire after serving their purpose.	Nil
4	**Cancer Programme** - funding to provide strategic and system-wide improvements. Uncommitted funding could be reprioritised without affecting current service delivery.	2.689	0.800	0.800	2.300	2.300	Funding remains uncommitted and therefore is being reprioritised to other high value services.	Reprioritisation would limit the capacity to contract additional services. Funding responsibility for the four regional cancer networks would become the responsibility of DHBs. Current Select Committee inquiry on prostate cancer may have financial implications.
5	**Electives Training** - funding from Budget 2009 specifically for additional staff for new elective theatres remains unallocated. It is now expected that the programme can be managed within a reduced budget.	20.000	5.000	5.000	5.000	5.000	Delays in establishing the new elective surgery facilities has allowed training of the required staff to occur within baseline. Approximately 25 percent of the funding remains unallocated and is not expected to be required going forward.	Nil
6	**Health Workforce New Zealand -** as part of the Ministry restructure to create HWNZ, funding for training and development that is transferred to HWNZ could be scaled.	39.000	9.800	9.800	9.800	9.800	The proposed scaling of funds that will be transferred to HWNZ for training is based on expected efficiency gains from grouping contracts as opposed to previous dispersed or individual contracts which were outside of the Clinical Training Agency.	Reprioritised funds are from Mental Health, Disability Support and/or Maori providers etc.
7	**National Drug Policy Discretionary Fund - r**esearch and information to inform policy and support Ministers. Propose to stop programme.	0.855	-	0.855	0.855	0.855	This programme is one of many information sources to support Alcohol & Drug policy advice. It does not directly contribute to frontline services.	A decrease in the volume of research on alcohol and drugs. Opportunities to source research and information from other programmes.
8	**Oral Health** - funding scaled for policy and strategy development to progress Good Oral Health for All, for Life.	3.100	1.100	1.100	1.100	1.100	Funding will be reallocated within this programme to address oral health issues identified in the 2009 New Zealand Oral Health Survey.	Nil

Ref	Description	2010/11 Baseline	2011/12	2012/13	2013/14	2014/15	Rationale	Impact of Reprioritisation
9	**Primary Health IT** - funding to improve the IT platforms available to Primary Care. Not a frontline service.	4.397	-	4.397	4.397	4.397	These functions can be delivered through the Ministry of Health's internal information directorate.	No impact on the sector. Will require successful shift of functions into the Ministry of Health.
10	**Primary Care Rural Innovation** - funding for the development and spread of innovations due to lower capacity for such development in rural areas. Low uptake of programme to date.	0.340	0.340	0.340	0.340	0.340	Very low uptake of this programme suggests that it is of little value to the sector.	Low risk due to low uptake of funding.
11	**Public Health Units** - proposed reprioritisation of approximately 10 percent of the total budget for public health services purchasing within the national services directorate (excluding screening and communicable diseases funding). This would include reprioritisation from areas such as tobacco, alcohol and drug, healthy eating, healthy action, social environments and PHU infrastructure.	176.372	17.777	17.777	17.777	17.777	Reprioritisation of funding from a variety of national programmes to valued frontline services. Individual budgets have been affected by no more than 10 percent. Reinvestment in public health will be considered in future budgets.	The impact of reprioritisation will vary depending on the programmes. Overall, it will restrict the ability to contract for preventative health programmes.
12	**Sexual Health** - uncommitted funding reprioritised without affecting service delivery.	2.500	2.500	1.600	1.600	1.600	Funding to be reallocated within this programme.	Nil
Sub total Infrastructure & capacity options			**37.817**	**42.569**	**44.569**	**45.169**		
Clinical service delivery & implementation options								
13	**Free GP visit for at risk women during pregnancy** - three DHBs are currently delivering additional services for at risk pregnant women prior to evaluation of the programme and possible national roll-out. Proposed reprioritisation of funding at the end of the pilot instead of rolling the programme out.	2.816	2.000	2.816	2.816	2.816	Recent new initiative with pilot phase. Feedback suggests that the impact on health outcomes has been less than sought. Extension of initiative will be decided separately.	Subject to decisions to extend - nil as total funding not in use.
Sub total Clinical service delivery & implementation options			**2.000**	**2.816**	**2.816**	**2.816**		
Risk Reserve funding								
								[9]
Departmental savings								
15	**Tranche two of departmental expenditure savings** - following on from MRG reforms in 2009, this reflects the further reduction of Ministry FTEs to 1290 by July 2011.		5.000	5.000	5.000	5.000	Part of the sector-wide programme of reducing back office functions to free up resources for valued frontline services as well as improving State sector performance and improving value for money from public spending.	Policy and monitoring functions will continue to be provided within reduced baseline funding.
Sub total Departmental savings			**5.000**	**5.000**	**5.000**	**5.000**		
One-off savings (all assessed as lower value)								
16	**Care Plus** - Forecast underspend for 2011/12.	53.082	2.044	0.638	-	-		Forecast may be inaccurate as this is a demand driven programme.
17	**Drinking Water Access Programme** - Savings due to criteria changes.	33.934	18.600	-	-	-		Nil

18	**Drugs and Alcohol**		0.787	-	-	-		Nil
19	**Meningococcal** - Unrequired funding due to the end of the vaccination programme.	1.500	1.200	-	-	-		Nil
Sub total One-off savings			**22.631**	**0.638**	-	-		
TOTAL SAVINGS OPTIONS			**115.551**	**89.501**	**90.863**	**91.463**		

Section 5: Summary of Financial Movements

Four-Year Budget Plan - Financial Summary Report (Operating - Including Operating Associated with Capital Initiatives 2011)					
Vote: Health	2010/11	2011/12	2012/13	2013/14	2014/15
Share Allocation	-	420,000	420,000	420,000	420,000
Operating					
Baseline (2010/11 OBU)	**13,040,772**	**12,983,386**	**12,958,695**	**12,910,264**	**12,916,520**
Changes:					
Centralised Saving					
Total Centralised Saving	-	-	-	-	-
Additional Well Child visits (scaled)	-	5,330	5,330	5,330	5,330
Antenatal and Newborn Screening Programme	-	159	159	159	159
Balancing FNA	44,862	(10,578)	(11,854)	(11,215)	(11,215)
Better Maternity Data	-	2,000	2,000	2,000	2,000
Boost Medical Student Places	-	1,178	3,270	5,412	7,560
BreastScreen Aotearoa	-	1,412	1,412	1,412	1,412
Cancer Programme	-	(800)	(800)	(2,300)	(2,300)
Care Plus	-	(2,682)	-	-	-
Child and Youth Clinical Networks (Paediatric Society)	-	(50)	(50)	(50)	(50)
Compulsory Alcohol and Drug Treatment	-	0	787	775	775
Cornerstone Accreditation of GPs	-	(868)	(868)	(868)	(868)
Deficit Support of DHBs	(15,000)	0	0	0	0
Departmental Restructure Savings	-	(5,000)	(5,000)	(5,000)	(5,000)
DHB Funding Package	-	350,000	350,000	350,000	350,000
					[6]
Disability Support Services - pressure	-	32,500	32,500	32,500	32,500
District Inspectors	-	(148)	(148)	(148)	(148)

	Drinking Water Access Programme	-	(18,600)	-	-	-
	Drugs and Alcohol - one-off Savings	-	(787)	-	-	-
	Elective Services	-	5,000	5,000	5,000	5,000
	Electives (additional discharges) - Ministry of Health share of Govt target	-	12,000	12,000	12,000	12,000
	Electives (funding to maintain 2009/10 discharge levels which were time limited)	-	5,000	5,000	5,000	5,000
	Electives Training	-	(5,000)	(5,000)	(5,000)	(5,000)
	Emergency Management Vaccine write-offs	-	8,000	8,000	8,000	8,000
	Emergency Preparedness Pandemic and Influenza Vaccines	-	(1,874)	(1,874)	(1,874)	(1,874)
	ESR Scientific Services Programme	-	527	527	527	527
	Establishment of Risk Reserve	-	37,395	21,216	21,637	21,454
	External Legal Services	-	(750)	(750)	(750)	(750)
	Family Violence - Elder Abuse & Neglect	-	78	78	78	78
	Free GP visit for at-risk women during pregnancy	-	(2,000)	(2,816)	(2,816)	(2,816)
	Geocoding	-	0	(375)	(375)	(375)
	Geostan Coding Services (Critchlow	-	(40)	(40)	(40)	(40)
	Health Benefits Limited	-	5,000	4,000	3,000	2,000
	Health Environments	-	(500)	(500)	(500)	(500)
	Health line	-	1,148	1,148	1,148	1,148
	Health of Older People (dementia services) -	-	10,000	10,000	10,000	10,000
	Health Workforce New Zealand (Baseline)	-	(9,800)	(9,800)	(9,800)	(9,800)
	Hepatitis C Service Improvement	-	(200)	(200)	(200)	(200)
	Hospital Chaplaincy Services	-	97	97	97	97
	Immunisation (including HPV	-	(4,840)	(4,840)	(4,840)	(4,840)
	Implementation of Maternity Quality and Safety Programme	-	2,000	2,000	2,000	2,000
	Implementation of new service specifications for DHB-funded maternity Services	-	5,500	5,500	5,500	5,500
	Implementation of Referral Guidelines and Processes for Transfer of Care	-	300	300	300	300
	Innovation Fund	-	(530)	(530)	(530)	(530)
	Innovative Quit Smoking Services	-	(250)	(250)	(250)	(250)
	International Health Organisations	-	(200)	(200)	(200)	(200)

	Maori Diabetes Pilots - CIP	-	(100)	(100)	(100)	(100)
	Maori Health Directorate	-	(16)	(16)	(16)	(16)
	Men's Health Primary Care	-	(120)	(120)	(120)	(120)
	Meningococcal	-	(1,200)	-	-	-
	Mental Health Blueprint	-	10,000	10,000	10,000	10,000
	Mental Health Commission	-	(705)	(705)	(705)	(705)
	National Cervical Screening Programme	-	929	929	929	929
	National Drug Policy Discretionary Fund	-	0	(855)	(855)	(855)
	National Emergency Services	-	230	230	230	230
	National Emergency Services – Ambulance Services	-	2,004	2,004	2,004	2,004
	National Health Committee Innovation Fund	-	3,000	3,000	3,000	3,000
	National Maternity Services	-	3,240	3,240	3,240	3,240
	NZ Health Survey	-	416	416	416	416
	Oral Health	-	1,100	1,100	1,100	1,100
	Oral Health repriorisisation	-	(1,100)	(1,100)	(1,100)	(1,100)
	Plunket Well Child	-	823	823	823	823
	Plunketline	-	315	315	315	315
	Primary Care	-	(5,000)	(5,000)	(5,000)	(5,000)
	Primary Care Development	-	(500)	(900)	(1,400)	(2,000)
	Primary Care Rural Innovation	-	(340)	(340)	(340)	(340)
	Primary Care: Very Low Cost Access / Under Sixes	-	3,400	3,400	3,400	3,400
	Primary Health IT	-	0	(4,397)	(4,397)	(4,397)
	Public Health Advice	-	(200)	(200)	(200)	(200)
	Public Health Units	-	1,838	1,838	1,838	1,838
	Pulbic Health	-	(17,777)	(17,777)	(17,777)	(17,777)
	Quit Group	-	(1,000)	(1,000)	(1,000)	(1,000)
	Research Access	-	(50)	(50)	(50)	(50)
	Rheumatic Fever	-	949	1,099	909	544
						[9]
	Sexual Health	-	2,500	1,600	1,600	1,600
	Sexual Health Reprior	-	(2,500)	(1,600)	(1,600)	(1,600)
	South Island Coordinator	-	(92)	(92)	(92)	(92)
	Tobacco Cessation Training	-	(155)	(155)	(155)	(155)

University of Otago National Poisons Centre	-	399	399	399	399
Unutilised Risk Reserve	(29,862)	-	-	-	-
Voluntary Bonding Scheme - additional registrations (time limited)	-	1,000	-	-	-
Waitemata and Waikato Change Management Contracts	-	(415)	(415)	(415)	(415)
Total Reprioritisation	-	420,000	420,000	420,000	420,000
Transfers Outside Vote					
Total Transfers Outside Vote	-	-	-	-	-
Total Changes	-	420,000	420,000	420,000	420,000
Total Proposed Operating Baseline	**13,040,772**	**13,403,386**	**13,378,695**	**13,330,264**	**13,336,520**
Four-Year Budget Plan - Financial Summary Report (Capital 2011)					
Vote: Health	2010/11	2011/12	2012/13	2013/14	2014/15
	-	-	-	-	-
Capital					
Baseline (2010/11 OBU)	510,921	408,714	131,034	36,396	83,060
Proposals for new Capital Funding					
Refurbish/Replace					
Health Capital Envelope 2011	-	220,000	229,900	240,246	251,057
Total Refurbish/Replace	-	220,000	229,900	240,246	251,057
Improve Functionality					
Total Improve Functionality	-	-	-	-	-
Meet Demand					
Total Meet Demand	-	-	-	-	-
Capital Associated with Operating Initiatives					
Total Capital Associated with Operating Initiatives	-	-	-	-	-
Total Capital Proposals	0	220,000	229,900	240,246	251,057
Total Proposed Capital Baseline	**510,921**	**628,714**	**360,934**	**276,642**	**334,117**