The Treasury

Budget 2018 Information Release

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THE TREASURY
Kaitohutohu Kaupapa Rawa

Treasury Report: Vote Health's Fiscal Position

Date:	8 November 2017	**Report No:**	T2017/2400
		File Number:	DH-1-2-3-2-3-2017

Action Sought

	Action Sought	**Deadline**
Minister of Finance (Hon Grant Robertson)	**indicate** areas where further advice is required	
Minister of Health (Hon Dr David Clark)	**indicate** areas where further advice is required	

Contact for Telephone Discussion (if required)

Name	**Position**	**Telephone**		**1st Contact**
Ashleigh Brown	Analyst, Health	[39]	N/A (mob)	
Carolyn Palmer	Manager, Health	[39]	[23]	

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

Return the signed report to Treasury.

Note any feedback on the quality of the report	

Enclosure: Yes (attached)

Treasury Report: Vote Health's Fiscal Position

Executive Summary

The Minister of Finance and the Minister of Health recently requested Treasury officials provide advice on the Vote Health fiscal position ahead of a meeting with the Treasury Health and ACC team. This report provides you with a high level overview of the fiscal position as context for considering your approach to Budget 2018 and to delivering health manifesto commitments, and highlights particular aspects of the health fiscal position that you may wish to consider further.

There are a large number of new investments signalled for the health system; these alongside business as usual cost pressures, and initiatives already in train, will require prioritisation and phasing in order to fit within the signalled additional $8 billion for health in the fiscal plan. There are also significant pressures in the capital investment pipeline and you will need to consider how and when to fund upcoming capital investments.

There are five key strategic questions that will need to be addressed in the lead up to Budget 2018:

1. The phasing of new health investments alongside initiatives already in train
2. Whether or not to provide an early funding signal to District Health Boards (DHBs)
3. What proportion of cost pressures to fund
4. How much support should be provided to DHBs by way of deficit support
5. How and when to fund upcoming capital investments.

This report provides an introduction to each of these questions ahead of further discussion at our upcoming meeting. We have also attached slides which provide a strategic overview of health sector issues as speaking points for this meeting.

Recommended Action

We recommend that you:

a **note** the health fiscal position, and

b **indicate** which of the following areas where you would like to receive further advice:

	Minister of Finance	Minister of Health
• The phasing of new health investments alongside initiatives already in train	Yes / No	Yes / No
• Whether or not to provide an early funding signal to district health boards	Yes / No	Yes / No
• What proportion of cost pressures to fund	Yes / No	Yes / No
• How much support should be provided to DHBs by way of deficit support	Yes / No	Yes / No
• How and when to fund upcoming capital investments	Yes / No	Yes / No

Carolyn Palmer
Manager

Hon Grant Robertson
Minister of Finance

Hon David Clark
Minister of Health

Treasury Report: Vote Health's Fiscal Position

Purpose of Report

1. The Minister of Finance and the Minister of Health recently requested Treasury officials provide advice on the Vote Health fiscal position ahead of a meeting with the Treasury Health and ACC team. This report provides an overview of the fiscal position as context for considering and approaching Budget 2018, the approach to delivering health manifesto commitments highlights, and particular aspects of the health fiscal position on which we can provide further advice. In particular:

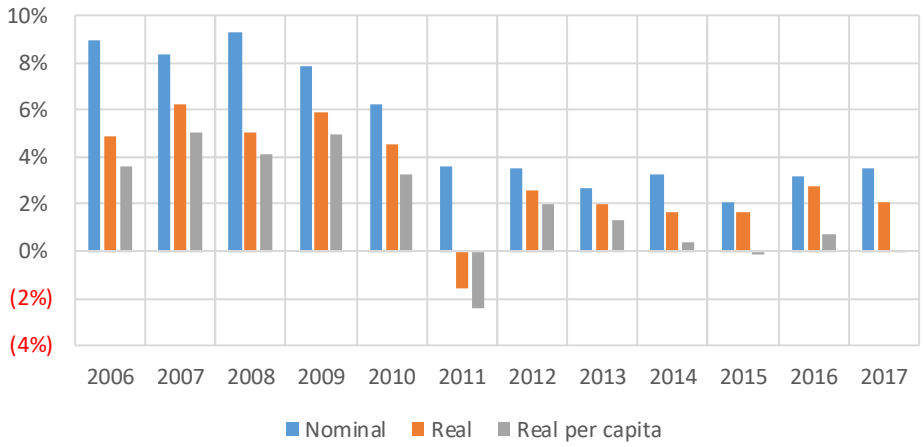
   - The phasing of new health investments alongside initiatives already in train
   - Whether or not to provide an early funding signal to DHBs
   - What proportion of cost pressures to fund
   - How much support should be provided to DHBs by way of deficit support
   - How and when to fund upcoming capital investments.

2. This report also provides an update on the Dunedin hospital rebuild (annex 1), as requested.

Vote Health Fiscal Position

3. Vote Health has a fixed nominal baseline and receives an annual budget funding increase reflecting demographic growth, population ageing, wage and other pressures, as well as some discretionary funding for new initiatives. As demonstrated in figure 1 below, funding in Vote Health has increased every year in nominal terms, and in real and real per capita terms in most years (albeit at a lower rate). A majority of this funding is devolved to DHBs using the population based funding formula (PBFF). The PBFF determines the share of funding to be allocated to each DHB, based on the population living in the district – the formula includes adjustors for population age, sex, relative measures of deprivation status and ethnicity.

Figure 1: Vote Health operating expenditure, annual growth



4. The baseline increases for Vote Health over the last four Budgets are summarised in the table below.

Table 1: Vote Health Budget Increase 2014-2017

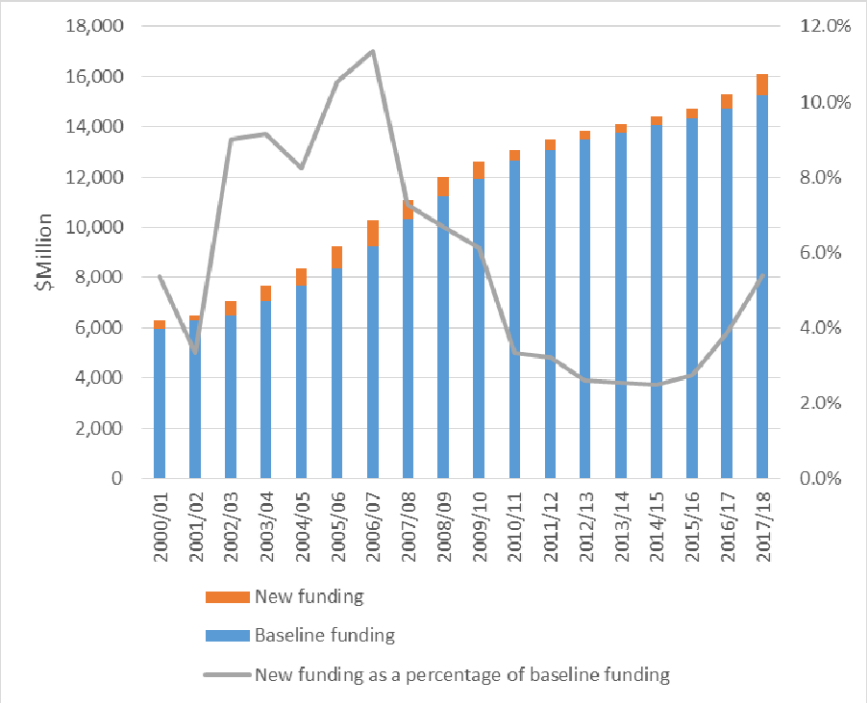
($m)	Four year total	4 year annual average
Budget 2014	1,386.4	346.6
Budget 2015	1,662.5	415.6
Budget 2016	2,221.5	555.4
Budget 2017	2,253.0	563.3

5. Vote Health baseline funding in the 2017/18 financial year is $16.8 billion, comprising departmental and non-departmental operating expenditure, and capital expenditure.[1]

Operating Expenditure

6. Operating expenditure totals $16.1 billion, with $12.6 billion devolved to DHBs. The remaining $3.4 billion is Ministry of Health managed departmental and non-departmental expenditure. Figure 2 below provides an overview of the trend in the operating baseline since 2000/01.

Figure 2: Vote Health Operational Funding 2000/01 to 2017/18



Note: 2017/18 includes the Terranova pay equity settlement

[1] Departmental expenditure is where outputs are supplied by a department and non-departmental refers to expenditure supplied on behalf of the Crown (e.g. DHBs are non-departmental)

7. The Ministry of Health have recently shared preliminary costing information with Treasury that they provided to the Minister of Health on cost pressures, manifesto commitments, and other initiatives underway in the system (AD62-14-2017 refers). These preliminary costings for Budget 2018 total around [33] This leaves [33] for allocation over the next three years within the additional $8 billion signalled in the fiscal plan. If a decision was made to fund the initiatives and cost pressures as signalled by the Ministry (noting that some significant policies and pressures were excluded from the information provided), it would leave an average of [33] per year per budget without additional funding or reprioritisation. The table below summarises the impact this would have on future allocations for Health based on the fiscal plan.

Table 2: Implications of signalled funding in Budget 18 on future allowances ($8b allocation)

($m)	2017/18	2018/19	2019/20	2020/21	2021/22
MoH Signalled for Budget 18	95	1,260	1,270	1,274	1,261
Budget 19			[33]		
Budget 20				[33]	
Budget 21					[33]

Note: these numbers are based off draft numbers provided by the Ministry of Health and set against the $8b signalled in the fiscal plan. This assumes no rephasing, scaling or deferral.

Capital Expenditure

8. For 2017/18, $185 million of unallocated funding remains in the Health Capital Envelope (HCE). The HCE is a group of non-departmental capital appropriations funded at budget to support DHB capital investment (primarily in hospital facilities). Funding is drawn down with the joint approval of the Minister of Health and the Minister of Finance upon submission of a business case by a DHB. All investments are subject to review by the national Capital Investment Committee, which also provides advice on prioritization. This is discussed in more detail below.

Contingencies

9. In addition to baseline funding, there are a number of funds held in contingency:

- $100 million contingency held outside of Vote Health established at Budget 2017 for mental health initiatives. The initiatives were announced by the previous government but none of the funding has been appropriated.
- Specific contingencies for the national bowel screening programme IT system [37] and [37]
- $8.8 million in the Emerging Health Risk Pool which is a contingency set aside to fund unforeseen risks in the health sector.

10. You will be receiving advice on these and other unallocated contingencies to help you make informed decisions on which could be reallocated.

Implications for Budget 2018 decisions

11. As part of Budget 2018 you will want to make choices about the phasing of the commitment to allocate an additional $8 billion to health over the next four years and the split between funding DHB pressures, other cost pressures, and new initiatives. You will also want to consider upcoming capital investments in Vote Health.

12. As an overall strategy, we would suggest packaging commitments and pressures by themes (e.g. primary care, mental health) and then taking a two phase approach as below:

    - Identify 'must do' investments for Budget 2018, this will require considering how to balance manifesto and party agreements, cost pressures, deficit support and work already in train, and

    - Progress high level reviews in areas such as primary care and mental health to help clarify how to get the best value from any additional investments.

13. We will provide further advice through the Budget process, and once initiatives are submitted, on possible options to manage expenditure to remain within your fiscal plan and the risks and implications of these.

Early funding signal to District Health Boards

14. Over the last few budgets the Treasury has attempted to align Vote Health with other votes in the budget process. This was done to ensure that Ministers can make choices and trade-offs within the health system and in the context of all government priorities. This included removing an early funding signal provided to DHBs around December each year. DHBs used this to assist in their annual planning process and to renegotiate contracts.

15. However, the funding signal served as a pre-commitment against the budget allowance and effectively was used as a negotiating tool by DHBs to subsequently increase funding levels. This undermined its usefulness as a tool to facilitate planning and manage negotiations. Past experience also suggested that having a funding signal relieves pressure on the Ministry of Health to understand and communicate how the sector as a whole is functioning.

16. Not providing the funding signal last budget created difficulties for DHBs when renegotiating these contracts. The Ministry of Health have advised us that this contributed to issues with timing around the sign off of DHB annual plans.

17. A key question for Budget 2018 is whether or not to provide an early funding signal. Treasury's advice would be to treat Vote Health in line with other spending areas and not pre-commit funding ahead of the budget process. However, unless there was a

change to DHB planning processes,[2] this is likely to be received negatively by the Ministry of Health and the sector.

Funding of cost pressures

18. Typical analysis by the Ministry of Health and others takes existing (or historical) baselines as the starting point and assumes that these represent the "correct" level of health funding for the population at that time. Cost pressures are then modelled by reference to demographic growth, wage and price inflation, and sometimes other factors such as population ageing and increased technology costs. Those pressures are compared to the actual funding path to determine the expected level of efficiency gains required. The rate of health funding growth has slowed considerably in recent years with the sector receiving less than its modelled cost pressures (based on high level assumptions about demographic change and wage/price increases). DHBs make up the largest share of cost pressures, but the Ministry of Health has signalled departmental expenditure cost pressures over the forecast period as well.

19. It is difficult to determine what the appropriate level of funding for Vote Health is given (i) demand for health services is not fixed and will likely expand to match available supply, (ii) we have limited information about the extent to which baseline funding is being used efficiently, and (iii) the accuracy of modelled cost pressures is unclear (for example, they do not consider if the marginal cost of a new patient is lower than the average cost of an existing patient).

20. As part of our strategic financial management assessment, we have encouraged the Ministry of Health to develop a bottom up understanding of cost pressures and what is driving them, and to undertake cost pressure modelling work beyond top down growth assumptions. This modelling would provide information on what the specific drivers of pressures in the system are and provide more transparency about funding requirements.

21. In response, the Ministry of Health has informed us that it is developing a series of in-house models for each major spending area in Vote Health. It expects to share some of these with Treasury and the health sector shortly. We think that it is important to test the credibility of the models and the key assumptions used in them.

22. A performance and outcomes framework would also create visibility over the effectiveness of the current spend, and make clearer the options for reprioritisation and efficiency gains. This was a key plank in the NZ Health Strategy. You may wish to inquire with the Ministry of Health as to the status of this work.

23. One reason to avoid an early funding signal is to allow time to get a better understanding of cost pressures in order to determine what proportion of modelled pressures to fund.

[2] Other agencies who do not receive a similar signal have adjusted their processes in line with budget timing.

24. In addition to cost pressures, there are also initiatives in train in the sector. These include:

    - The national bowel screening programme - there is currently only funding for roll out to five DHBs, and funding held in contingency for the national IT system, which is a key dependency for the programme. Funding for all 20 DHBs was not provided due to high levels of uncertainty around timing of the rollout. Additional funding will be required for the remaining 15 DHBs, although there are phasing opportunities available. The Ministry of Health has informed us that the IT business case will be delayed from November 2017 to mid-2018 calling into question the achievability of the overall programme rollout timeframes. We can provide separate advice before the issue returns to Cabinet (the contingency for the IT system will need to be extended beyond February 2018), but you may wish to inquire about options for the programme from health officials.

    - There are currently a number of multi-employer collective agreements (MECAs) being negotiated, with the NZNO Nurses & Midwifery agreement about to settle (TR 2017/2430 refers). DHBs currently plan for [38] increases through these bargaining agreements, but the proposed offer is for a 2.34% increase. The intention is for this cost uplift to be funded from DHB baselines in the current year, but this calls into question the affordability of the settlement given the financial position of DHBs. As more DHB funding is allocated to pay settlements, it has implications for the sector's ability to fund other priorities and commitments.

    - Other areas with initiatives underway include [33] and air ambulances (contracts expiring in 2018, system reconfiguration business case in progress).

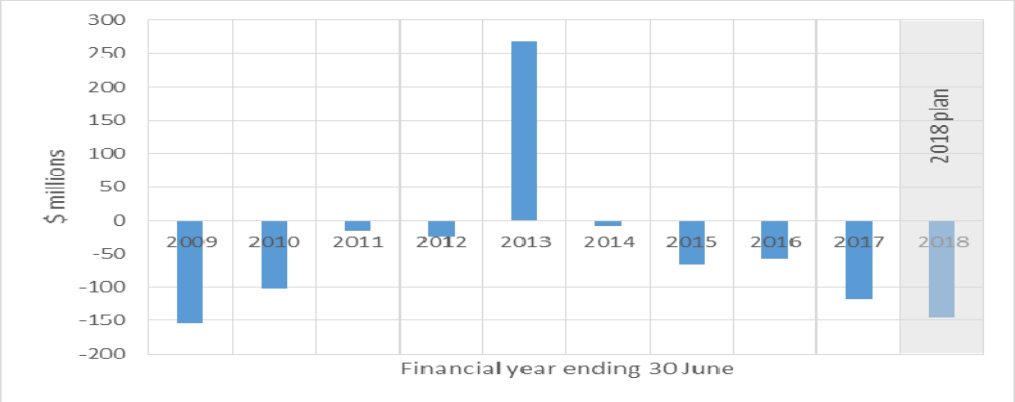
25. These initiatives will need to be considered when making budget decisions. Specific decisions would need to be made to unwind these processes. We can provide further advice if required.

District Health Board Deficits

26. As part of Budget 2018, a decision will also need to be made about the level of deficit support to provide to DHBs.

27. Total DHB sector deficits increased from 2015/16 to 2016/17 and are forecast to increase again in 2017/18 (Figure 2). The latest forecast deficit for 2017/18 is $94.2 million and reflects expected deficits in fifteen DHBs and breakeven positions or small surpluses in the other five. Persistent deficits are problematic as they may indicate that DHBs' attention is drawn toward financial management challenges (and away from their health service provision role) and that they may have insufficient funds to build a cash reserve to fund future capital investments. The following chart shows DHB positions over the past decade.

Figure 3: DHB total net surplus/deficit.



Note: 2013 results include the Canterbury DHB earthquake insurance settlement ($320m)

28. DHBs receive this funding through the "deficit support for DHBs" capital appropriation. Table 3 shows the amounts contained in the appropriation over time. Under current sector policy, deficit support is only provided to fund DHBs' operating cash requirements. Non-cash items (such as depreciation) are not funded. Accordingly, the amount of deficit support provided is usually less than a DHB's net deficit.

Table 3: DHB deficit support appropriation 2015/16 – 2018/19

$ millions	2015/16	2016/17	2017/18	2018/19
Appropriation (including carry forwards)	55.000	74.624	86.924	39.000
Draw down	30.376	37.700		
Carry forward	24.624	36.924		

29. DHBs' draft 2017/18 plans include deficit support requests of $94.2 million which exceeds the available appropriation of $86.9 million. Accordingly, tight fiscal management will be required to manage within the existing deficit support appropriation. There is also a risk that net deficits may increase from planned levels, as they did in 2016/17 (from $50.2 million to $117.5 million), raising the level of deficit support required.

30. On the other hand, some DHBs may require less support than the level indicated in their draft plans. [34]

31. Looking to next year, the deficit support appropriation for 2018/19 decreases to $39 million which is considered to potentially be too low by the Ministry of Health and a budget bid is expected in Budget 2018 for additional funding.

32. The tight financial position faced by many DHBs is resulting in many of them utilising their balance sheet to cover operating expenses, rather than provisioning for future capital investment. Coupled with sector capital requirements that often exceed depreciation, this means that significant extra Crown equity is likely to be needed going forward, particularly to support major hospital builds.

Capital Pressures

33. The pipeline of health capital investment is a significant fiscal risk. The investment demand is being driven by asset age and condition, population growth (primarily in Auckland) and ICT innovation. There is not sufficient capacity and capability in the system to deliver on the pipeline under current settings, creating a need to re-consider the way in which the Government approaches the health investment portfolio, how hospitals are planned and delivered, and how the affordability challenges facing the sector are managed.

Financial Year 2017/18

34. The current unallocated appropriations in the health capital envelope ($185 million) may not be sufficient to meet demand from investment-ready business cases expected by the end of the fiscal year from DHBs. Decisions likely to be presented by Christmas include:

    - Land purchase for Dunedin Hospital [37]
    - Crown contribution to Wellington Children's Hospital [37]
    - [33]

35. Some decisions may be deferred until the next fiscal year due to delays in business case delivery, we recommend that you seek advice on prioritisation, scaling and deferral options from the national Capital Investment Committee.

Budget 2018

36. The Ministry of Health has signalled a requirement for $2.805 billion capital in 2018/19. [33]

37. In addition to Dunedin Hospital, there are other significant pressures in the system (including any current business cases deferred from 2017/18) that will need to be considered. [33]

Medium-term horizon

38. In the next three years, there are several other major site redevelopment projects at various stages in the business case process which could reasonably result in full site redevelopments on new or existing sites emerging as the preferred option: [33]

39. The Northern region (Auckland-metro and Northland DHBs) is completing a regional long-term investment plan that is signalling the need for an average of $800 million in capital investment each year until 2025/26. To put this into context, over the past 6 years the average annual expenditure on all DHB facilities and equipment across New Zealand, including the Christchurch Hospitals projects, has been $490 million. This volume of expenditure is neither affordable nor achievable (it anticipates four simultaneous major developments, including a new hospital in South Auckland) under current settings and structures. Nevertheless, the plan indicates the scale of the challenge facing the region in order to remediate existing assets and build new capacity to address current and future population demand.

40. We would like to talk to you about the health capital pipeline and the changes needed at a system level to respond to the challenges the pipeline presents.

Consultation

41. The Ministry of Health have been consulted on this report.

Next Steps

42. The Minister of Health will shortly meet with the Treasury Health and ACC team to discuss the health sector fiscal position and system performance. In particular, we would like to discuss the five key Budget 2018 questions outlined in this report and the overview of health related issues in the attached slides.

43. We will also shortly provide advice on primary care settings including advice on how the government may want to respond to the Ian Axford Fellow report released in late September 2017.

Annex 1: Dunedin Hospital Status update

This annex provides a high level status update on the Dunedin Hospital project as requested.

Southern Partnership Group (SPG)

Strong external governance and project management support are essential to the delivery of the project. The SPG is functioning well under intense time pressure to deliver a detailed business case (DBC) in June 2018 as scheduled. There are questions at the margins around scope and the roles and responsibilities of the parties (SPG/Ministry/Southern DHB) which need to be clarified in revised terms of reference, but relationships are collegial and there is a common purpose. We recommend an early meeting with the SPG to confirm your expectations.

Time frames

Meeting the Government's commitment to expedite the build timeframes to begin within three years will be difficult, and clarification will be needed from Ministers' about what progress is required to meet this commitment.

The service planning to inform the redevelopment is essential to determining the scale of the new facility and informing the concept design. While underway, timelines for this work are tight and if it is not sufficiently progressed by early in the new year, production of an investment-ready DBC would be at risk.

Land

Several central city sites have been identified, work is underway to determine a preferred option(s), and there is funding with existing health capital appropriations to finance a land transaction. Challenges under the Public Works Act or Resource Management Act to the site selection are a key risk to expediting the build timeframes, along with negotiation risk once a preferred site has been identified. These processes will need to be carefully managed by the Ministry of Health.

Procurement

The size and complexity of this project will be without precedent in the New Zealand market. Ensuring a competitive procurement process for the main contractor to build the hospital will be critical to successful delivery and has strategic implications for other projects in both the health and the wider infrastructure pipeline. Recognizing the concerns raised about a Public Private Partnership (PPP) model, alternative approaches for achieving the benefits of a PPP (certainty of cost and delivery schedule, ongoing asset management, etc.) should also be considered.

Risk mitigation in the existing facility

The need for additional investment to mitigate risk in the current facility over the build period has been signalled by the DHB, and given the Southern DHB's financial position, Crown equity support will be needed.

We will provide further advice ahead of the Christmas decisions.