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TE TAI ŌHANGA
THE TREASURY

Treasury Report: Making a safe move to multi-year funding for Vote Health

Date:	8 March 2022	**Report No:**	T2022/355
		File Number:	SH-1-6-14

Action sought

	Action sought	**Deadline**
Hon Grant Robertson **Minister of Finance**	**Agree** to proceed with transitional multi-year funding for Vote Health at Budget 2022, in the expectation of moving to permanent multi-year arrangements from Budget 2024.	11 March 2022

Contact for telephone discussion (if required)

Name	**Position**	**Telephone**		**1st Contact**
Amy Russell	Principal Advisor, Health	[39]	N/A (mob)	✓
Jess Hewat	Manager, Health		N/A (mob)	

Minister's Office actions (if required)

Return the signed report to Treasury.

Forward the signed report to the Minister of Health.

Note any feedback on the quality of the report	

Enclosure: No

Treasury Report: Making a safe move to multi-year funding for Vote Health

Executive Summary

1. In July 2021, you and the Minister of Health agreed to introduce multi-year funding arrangements for Vote Health from Budget 2024, preceded by a two-year transitional arrangement at Budget 2022. You agreed that the first multi-year funding arrangement (ie from Budget 2024) "should only be implemented once Ministers have confidence that adequate system settings to support improved planning and financial control will be in place (including, but not limited to, the first full NZHP and accompany employment relations and workforce strategy)" [T2021/1579 refers]. Cabinet subsequently made a similar agreement [SWC-21-MIN-0157 refers].

2. In practice you also need to be satisfied that it is safe to make the shift at Budget 2022 to two-year transitional funding. This will create a lot of momentum across the system toward multi-year funding and increase the costs of not making the envisaged permanent change at Budget 2024.

3. This briefing provides Treasury's advice that this move at Budget 2022 is indeed advisable, given the safety net in place and the relative cost and benefit of alternative options. The key elements of the safety net are:

    a Governance controls via skilled and accountable boards, supported by Budget 2022 information-sharing and financial decision rights;

    b Direction-setting and planning via the interim Government Policy Statement, interim New Zealand Health Plan and Letters of Expectations;

    c Interventions ranging from soft levers to statutory interventions provided via the Crown Entities Act 2004 and Pae Ora (Healthy Futures) Bill, as outlined in recent advice to Ministers from the Ministry of Health and Transition Unit [DPMC briefing forthcoming]; and

    d Monitoring and reporting via a comprehensive and detailed range of products, as also outlined in recent advice to Ministers [DPMC-2021/22-1550 refers].

4. The proposed change is not risk-free, and our ongoing engagement with the reform process will focus on tracking and managing the main areas where we think issues could arise. But we are satisfied that the change is safe enough to go ahead as planned, and that it will generate a better balance of risk and reward than alternative options available to Ministers. For this reason we recommend that you agree it go ahead. Budget planning for Vote Health is proceeding on this basis.

5. We will provide advice in the lead-up to Budget 2024 about the safety of implementing a permanent multi-year funding arrangement as agreed by Cabinet.

6. For avoidance of doubt: Treasury's near final advice on the rebase and cost pressures for Vote Health will be provided ahead of the Budget Ministers' 5 meeting on 2 March 2022. We are not seeking decisions on these things at Budget Ministers' 4 on 9 March 2022.

Recommended Action

We recommend that you:

a. **note** Treasury's view that the proposed move to transitional multi-year funding for Vote Health at Budget 2022, leading to permanent multi-year arrangements from Budget 2024

- will occur with an adequate safety net in place in terms of governance, monitoring, accountability and intervention settings, and
- represents the best value of the options currently available to Ministers for health system funding.

b. **agree** to proceed with transitional multi-year funding for Vote Health from 1 July 2022, in the expectation of moving to permanent multi-year arrangements from 1 July 2024

Agree/disagree.

c. **note** that will provide advice in the lead-up to Budget 2024 about the safety of implementing a permanent multi-year funding arrangement as agreed by Cabinet.

d. **note** that Treasury's near final advice on the rebase and cost pressures for Vote Health will be provided ahead of the Budget Ministers' 5 meeting and we are not seeking decisions on these things at Budget Ministers' 4, and

e. **forward** this report to the Minister of Health.

Forwarded/not forwarded.

Jess Hewat
Manager, Health & ACC

Hon Grant Robertson
Minister of Finance

Purpose of Report

7. This report seeks your agreement to proceed with transitional multi-year funding for Vote Health at Budget 2022, in the expectation of moving to permanent multi-year arrangements at Budget 2024.

Background

8. In July 2021, you and the Minister of Health agreed to introduce multi-year funding arrangements for Vote Health from Budget 2024, preceded by a two-year transitional arrangement at Budget 2022.

9. Fiscal risks are high in the new system because:

    a Fiscal control in health is inherently difficult because of (in practical terms) unlimited demand, and the fact that costs are driven by many individual treatment decisions by clinicians, to most of whom aggregate system-level cost has relatively low salience.

    b Financial planning culture and control in the existing system is weak, with most District Health Boards approving ineffective planning documents and running deficits.

    c Health New Zealand will be a Crown entity in New Zealand of unprecedented scale and influence, with around 80,000 staff, an operating budget of about $20 billion excluding COVID funding, and built assets with an estimated replacement value of approximately $24 billion.

    d Cost control and planning are often difficult during a time of system change. In this case, the combination of reforms and COVID mean it is especially hard to plan delivery with confidence, and hard to tell whether or not given costs are reasonable. As most of the costs for the next few years are already fixed via existing contracts and employment agreements, opportunities to generate savings in the short term are limited.

10. In recognition of these challenges, you agreed that the first multi-year funding arrangement (ie from Budget 2024) “should only be implemented once Ministers have confidence that adequate system settings to support improved planning and financial control will be in place (including, but not limited to, the first full NZHP and accompany employment relations and workforce strategy)” [T2021/1579 refers]. Cabinet subsequently made a similar agreement [SWC-21-MIN-0157 refers].

11. In practice you also need to be satisfied that it is safe to make the shift at Budget 2022 to two-year transitional funding. This will create a lot of momentum across the system toward multi-year funding and increase the costs of not making the envisaged permanent change at Budget 2024.

12. This briefing provides Treasury’s advice that this move at Budget 2022 is indeed advisable, given the safety net in place and the relative cost and benefit of alternative options. Budget 2022 planning for Vote Health is proceeding on this basis.

13. We will provide advice in the lead-up to Budget 2024 about the safety of implementing a permanent multi-year funding arrangement as agreed by Cabinet. We will start preparing for Budget 2024, including reorienting the Vote team to operate in a multi-year environment and working with partner agencies to agree a medium-term work plan, once Budget 2022 is completed.

Analytical approach

14. In considering the advisability of moving to multi-year funding for Vote Health, we have sought to answer two key questions:

    a **Is it safe enough?** Given the expected fiscal risks and risk management strategies, are the residual risks small enough to be acceptable for this type of change?

    b **Is it the best bet?** Given the balance of risks and expected benefits, are there any better options available to Ministers at this time?

15. We discuss each question below and in the annex. Our conclusion is that the proposed change carries an acceptable level of residual risk and is the best option available to Ministers.

The fiscal safety net

16. Below we outline the key components of the safety net enabling officials and Ministers to manage fiscal risk in the new health funding system from 1 July 2022. This diagram shows the key elements:

Governance

17. The first, best safeguard against fiscal risk in the health system is a widespread belief that **Ministers can and will fairly and credibly hold boards**[1] **to account** for staying within their allocated budgets.

[1] The interim Health New Zealand and Māori Health Authority are departmental agencies within the Ministry of Health, and in technical terms their interim boards are Ministerial committees under section 11 of the New Zealand Public Health and Disability Act 2000. Permanent entity boards cannot be appointed until the Pae Ora (Healthy Futures) Act comes into force on 1 July 2022.

18. To enable Ministers to do this:

    a Health New Zealand and the Māori Health Authority will be led by high-quality boards with experienced chairs.

    b The authorising environment of the health entities – including planning architecture, budget-setting, financial delegations and policy settings – has been designed to ensure that health budgets are reasonable, and that boards have meaningful control over expenditure.

19. In particular:

Legal accountabilities

20. Board accountabilities will be clearly set out in law via the Pae Ora (Healthy Futures) Bill. The Bill is explicit that the board of Health New Zealand must ensure that the agency "operates in a financially responsible manner and, for this purpose, endeavours to cover all its annual costs (including the cost of capital) from its net annual income".

Budget 2022 information sharing

21. Budget 2022 processes and information-sharing for Vote Health have been explicitly designed to give interim boards early visibility of their baselines from 1 July 2022. This is to enable them to meaningfully plan internal budgets and delivery so that they can be held meaningfully accountable for expenditure [T2022/47 and T2022/328 refer].

Financial decision rights

22. For boards to be held accountable for financial outcomes, they need meaningful control over entity finances (both operating and capital). At the same time, Ministers need safeguards in place to ensure expenditure is reasonable and reflects Parliamentary and Governmental intentions.

23. Officials in the Ministry of Health, the Transition Unit, the interim entities and the Treasury are working together to arrive at a set of initial financial delegations and Budget Management Rules that get this balance right. These will change over time as the system matures. We have recently advised you on proposed settings for capital expenditure [T2022/425 refers] and will advise you on proposed settings for operating expenditure in due course.

Direction-setting and planning

Government Policy Statement

24. The Government Policy Statement (GPS) will be the key direction-setting document for the new health system. The Ministry of Health is currently drafting an interim GPS (iGPS) to cover the period to 1 July 2024. We expect to receive the Financial Expectations section for comment shortly; we were consulted in late 2021 on the draft outline which contained all the messages we would expect.

New Zealand Health Plan

25. Health entities will respond to the iGPS via an interim New Zealand Health Plan (iNZHP) which they are currently preparing.

26. From 1 July 2024 onward the New Zealand Health Plan will be a fully costed delivery plan for the health system. While the iNZHP will not achieve full coverage, based on our conversations with the Transition Unit and interim Health New Zealand we think it is likely to provide an adequately comprehensive set of delivery and fiscal expectations to form the basis for monitoring and reporting within health entities and by the Ministry of Health.

27. For example, in terms of hospital delivery, the iNZHP will be based on rapid and incomplete analysis of the status quo, and will identify limited productivity or quality "quick wins" or areas for improvement. In contrast we expect the full NZHP from 1 July 2024 to show a multi-year roadmap to an efficient reconfiguration of hospital services based on detailed national analysis of costs and capacity. The full NZHP will also include a range of critical sub-plans, including the health service plan.

Letters of Expectations

28. Letters of Expectation are informal levers that enable Ministers to express expectations to agencies in writing. Any such expectations need to be in keeping with the formal directions given through (for example) the iGPS or New Zealand Health Strategy.

29. The Minister of Health wrote to interim health entity CEs and boards in December 2021 outlining his expectations of them in the period through to 1 July 2022. He may choose to write a further Letter of Expectations to the new boards after 1 July 2022.

30. You have indicated you will write to interim boards reiterating your expectations about financial management, in line with the content of the draft iGPS [T2021/1992 refers]. We will provide you with a draft letter after your meeting with interim boards on 16 March 2022.

Interventions

31. The Transition Unit (TU) recently provided advice to Ministers on the intervention framework for the new system, noting that the Crown Entities Act 2004 and Pae Ora (Healthy Futures) Bill between them provide a comprehensive series of escalated steps to enable Ministers to deal swiftly and proportionately with issues as they arise [DPMC briefing forthcoming].

32. The intervention framework now includes a Crown Manager intervention for Health New Zealand so that Ministers can, if necessary, have direct control over particular decisions (for example, relating to a specific capital project) while the board continues to govern.

Monitoring and reporting

33. The TU recently provided advice to Ministers on reporting and outcomes frameworks to support accountability in the new system [DPMC-2021/22-1550 refers]. This included an annex (Annex 2 in the TU report) outlining who will receive what kind of monitoring and reporting information in the new system at Day 1, how often and via what vehicle. The picture it presents is detailed and comprehensive, and gives us confidence that the design of performance and risk monitoring has enough breadth and resilience to accommodate the occasional point failures that are inevitable in any complex system.

34. Many of the reporting products in the new system already exist in the current system. They will be improved by an uplift in national consistency, thanks to the unification of financial information management systems and reporting standards. Some improvements may be instant, while others will take time to materialise as entities and the Ministry create and become familiar with the new datasets.

Main outstanding concerns

35. The main things we are still worried about (though not to the extent that we think that implementation should be changed or paused) are:

    a **The risk that the Ministry of Health's need to manage various short term issues crowds out its ability to build monitoring capacity and capability for the medium term.** The Ministry needs to reorient and build its monitoring capacity and capability to reflect the new system design. [34] The strategic redesign and change management will demand time and energy from leaders who are already stretched managing issues day to day. This risk is for the Director-General of Health to manage; central agencies have offered their support.

    b **The risk of gaps and overlaps across different parts of the system doing different types of monitoring and reporting.** We think overlaps (eg, between Health New Zealand reporting against the interim New Zealand Health Plan, and the Health Quality and Safety Commission reporting on the Health System Indicators) are more likely than gaps. Overlaps may be inefficient but do not represent a performance risk and can be identified and addressed during the transitional period to Budget 2024. Some overlap in monitoring and reporting can also be helpful in providing resilience to point failures, provided it is low cost.

    c **The risk that locality reporting takes time to realise its potential to create meaningful local-level accountability for health system performance.** This will mean more reliance on the centre (Health New Zealand, the Māori Health Authority and the Ministry of Health) to monitor and respond as necessary to variation in access or delivery across different parts of the country.

    d **The risk that the interim NZ Health Plan does not closely map to actual delivery in the next two years.** We think this is almost inevitable in the transitional period (especially given the evolving nature of the COVID health system response) and can be accommodated by good monitoring and reporting. The focus on the transitional period should be on transparency and information-sharing so that everyone in the system can learn about its behaviour together.

Alternative options

36. The annex presents the main options available to Ministers if they were to consider it unsafe to move directly to the envisaged multi-year funding approach, and considers their benefits and costs. These include options to:

    - retain the status quo;
    - introduce multi-year planning but with annual funding;
    - introduce multi-year planning and funding but with additional Treasury monitoring or Ministerial controls on material financial decisions;
    - introduce multi-year planning and funding but with at a funding level that requires health entities to ration or find efficiencies during the transitional period; and
    - provide multi-year cost pressure funding but hold back the rebase, or vice versa.

37. We think none of these presents a better balance of risks and benefits than the default option agreed by Cabinet.

Next steps

Budget processes

38. Planning for a two-year transitional package at Budget 2022 is well underway and is proceeding on the assumption that you agree to the recommendations in this report. If you decide that you would prefer an alternative approach, we will work with you to implement it rapidly.

39. We will provide advice in the lead-up to Budget 2024 about the safety of implementing a permanent multi-year funding arrangement as agreed by Cabinet.

40. For avoidance of doubt: Treasury's near final advice on size of the rebase and cost pressures for Vote Health will be provided ahead of the Budget Ministers' 5 meeting on 22 March 2022; we are not seeking decisions on these things at Budget Ministers' 4 on March 2022.

Ministerial and sector communications

41. We recommend you forward this report, when signed, to the Minister of Health.

42. You are meeting with the chairs and chief executives of Health New Zealand and the Māori Health Authority on 16 March 2022. Subject to your agreement to this paper, that will be an opportunity for you to confirm your commitment to multi-year funding and planning for the health system, while also noting (in line with Cabinet's agreement) that the introduction of permanent multi-year funding at Budget 2024 will be conditional on the entities demonstrating prudent financial management during the transitional period.

43. After your meeting we will provide you with a draft letter to the interim boards outlining your financial management expectations [T2021/1992 refers].

Advice to come

44. In the coming months you and/or the Minister of Health will receive advice on several key outstanding pieces of the new health performance management system, including:

    a a briefing from the Transition Unit to you and Minister of Health on the role of public and Parliamentary reporting, due mid-March;

    b [33]

    c

    d draft Statements of Intent and Statements of Performance Expectations for Health New Zealand and the Māori Health Authority to be provided to the Minister of Health in April (and likely to be available to you on request if desired);

    e potentially, advice on new Letters of Expectations for the permanent entities from 1 July 2022.

45. We will brief you or your office on these as needed.

Annex: Alternatives to the multi-year funding and planning approach agreed by Cabinet

Note: Options A, C, D and E are consistent with Cabinet's previous decisions; options B, F and G would require Cabinet to agree to change these decisions.

	Option	Main benefits	Main risks and costs
A	Annual funding and planning (status quo).	Reduces costs of change. Allows decisions about new initiatives to be made at each annual budget based on the freshest possible information. Depending on the treatment, can lower the fiscal impact on any one budget. Structural changes (eg adding or removing funds, moving COVID funding into baselines) can be made easily in any year, rather than needing to wait for the end of a funding cycle.	Undercuts a key fiscal goal of reform to shift away from inefficient "here and now" financial management, toward medium-term productivity-enhancing and "invest to save" approaches that can generate better outcomes while controlling costs. Problematic short-termist deficit culture of old system will transition into new system, instead of leveraging the structural change to achieve a culture change.
B	Multi-year planning via the iNZHP, but with annual funding.	Would realise the benefits of medium-term planning without having to make any forward fiscal commitment.	In our view (and based on strong advice from the Ministry and DHBs) this is not workable. In practice, operating funding and planning cannot be meaningfully divorced; the sector will not believe in a multi-year plan if they know that it will likely change at next year's budget. From the delivery perspective, DHBs consistently report that small changes at the margins have sizeable ripple effects in the system. Even apparently minor annual budget changes (eg adding new initiatives) therefore undermine the integrity of a multi-year plan.
B1	A variant on the Option B would be to have annual funding decisions, but with an agreed funding minima for outyears. This essentially has the same risks and benefits as the Cabinet-agreed option (which involves upfront agreement to a funding "floor" for outyears), but with the added cost of an annual budget process with annual new initiatives.		

C	Multi-year planning and funding as agreed by Cabinet, but with Treasury having a formal monitoring role alongside the Ministry of Health.	Reduces critical reliance on the Ministry and give them time to build their capacity and capability in this new system. Treasury has broad expertise it can bring to bear in Crown entity monitoring.	Undermines the Ministry's role in this space and reduces its incentives to invest in its capability and capacity "Shared accountability" often reduces rather than enhances actual accountability. *Note: In practical terms Treasury will stay very close to health system monitoring for the foreseeable future, as we need to learn how the new system will behave. We can achieve many of the benefits of formal involvement without the downside of undermining the Ministry's role.*
D	Multi-year planning and funding as agreed by Cabinet, but with the requirement that (at least for the transitional period) new health entities seek Ministerial approval for material financial decisions.	Reduces risk that major decisions are made in a way unacceptable to Ministers. Closer connection between Minister's direct control and his or her accountability to Parliament for expenditure. Gives time for new entities to grow strategic financial capability.	Undermines the ability of new health entities to manage their own finances, shifting accountability for financial outcomes away from them and toward Ministers. Shifts the need for strategic financial capability away from health entities and toward the Minister/Ministry. Reduces entities' incentives to invest in this capability. Slows down investment processes, which often increases costs. In the context of newly appointed boards with no existing performance issues, could suggest low confidence or be seen as a bad-faith move. *Note: Good monitoring and expectation-setting, backed up by with intervention powers if needed, give Ministers significant influence in practice over material financial decisions.*

E	Multi-year funding and planning as agreed by Cabinet, but with a smaller upfront allocation than hitherto indicated, in the expectation that HNZ will ration or find efficiencies to reduce costs.	Places pressure on entities to prioritise looking hard for savings and efficiencies. Judging by Crown monitors' experience with DHBs, significant savings and efficiency gains are likely to be possible across the system. [27]	In a changing system where new information is gradually coming on stream, cost-saving decisions taken quickly are more likely than in more stable times to have unforeseen consequences or to turn out to be far from optimal. Encourages short-termism in finding savings, which often leads to false economies and cutting of corners. Alternatively, would mean setting an employment relations strategy that is not deliverable, leading to deficits during the transition period. Establishes the new entities in a situation in which they are quite likely to speedily end up in deficit, resulting in a swift return to the deficit culture the reforms intend to remedy. May require Treasury to forecast a deficit if we think the required savings are unlikely to be achieved.
	Note on Option E: Finding savings and efficiencies needs to be a medium term goal for the health system. [33] But for the reasons noted above, we think it is inadvisable to push this goal hard in the transitional period, let alone rely on it for the system to break even.		
F	Provide a rebase up front, but decide cost pressures annually.	Benefits and costs as per Option A, with the additional benefit that it would help to address the existing deficit culture.	
G	Agree multi-year indexed cost pressures up front, but hold back the rebase.	Benefits and costs as per Option E, with the additional cost that it establishes the entities in a guaranteed deficit position which is unhelpful to culture change, and less transparent than putting in the required funding upfront.	