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TE TAI ŌHANGA
THE TREASURY

Treasury Report: Health and Disability System Review

Date:	4 June 2020	Report No:	T2020/1710
		File Number:	SH-1-6-14 (Health and Disability System Review (HDSR))

Action sought

	Action sought	Deadline
Hon Grant Robertson **Minister of Finance**	**Support** the 8 June Cabinet paper on the Response to the Health and Disability System Review	Prior to Cabinet on 8 June 2020

Contact for telephone discussion (if required)

Name	Position	Telephone		1st Contact
Jill Caughey	Principal Advisor, Health	s9(2)(k)	N/A (mob)	✓
Jess Hewat	Acting Manager, Health & ACC		s9(2)(g)(ii)	

Minister's Office actions (if required)

Return the signed report to Treasury.

Note any feedback on the quality of the report	

Enclosure: No

Treasury Report: Health and Disability System Review

Executive Summary

The Prime Minister and Minister of Health are taking a paper to Cabinet on 8 June seeking agreement to:

- the direction of travel articulated in the final Health and Disability System Review (HDSR) report (but not to individual recommendations), and
- establishing a transition unit housed in DPMC to lead the next stage of work – you would be part of the Ministerial oversight group and Treasury would second some resource to the transition unit.

Treasury recommends you support the Cabinet paper. The HDSR offers a compelling vision for change and we strongly support the proposed transition unit for taking forward the next stage of work. It will be critical to see the following elements to ensure the next stage of work is successful (see paragraph 11 for more detail):

- policy design and implementation underpinned by the HDSR's principles of putting people and whānau at the centre of the system, a population health approach and an effective Treaty-based partnership.
- prioritising and sequencing measures based on the extent to which they address health inequities and financial sustainability.
- sufficient attention given to changes that improve financial sustainability, particularly in light of growing DHB deficits and the long term fiscal challenge. This should include considering alignment and sequencing of the planning, funding and performance changes in the HDSR with the Public Finance System reform proposals.
- in developing advice on machinery of government changes, a focus on how structural changes might support improved capability and behavioural change, including the extent to which capabilities could be strengthened by shifting or pooling resources that already exist in the system.

Treasury supports the proposal in the Cabinet Paper for $30 million over two years to establish the transition unit. This cost is in line with the cost of other similar reforms. We would expect costs of the HDSR proposals to be sought in future Budgets. Whilst funding the costs of health reform in a difficult fiscal environment will require trade-offs with other priorities, well designed and implemented changes have the potential to reduce funding needed in the future.

The Cabinet paper proposes an **end of June Cabinet report back on initial work priorities for the transition unit** for its first six months. It will be important **to focus this on agreeing the transition unit's work programme, and avoid narrowing the unit's work in a way that is inconsistent with the vision in the HDSR report**. To manage key financial risks there is likely to be value in an early consideration of options for taking forward proposals in the HDSR for centralising employment relations and strengthening the DHB performance function. Treasury will work with DPMC, SSC and the Ministry of Health on options for expediting work in these areas for the end of June Cabinet report back.

Recommended Action

We recommend that you:

a **support** the 8 June Cabinet paper on the Response to the Health and Disability System Review, and

b **indicate** whether you would like to meet with Treasury officials to discuss the Health and Disability System Review to inform the end of June Cabinet paper on work priorities for the transition unit.

Agree/disagree.
Minister of Finance

Jess Hewat
Acting Manager, Health & ACC

Hon Grant Robertson
Minister of Finance

Treasury Report: Health and Disability System Review

Purpose of Report

1. This report provides Treasury's advice on the Government's initial response and process for responding to the final report of the Health and Disability System Review (HDSR). A Cabinet paper on this is to be discussed at Cabinet on 8 June 2020. The paper seeks agreement to:

    - the direction of travel articulated in the final HDSR report (but not to individual recommendations), and
    - establishing a transition unit housed in DPMC to lead the next stage of work.

Background

2. The HDSR was announced in May 2018 to "identify opportunities to improve the performance, structure, and sustainability of the system with a goal of achieving equity of outcomes, and contributing to wellness for all, particularly Māori and Pacific peoples". It was led by an independent panel chaired by Heather Simpson. The Interim Report was published in August 2019 and the Final Report provided to the Minister of Health in late May 2020.

While New Zealand's overall health outcomes are good, we need to address longstanding health inequities and a growing financial sustainability challenge….

3. Health and disability services are important in achieving inclusive growth, play a key role in the economy and are a significant component of Government spending. Overall New Zealand's health outcomes are comparable or better than other developed countries, for example, life expectancy is above the OECD average and we have high levels of self-rated health and wellbeing. However, New Zealand has:

    - significant and long-standing health inequities across populations and the life-course, particularly for Māori, Pacific people, disabled people and people experiencing poverty, and
    - significant DHB deficits, and like other countries, a growing financial sustainability challenge.

There is broad consensus on the problems that need to be addressed

4. Whilst our health and disability system has a number of strengths, including a highly committed health workforce, there are a range of issues that underpin our equity and sustainability challenges. In particular:

    - the system tends to be designed around providers rather than what users value, and lacking shared values and culture.
    - the system needs stronger leadership at all levels – Māori as Treaty partners aren't adequately involved in decision making, there is a lack of effective long term planning, and weaknesses in DHB governance and performance.

- issues with the institutional framework make coordination challenging – for a small country our system is fragmented, accountabilities are unclear and the decision making framework lacks coherence.

- there are barriers to rebalancing the system towards primary and community healthcare, for example, barriers to workforce flexibility, cultural competency, and limited incentives for collaboration and sharing resources and best practice.

- the system needs more systematic use of data and evidence to inform decisions.

5. COVID-19 has reinforced some of the weaknesses with the health system but has also shown that change is possible, for example, rapid adoption of practices that the sector has been slow to adopt such as virtual consultations and e-prescribing. As the focus switches to the Wave 3 economic and social recovery from COVID-19, there is an opportunity to use implementation of the HDSR to ensure the health system responds to provide equitable outcomes for all New Zealanders and is fiscally sustainable.

Health and Disability System Review Proposals

The HDSR articulates a compelling vision for the future of New Zealand's health system

6. The Review articulates a compelling vision for a more cohesive and integrated health and disability system that puts people, whānau and communities at the heart of the system, and incorporates and embeds the principles of te Tiriti o Waitangi and mātauranga Māori throughout.

HDSR's recommendations range from legislative, structural and funding changes to cultural and capability changes

7. The HDSR has a large number of recommendations that are outlined in 12 interdependent themes. The report envisages that collectively its proposals will build a more people and whānau centred system that improves health inequities and system sustainability. By their nature the recommendations tend to be centred around legislative, structural and funding changes to support cultural and capability changes. The recommendations are intended to be implemented together to fully realise improvements to equity and system sustainability.

8. The Cabinet Paper and executive summary of the HDSR include a good summary of the proposals. Key proposals in the HDSR include:

    - making a **population health approach** a foundational principle in order to address long standing inequalities. In practice this means shifting form the current system which tends to be designed around providers to a system that uses population information to design and deliver services.

    - **more focused leadership** including clearer definition of functions and structures, more collective responsibility and more deliberate upskilling throughout the sector. Key elements of this include:

        - a **legislated charter** setting out common values and workforce behaviours throughout the system.

        - **structural changes to central Government health agencies** including separating stewardship functions from service delivery. A new Crown entity, Health NZ, will be the "operational brain" and provide national

leadership of health service delivery, both clinical and financial. A new Māori Health Authority will provide policy and strategy advice on Māori health and commission Māori provider and workforce development.

- **a reduction in DHBs** over five years (from 20 to 8-12), and strengthening their accountability for improving equity and contributing to the efficiency and effectiveness of the wider system. **DHB Boards are to be appointed** rather than elected.

- coherent and aligned **long-term planning** at all levels of the system, including a Long Term Health Outcomes and Services Plan (NZ Health Plan) and 5 year DHB strategic plans, supported by **legislated guaranteed annual funding increases**.

- creation of a **networked approach to primary and community services** ("Tier 1 services") to improve equity, accessibility and effectiveness. Provision of Tier 1 services is to be planned by DHBs who will be accountable for access and outcomes. This would see the devolution of services such as maternity and disability services from the Ministry of Health to DHBs, and from hospitals into primary and community care. The range of services is expected to increase, funding will be ring-fenced, and it will no longer be mandatory for DHBs to contract Primary Health Organisations for primary health care services.

- effective **te Tiriti o Waitangi partnerships and a health system that works for** Māori. This includes embedding Treaty principles in legislation, strengthening DHB-iwi partnerships, requiring DHBs to improve equity of Māori health outcomes in their strategic and locality plans, and ensuring funding formulae better reflect unmet need.

- improving **system sustainability** through a **dedicated performance function** in Health New Zealand to drive changes in system effectiveness and efficiency, and **funding to rebalance the system**.

9. The Tier 1 changes are expected to have the biggest potential to address health inequities. The wider changes to strengthen leadership and planning will support better system sustainability, but are also a key enabler of the Tier 1 changes.

Treasury supports the recommendation in the Cabinet Paper to agree to the direction of travel articulated in the Review …

10. Treasury strongly supports the case for reform and we broadly agree with the directions signalled in the HDSR. We agree with the approach in the Cabinet Paper to seek agreement to the overall direction of the HDSR report, but not to seek agreement to specific recommendations until after further policy work. We do not think individual recommendations should be ruled out at this point given that they are intended to work together as a package.

… but there are a number of things we would like to see in the next stage of work to ensure success

11. The next stage of policy development, change management and legislative work will be critical. We would like to see:

- **Underpinning principles** of putting people and whānau at the centre of the system, a population health approach and an effective Treaty-based partnership, **carry through to policy design and implementation**.

- **Prioritising and sequencing** packages of measures based on the extent to which they address health inequities and financial sustainability, relative to fiscal costs and implementation difficulty. This will require a careful balance between responses to increase capability, cultural responsiveness and partnership, as well as supporting structural, funding and legislative changes. This work needs to be cognisant of the Government's fiscal strategy and other significant sector reviews, for example, in welfare and education.

- **Sufficient attention** given to changes that improve **financial sustainability**, particularly in light of growing DHB deficits and the long term fiscal challenge. HSDR includes a number of important enablers, such as better planning and improving the flow and use of data, but little mention of the interventions and levers needed where DHBs are not performing. Further work on this is needed to inform the design of the proposed DHB performance function to sit in Health New Zealand and to give practical effect to the proposal in the report to hold Health New Zealand accountable for the overall financial balance of the system.

- **Alignment of planning and funding changes with Public Finance System reform proposals** – the Treasury has been developing proposals to modernise the Public Finance System with an aim of encouraging more collective decision making, improving value for money and raising stakeholders' perspective from the short to medium term. Proposals include strengthening priority-setting, planning, performance information and transparency, along with multi-year funding arrangements and a more comprehensive strategic baseline review process. It will be important to consider alignment and sequencing of the planning, funding and performance changes in the HDSR with the Public Finance System work.

- In developing advice on **machinery of government changes**, a focus on **how structural changes might support improved capability and behavioural change**, including the extent to which capabilities could be strengthened by shifting or pooling resources that already exist in the system. We agree that there is a strong case for considering the institutional settings to drive stronger system performance, but think that further consideration needs to be given to the function, form and key levers and enablers of the proposed Health New Zealand and Māori Health Authority.

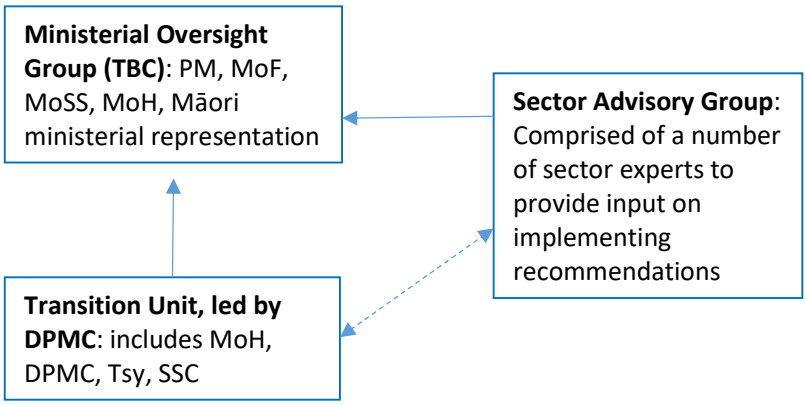
Proposed process for responding to the Health and Disability System Review

Treasury supports the proposed process in the Cabinet Paper for taking forward the next stage of work…

12. Treasury strongly supports the proposal in the Cabinet paper to establish a transition unit, housed in DPMC, to lead the next stage of work. The unit would be time-limited to two years. The paper proposes an end of June Cabinet report back on initial work priorities for the transition unit for the first six months.

13. The governance arrangements for the unit are set out in the diagram below. You would be part of the Ministerial oversight group and Treasury would second some resource to the transition unit.

Proposed governance arrangements for HDSR response



14. A high quality and well-resourced cross-agency transition unit is critical to the success of health reform. s9(2)(f)(iv) [redacted]

… and Treasury supports new funding for the transition unit

15. Treasury supports the proposal in the Cabinet Paper for $30 million over two years to establish the transition unit. $25 million of that is to be set aside in a contingency. There is a choice about whether the costs for this come from the Between Budget Contingency or the COVID-19 Response and Recovery Fund.

16. This cost is in line with the cost of other similar reforms, for example the establishment of Oranga Tamariki and the set-up of the social housing reform programme implementation unit in Treasury.

There is an opportunity to advance some work more quickly to manage short term financial risks…

17. In the short term there are two key related areas of financial risk; employment relations and a risk that the prospect of reform further reduces the incentive on DHBs to manage deficits. We suggest mitigating these risks via clear communications and an early consideration of options for proposals in the report for centralising employment relations and strengthening the DHB performance function. Treasury will work with DPMC, SSC and the Ministry of Health on options for expediting work in these areas for the end of June Cabinet report back.

Costs of HDSR

18. Whilst funding the costs of health reform in a difficult fiscal environment will require trade-offs with other priorities, there is an opportunity to position health reform as a key part of Wave Three social and economic transformation. Reform is critical to addressing system sustainability, and so well designed and implemented changes have the potential to reduce funding needed in the future.

19. We would expect costs of the HDSR proposals to be sought in future Budgets. The HDSR proposals include costs in the following areas:

    - A relatively small amount of funding to strengthen system stewardship. This would include measures to build capacity, capability and facilitate cultural change, along with some supporting structural changes to address weaknesses in the institutional framework.

    - Improvements in the way primary and community (Tier 1 services) are organised – these costs are likely to be significant. Costs are likely to include targeted improvements to service coordination, accessibility and coverage delivered by a broader range of clinical and non-clinical workforce, as well as targeted reductions in co-payments. There are choices here on scope, focus and pace.

    - Additional funding to rebalance the system ie to partially address DHB structural deficits. There are choices here about approach and timing. Treasury thinks there's a case for putting in additional funding after key performance enablers and levers are in place (for example, planning, DHB performance function etc) and following any DHB mergers. Doing it prior to this risks losing impetus for change and would be more expensive, reducing funding available for other priorities.

20. The report also includes a proposal for legislative annual funding increases. Whilst the underpinning rationale of greater funding certainty and better performance information to support better planning and service delivery is sound, more work is needed on the best way to achieve the objective, including alignment and sequencing with Public Finance System work.

Next steps

21. The 8 June Cabinet paper proposes an end of June Cabinet report back on initial work priorities for the transition unit for its first six months. It will be important to focus this on agreeing the transition unit's work programme, and avoid narrowing the Unit's work in a way that is inconsistent with the vision set out in the HDSR report.

22. Officials are available to meet with you to discuss the HDSR report further and any expectations you have for the next stage of work, to inform the end of June Cabinet paper.

TE TAI ŌHANGA
THE TREASURY

Treasury Report: Health and Disability System Reform - Briefing for Ministerial Oversight Group, 9 March 2021

Date:	5 March 2021	**Report No:**	T2021/419
		File Number:	SH-1-6-14

Action sought

	Action sought	Deadline
Hon Grant Robertson **Minister of Finance**	**Agree** that substantive advice on funding settings and fiscal management issues with health should be provided jointly by the Treasury and the Transition Unit.	Ahead of the Ministerial Oversight Group meeting on 9 March

Contact for telephone discussion (if required)

Name	Position	Telephone		1st Contact
Niki Lomax	Senior Analyst, Health & ACC	s9(2)(k)	s9(2)(g)(ii)	✓
Jess Hewat	Manager, Health & ACC			

Minister's Office actions (if required)

Return the signed report to Treasury.

Note any feedback on the quality of the report

Enclosure: Annex – Talking points for MOG meeting on 9 March

Treasury Report: Health and Disability System Reform - Briefing for Ministerial Oversight Group, 9 March 2021

Executive Summary

This report provides you with a briefing ahead of the meeting of the Ministerial Oversight Group on Health and Disability System Reform on 9 March 2021. The purpose of this meeting is to discuss the draft Cabinet paper, which has now been provided to your office, outlining the proposed new system operating model for health. It is expected that this paper will be discussed at Cabinet later this month.

We are supportive of the overall case for change; whilst the health and disability system performs well in many international comparators, it has continued to struggle to deliver equitable health outcomes, does not meet the Crown's obligations to Māori, and the system remains unnecessary complex and fragmented. Deteriorating financial performance is symptomatic of governance and management issues, and an inability to adequately shift the focus of the system towards primary and community care.

This Cabinet paper is the first in an expected series of papers, with the initial focus being on how core functions are allocated and discharged, where decision rights are located and how the system entities work together. Under the new system operating model, the Ministry of Health's role will focus on system stewardship, supported by a new operational lead agency (Health New Zealand) and a Māori Health Authority tasked with driving a focus on hauora Māori in the system.

We support the design of the new system operating model. We consider that the proposals:

- simplify and strengthen accountabilities and reduce complexity in the system;
- rebalance the system towards primary and community care, which is likely to drive marked improvements in health outcomes and begin to reduce inequities; and
- better enable integrated national, regional, and local strategic planning and delivery

The system operating model is the beginning of a significant volume of work required to design and implement reform. The scale of this cannot be understated. Whilst we are supportive of the need to move at pace (owing to the urgency in addressing inequities and poor performance), this needs to be balanced against the need to ensure that sufficient work is undertaken to successfully implement reform.

The Treasury will continue to prioritise its focus in the areas of reform which we consider have the largest cross-government implications and economic and financial impact. In particular, health system funding and financial sustainability, health system performance, and capital and digital investment. Given the interdependencies with the public finance modernisation work, we recommend that substantive advice on funding and fiscal management issues should be provided jointly by the Treasury and the Transition Unit.

A number of bids have been received in Budget 2021 to: enable the establishment of new entities; prototype new models of primary care delivery; begin building hauora Māori capacity; and progress fundamental IT enablers of reform. The Treasury supports these bids in full. More significant funding requests are expected in Budget 2022 and beyond, including to support the transformation of primary and community care, and to "refloat" the system to address deficits. Whilst the costs of reform are great, we have confidence these will be outweighed by the overall benefits of reform. In particular, it is expected that reform will have

some impact on the rate of health expenditure growth over time through improved management levers and accountability settings.

Recommended Action

We recommend that you:

a **note** that the Treasury is supportive of the proposed new system operating model for the health system, noting that a significant amount of detail remains to be worked through and planned timeframes for doing so will be challenging;

b **note** that the Treasury intends to focus on areas of reform with the largest cross-government and economic and financial impact, including matters related to funding and financial sustainability, health system performance, and health capital and digital investment;

c **note** that the Treasury will provide you with further advice ahead of the joint Ministers Monthly Health Check Up on 15 March on DHB financial performance through the period of reform transition; and

d **agree** that substantive advice on funding settings and fiscal management issues with health should be provided jointly by the Treasury and the Transition Unit to ensure the health reform proposals align with the public finance system modernisation work programme.

Agree/disagree.
Minister of Finance

Jess Hewat
Manager, Health & ACC

Hon Grant Robertson
Minister of Finance

Treasury Report: Health and Disability System Reform - Briefing for Ministerial Oversight Group, 9 March 2021

Purpose of Report

1. The purpose of this report is to provide you with advice ahead of the Ministerial Oversight Group on Health and Disability System Reform (MOG) meeting on 9 March 2021. The only agenda item for this meeting is a discussion of the draft Cabinet paper on the proposals for a reformed health system operating model, expected to be considered by Cabinet in the last week of March. You will receive papers for the MOG meeting on Friday 5 March, including a copy of the draft Cabinet paper and a short covering note.

2. This report provides a high-level Treasury view on these proposals and sets out the key areas in which we intend to provide further advice as the reform work progresses. Whilst we will provide further covering advice when the Cabinet paper is lodged, this paper is intended to be Treasury's substantive advice on the proposals.

3. We have provided you with suggested talking points for the MOG meeting on 9 March in the Annex to this report.

Draft Cabinet paper on the proposed health system operating model

4. The draft Cabinet paper sets out foundational proposals for reform of the public health system, in response to the Health and Disability System Review (HDSR). The Cabinet paper is, by necessity, very long and is split into five parts:

    a Part A recaps the context for reform and the case for change;

    b Part B describes a vision for the future system and the key changes that people will experience;

    c Part C proposes a new system operating model to deliver the necessary change and define roles and functions for organisations;

    d Part D describes how the proposed new system model will reinforce a focus on shared outcomes and accountability; and

    e Part E sets out the pathway to reform, including critical enabling activity and the roadmap to implementation.

5. The draft Cabinet paper does not address the HDSR's recommendations relating to services and support for disabled people, deferring decisions to later this year. There are a number of policy processes underway in this area that could be better aligned (decisions on a social insurance scheme, the roll out of Enabling Good Lives nationwide, and on where accountabilities for policy and delivery of disability services will reside in government).

6. This report does not summarise the content of the Cabinet paper, and instead we recommend that this report is read alongside the draft Cabinet paper that has now been provided to your office. The following sections of this report therefore provide Treasury's advice on the proposals outlined in the draft Cabinet paper.

The Treasury's view on the proposed health system operating model

Context for reform and vision for the future system

7. The Treasury is strongly supportive of the case for change outlined in the draft Cabinet paper (**Part A**) and agrees that there is a need to address the governance and accountability issues, inequities, and fragmentation in the current health system. We support the vision for the future system (outlined in **Part B**) which seeks to rebalance the health system: away from a reliance on hospital and inpatient services and towards a population health approach that invests in better, more equitable, more user-centric access in primary and community services. This rebalancing is necessary to lift system performance and improve health outcomes for all New Zealanders.

New system operating model

8. The Treasury's view is that the proposed system operating model (**Part C**) appears to address the current elements of the system that under-deliver and will better enable the system shifts required to improve system performance, equity, and health outcomes.

9. We consider there is a strong case for disestablishing district health boards (DHBs) and replacing them with a single entity – Health New Zealand (HNZ) – to lead system operations, planning, commissioning, and delivery of health services.

10. A more centralised health system will significantly simplify and strengthen accountabilities and better enable integrated national, regional, and local strategic planning and service delivery, which is foundational to raising system performance. HNZ will be well positioned to drive national consistency, take equitable and efficient allocative decisions, and reduce variation across the system. We also expect that this system will be much more amenable to adaptation over time as the needs of the population and the system evolve.

11. When established, DHBs were intended to lead on implementation of the Primary Care Strategy (2001) whilst also funding and delivering hospital services. It was anticipated that services and investment would gradually shift out of hospitals and into the community, but this did not eventuate. Acute care demands and fiscal constraints have prevented primary and community services (where the real health gains are made) from receiving the necessary focus and investment.

12. The reforms propose to split the current DHB functions into two distinct 'arms' of HNZ. This will ensure there is appropriate separation between these functions and avoid the current disincentives in the system for hospital providers to perpetuate hospital centricity. The necessary linkages between the two arms and the need for regional planning and service provision will be managed through the four regional divisions of HNZ. The locality networks will remove many of the constraints and barriers to effective, efficient primary care through integration across providers and local input to service commissioning.

13. Central to the reforms is effective and meaningful Māori leadership and partnership with Māori at all levels of the health system. The proposal to establish the Māori Health Authority (MHA) as lead commissioner for kaupapa Māori services and co-commissioner for all health services, and the empowered role of Iwi-Māori Partnership Boards, appears to give effect to this. This is not an area that we are intending to provide further advice on, beyond advising on the related Budget initiative.

14. The proposals seek to shift away from a provider-centric health system, towards a system that ensures services are commissioned (designed, procured, monitored) in accordance with national and regional plans and the assessed needs of whānau and communities. This shift, and the establishment of HNZ and the MHA, will necessitate a reorganisation of the existing commissioning capability in the system as well as an

overall capability uplift over time. Performance monitoring and management will be a critical element of these functions, and will require strong performance and service measurement and high quality performance information.

15. The Ministry of Health's role under the new system operating model would narrow towards a focus on system stewardship, through its role as lead on the delivery of strategy and policy functions. Whilst this will entail a significant change to the Ministry in its current form, we consider this will likely enable it to operate in a more agile and focussed manner, working across the system to improve health outcomes and inequities.

16. The proposed structural changes will provide the foundation necessary for system performance improvement, but structural reform alone will not be sufficient to deliver transformation. Managing the necessary cultural change in the health sector will be challenging, but will be enabled by the simplified institutional structures. Other critical enablers will be a significant uplift in the sector's digital capacity and capability as well as clinical leadership and engagement.

Focus on shared outcomes and accountability

17. **Part D** of the draft Cabinet paper focusses on how the new system model will deliver outcomes. The current devolved arrangements have not supported collective system focus around objectives. We agree that the advantage of the new system operating model is that the greater centralisation will enable clearer 'line of sight' that will strengthen the collectivity in the system and focus on ensuring common outcomes are delivered at all levels.

18. This section also describes how the New Zealand Health Plan will be a critical tool to ensure strategic priorities and policies flow through to the front-line coordination and commissioning of services. The draft Cabinet paper proposes that HNZ will lead development of the New Zealand Health Plan, in partnership with the MHA. The Minister of Health will sign off the plan, with advice from the Ministry of Health. To the extent that this plan also serves as a financial plan for the health sector, it may also be appropriate for the Minister of Finance (or possibly Cabinet) to have a formal role in this process. Whether through this document or another vehicle, it will be important that central agencies have a role in supporting the health sector planning process and retain access to detailed financial and performance information to continue to provide timely advice to Ministers on the performance of the health sector.

Pathway to reform

19. There remains a significant amount of work to do on the details of various aspects of the proposal. **Part E** of the draft Cabinet paper signals future work on critical enablers for reform, including funding and financial flows, workforce development, data and digital infrastructure, and facilities and equipment. We agree that ensuring the enablers are in place will be critical to the success of the reforms. This has informed our Budget 2021 assessments, which we cover in more detail in paragraphs 40-42 below.

20. It is proposed that HNZ and the MHA will be established in legislation, commencing on and operational from 1 July 2022. To manage through transition, interim entities will be established in the Ministry of Health as two separate departmental agencies to enable commencement of new functions well ahead of July 2022.

21. While these timeframes are ambitious, we agree that it is necessary to progress reforms at pace to expedite the system shifts the reforms are expected to deliver. There will be significant risk for DHB financial performance in the short term if the transition is not carefully managed, particularly given the pressures on the sector from COVID and the vaccine roll-out. However, a prolonged period of uncertainty, if implementation was to be slowed, would exacerbate these risks. **Managing a smooth**

transition to new system settings through a period of elevated risk for DHB performance must be a priority over the coming months. The risks associated with growing deficits and future reform are significant and have important implications for upcoming Budgets and for the government's fiscal strategy.

22. With a transition of this size, robust implementation planning is critical to ensuring the right capabilities are in place. The draft Cabinet paper notes that a further paper will be provided to Cabinet in May, providing more detail on the implementation and transition plan. As part of this, we would expect to see a clear plan for managing DHB performance through transition, addressing the elevated risks of further deterioration in financial performance during what will be a period of instability and change. We would expect this to include a plan for the transition of the DHB financial performance management function into the new monitoring and management functions for health system performance within Health New Zealand.

23. At this stage we have not seen detailed transition planning from either the Transition Unit or the Ministry of Health. We will provide further advice on this next week and suggest you discuss this further with the Minister of Health at the next Joint Ministers meeting on 15 March.

Treasury's HDSR work programme

24. Given constraints on the Treasury's capacity, we are not proposing to provide advice on all aspects of reform. It is our intention to continue to focus on the following areas over the period of reform , which we consider have the largest cross-government implications and economic and financial impact:

    a **Funding and fiscal sustainability** – including fiscal management issues, financial controls, and ensuring that health reform is consistent with the Public Finance Act 1989 and Public Finance System Modernisation reform proposals.

    b **Health system performance** – including governance and accountabilities in the new system operating model, performance management levers, and reporting, monitoring and evaluation processes and frameworks.

    c **Health capital and digital investment** – including systems, settings and capability for planning, delivering, managing and monitoring health capital assets and infrastructure, including data and digital infrastructure.

    d **Advice on Budget initiatives**.

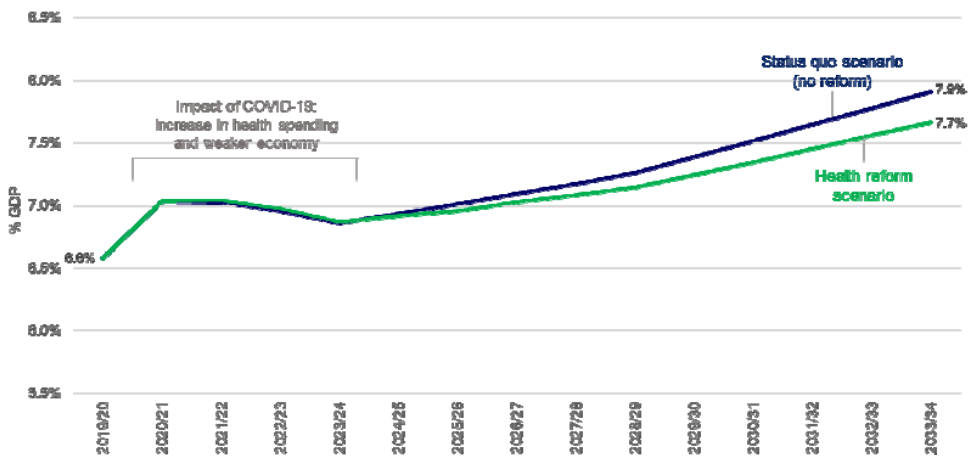
Funding and fiscal sustainability

25. There is a significant financial sustainability challenge in health, both in the short-term and in coming decades. DHB financial performance has deteriorated significantly in recent years, notwithstanding large funding increases in the last two Budgets, and this is likely to continue under the status quo.

26. Acknowledging significant structural pressures on the system and historic underfunding, growing deficits demonstrate, and are a result of, the limited influence we have over DHB financial management under current settings. The reforms provide a critical opportunity to reset the funding and budget management settings for the health sector to improve incentives and provide more certainty for health service providers, and for the Crown, by enabling more effective financial control in the face of these pressures.

27. Improving fiscal management levers over health expenditure will be fundamental to delivering the Government's fiscal strategy over the medium-term. It is expected that reform will have some impact on the rate of expenditure growth over time, through improved management levers and accountability settings. However the health sector will continue to need significant investment, particularly in the short term – including a one-off uplift to rebalance or "refloat" the sector and additional funding to meet price and volume cost pressures. Figure 1, provided by the Transition Unit, suggests that within 15 years health reform could result in avoided cost growth of 0.2% of GDP, or approximately $1.4 billion. This is informed by OECD work on health systems efficiency. Although it necessarily uses some very high level assumptions about the cost of reform, we agree that it is broadly the level of savings that could be expected.

Figure 1: Core Crown Health Expenses, 15 year projection (% GDP), using PREFU 2020 base



28. There are a significant number of policy issues to work through over the coming months on fiscal management issues (i.e. the mechanics of a multi-year funding approach), funding flows and financial controls, and planning and reporting. The draft Cabinet paper commits to providing further advice to Cabinet on these issues in June 2021.

29. Decisions taken with respect to the health system settings will have significant fiscal implications, as well as implications on the broader public finance system. **We recommend that the substantive advice on these issues should be provided jointly by the Treasury and the Transition Unit. This will also ensure the proposals align with the intent of the Public Finance System Modernisation work programme.**

Health system performance

30. The current health system is complex and unnecessarily fragmented, with unclear roles, responsibilities and boundaries, and accountability mechanisms that provide limited levers to influence DHB performance. Over time, this has resulted in an inability to effectively manage deteriorating financial performance and clinical variation, resulting in inequitable outcomes for New Zealanders. The new system operating model proposed in the draft Cabinet paper seeks to address these challenges and support improved management of health system performance.

31. HNZ, as operational lead, will monitor and manage the performance of the health system, including clinical and financial outcomes, across all layers of the system, across years. The provider arm of HNZ will have direct management levers to address poor performance and incentives to manage providers with the whole system in mind. This offers significant benefits over the current system, where the Ministry of Health does not have direct levers and the Minister of Health's governance levers are rarely exercised.

32. The Ministry of Health's monitoring role will change from monitoring twenty discrete entities to monitoring performance of the MHA and HNZ at a more strategic level. This is more consistent with the Ministry's size and capacity, and will provide the Minister with more strategic and impactful advice, whilst being supported by multi-layered operational monitoring by HNZ.

33. It is expected that pooling capability and resource in one entity, rather than spreading executive and management talent across 20 entities will also greatly improve system performance. Centralisation also offers the opportunity for greater control in many of the key areas that drive expenditure across the system; for example, centralised employment relations in HNZ will enable better oversight and management of the costs associated with workforce.

Capital and digital investment

34. The proposed health system operating model would establish a national hospital network and increase levers over delivery of capital projects compared to the current, decentralised model. This network model would be developed based on a broader national service plan that would become the basis of the commissioning of services across New Zealand.

35. The Treasury strongly supports this approach as it has the potential to overcome key weaknesses of the current system by facilitating national prioritisation of projects; the development and use of facility design standards; and national oversight and coordination of the pipeline of major projects. This approach should result in more effective and efficient delivery and management of capital assets.

36. The Minister of Health has submitted a Budget initiative for Accelerating the Health Infrastructure Unit (HIU) Work Programme. We have recommended this initiative be included in the Budget 2021 package as it will help lay the groundwork for reform by undertaking additional asset assessment, project oversight, planning, and prioritisation of health capital projects.

37. The draft Cabinet paper also notes the significant technology deficit that has been accrued in the health sector over many years of under-investment. We agree that there is likely to be a need for significant investment, both to update and address major risks in current systems (for example, to digitise paper records and upgrade vulnerable end-of-life IT systems) and to realise more value from health data and health expenditure. We have recommended that the following initiatives be included in the Budget 2021 package, with funding to be held in contingency until initiatives are investment ready, with Business Cases expected imminently:

    a The Health Sector Agreements and Payments Programme – this would replace the current system for managing agreements and distributing payments in the health sector, which is critically outdated and at high risk of failure. It is unlikely that reform could be delivered without replacement of this system.

    b A $400 million contingency for data and digital investment in health. Funding for Hira, a major programme to expand access to, use of, and sharing of health data,

for which a Budget bid has also been submitted, could be considered against this contingency subject to a detailed business case. We recommend that the contingency be underpinned by a data and digital strategy and clear criteria for prioritising initiatives for development and funding, drawing on the existing Capital Investment Committee process for health capital projects.

38. Further work will be needed over the coming months to develop the new operating model for health capital and digital investment in a range of areas. This could include:

    a clarifying the roles and responsibilities of the Ministry of Health, HNZ and other entities involved in the planning and delivery of health capital builds and data and digital projects;

    b determining how capital and service planning will be coordinated;

    c establishing delegations and approval processes for project delivery and asset management; and

    d a review of capital charge and depreciation.

39. Work is being undertaken for the Infrastructure Commission that could inform the development of this new model. This work includes an assessment of the current state of infrastructure and key issues in several sectors (including health) as well as an investigation of Australian models of health capital. We will support the Infrastructure Commission to work closely with the Transition Unit to ensure this work is aligned.

Implications for Budget

Budget 2021

40. In Budget 2021, the Transition Unit is seeking $126 million operating per annum – to begin establishment of HNZ and the MHA, for the initial roll out or prototyping of new models of primary care delivery (Locality Networks), for building hauora Māori capacity, and an initial commissioning budget for the MHA.

41. We recommend supporting these initiatives in full. It is necessary that the new institutions are set up to succeed, and experience from recent reforms (such as with Oranga Tamariki and the Reform of Vocational Education) underscores the importance of adequately resourcing the transition and implementation phases on this work. We have tested costing assumptions within these bids and are comfortable they are broadly in line with those seen with other large reforms. Scaling options are unlikely to be viable and deferring these initiatives would delay implementation of reform.

42. As referred to in paragraph 36-37 above, there are also a number of capital and digital initiatives we recommend you include in the Budget package, as they are critical enablers for reform. You will receive further advice next week on the Budget 2021 health package ahead of your bilateral with Minister Little on 15 March.

Budget 2022

43. The funding sought in Budget 2021 represents a small portion of what will be required to implement health system reform. While this will create affordability challenges for Budget 2022, health reform that supports improved financial performance and sustainability will be critical for delivering the Government's medium-term fiscal strategy.

44. The draft Cabinet paper notes that Ministers can expect most of the ongoing costs of health reform to be agreed in Budget 2022 and beyond (subject to Minsters' choices on phasing). The paper outlines that further funding will be required to:

    a support the transformation of hauora Māori and primary and community-based services;

    b support digital enablement and consumer-centred digital services;

    c provide a substantial baseline uplift to "refloat" future organisations once new accountabilities are in place;

    d provide for costs of changes to IT systems arising from consolidation and establishment of new entities; and

    e any remaining costs of structural changes and system improvements – as more detailed design work is undertaken by the establishment Health NZ and the MHA, some additional investments might be required, for example to enhance functions or capabilities.

45. Further policy work is required before these elements of reform can be costed in detail, and it is likely that there will be additional costs that surface as the reforms progress. Despite this uncertainty, we still consider it likely that the overall benefits of reform will outweigh the costs.

46. As an initial estimate we expect that in Budget 2022 the health sector is likely to require investment approximate to 65-90% of the current operating allowances (or $1.7 - $2.4 billion per annum). This estimate includes ordinary health sector cost pressures but excludes other new policy (e.g. outstanding manifesto commitments).[1] The range reflects choices Ministers will have around scale and timing of investment in hauora Māori and primary and community-based services. Importantly, the cost of the system "refloat" is highly dependent on the combined DHB deficit position for 2020/21 and given the risk of deterioration across the year, it is likely that our initial estimate is conservative.

47. The draft Cabinet paper also notes the intention to agree the first multi-year financial settlement for health in Budget 2022. Treasury supports the high-level case for shifting to a multi-year approach, in the health sector and across broader government. However, our ongoing support of this proposal will be dependent on the specific design features and mechanics of a multi-year approach, and its alignment with the broader public finance system modernisation work programme. We expect that the health sector will favour an approach that offers a high degree of certainty, however it will be important that the approach retains sufficient flexibility to accommodate changes in government priorities or circumstance.

48. You will receive further advice on expected costs ahead of the June 2021 Cabinet paper on funding-related issues.

s9(2)(b)(ii)

Annex: Talking points for MOG meeting on 9 March

On the draft Cabinet paper, we recommend you raise the following points with your colleagues:

- Funding and fiscal sustainability:
    - The economic and fiscal impacts of health sector performance are significant and reform presents a critical opportunity to address the fiscal sustainability challenges in health and improve incentives for cost effectiveness and financial management. Broadly, it appears the proposed system operating model will support this, however there remains a significant amount of detail to work through funding and financial management issues.
    - While funding certainty is understandably important to the health sector, it is important that the new arrangements maintain flexibility to respond as economic circumstances change or as governments change their priorities. Achieving balance between these objectives is vital if the new arrangements are to endure. It will also be important that the health reforms align with the direction of the Public Finance System modernisation work programme.
    - It will be a challenge to accommodate the costs of reform within the government's current fiscal strategy, however getting these reforms right is fundamental to addressing sustainability challenges over the medium and long term.
    - **I expect that the advice ahead of a June Cabinet paper on funding and financial management issues will be prepared jointly by the Treasury and the Transition Unit**, in consultation with the Ministry of Health.
- Implementation and transition risks:
    - The expected recommendations for the new system operating model – while providing the settings necessary to drive sector improvement in the medium and long term – will trigger a transitional phase that carries considerable risk if not managed carefully. In particular, there are risks that DHB financial performance will further deteriorate across this period if risks are not adequately managed.
    - A careful plan will be needed, with the Transition Unit working in partnership with the Ministry of Health. I would like to discuss this further at the joint Ministers Monthly Health Check Up next week (March 15).

IN CONFIDENCE

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

MINISTRY OF HEALTH
MANATŪ HAUORA

TE TAI ŌHANGA
THE TREASURY

Briefing

HEALTH REFORM: APPROPRIATIONS, BUDGET RESPONSIBILITIES AND FUNDING DESIGN PRINCIPLES

To: Hon Andrew Little, Minister of Health; Hon Grant Robertson, Minister of Finance; Hon Peeni Henare, Associate Minister of Health			
Date	13/08/2021	**Priority**	Routine
Deadline	20/08/2021	**Briefing Number**	DPMC-2021/22-45 HR20211849 T2021/2054

Executive summary

Purpose

1. This paper seeks decisions from you on overall national level funding settings for the new system operating model, to inform a September Cabinet paper. Cabinet decisions are needed in September in order to meet timeframes for Budget 2022 and provide clarity for interim entities in setting internal budgets for July 2022. The September Cabinet Paper will also include your decisions on a recent Treasury led paper on a multi-year funding approach for health (refer DPMC-2021/22-40).

The relationship between funding settings and accountability

2. Funding settings sit alongside a broader suite of governance and accountability settings for the reformed system which will drive planning and commissioning. In general, Health New Zealand (Health NZ) and the Māori Health Authority (MHA) should have funding flexibility and certainty in return for clear accountabilities and comprehensive reporting. This is so that resources can be allocated by Health NZ and the MHA to where they are most effective at improving population health outcomes.

3. The diagram on the next page shows a high-level overview of how Government expectation setting, entity plans and reporting functions cascade and relate to each other for both planning and allocative funding decisions. Key decisions needed for legislation have been taken on planning and accountability settings (left hand side of the diagram), but further work is needed on the detailed design. The Transition Unit will provide a briefing to Joint Ministers summarising how the governance and accountability framework for the new system operating model will work in practice at the end of August.

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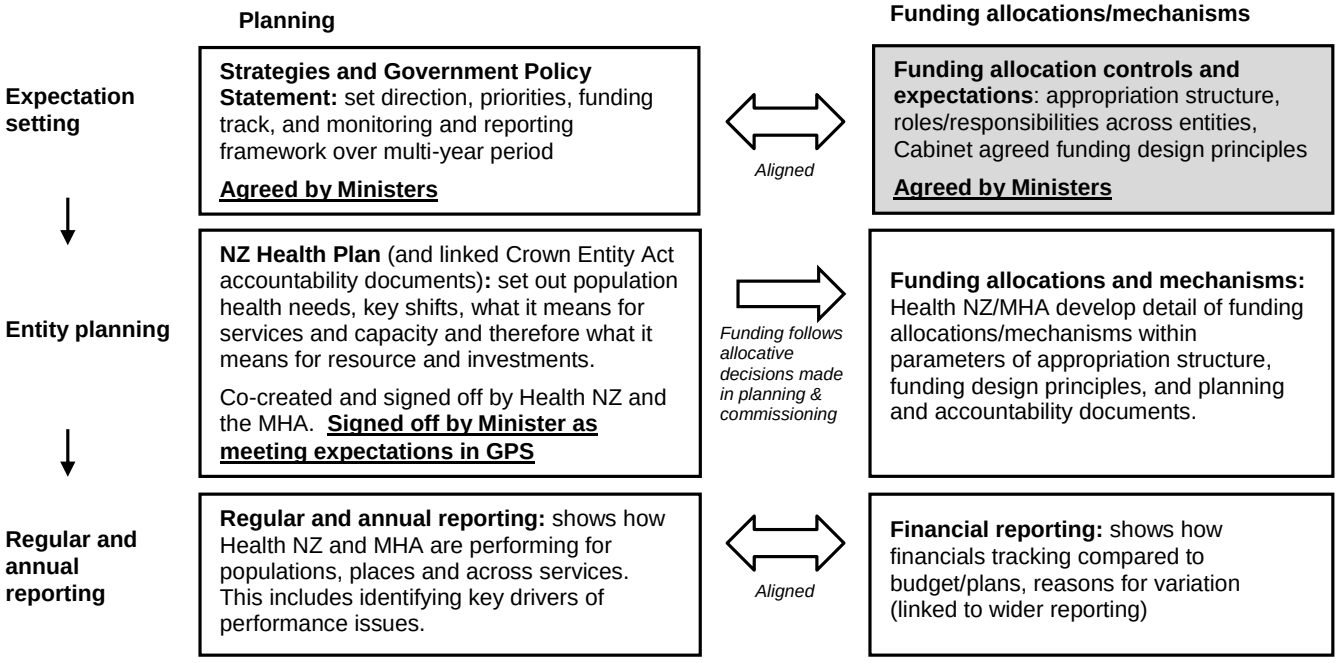
4. The focus of this paper is on agreeing funding allocation expectations and controls (grey shaded box); this includes the appropriation structure, budget holding roles and responsibilities across entities, and Ministerial expectations around internal funding allocations.

High level overview of Government expectation setting, entity plans and reporting for planning and funding allocations/mechanisms



Vote Health appropriation structure

5. **This paper seeks agreement to shifting to a more coherent and smaller set of appropriations for Vote Health** to mirror a system operating model that is less fragmented, supports rebalancing of the system to prevention and primary and community care, ensures flexibility to deploy resources to improve population health outcomes, and supports Parliamentary authorisation at a more meaningful level. The new structure would consist of around ten appropriations, including “primary, community, public and population health services”, “hospital and specialist services”, “hauora Māori” and “pharmaceuticals”, alongside a number of existing appropriations including for the Ministry of Health’s outputs, COVID-19 vaccine, the COVID-19 response and the health capital envelope.

6. The appropriation structure needs to be seen alongside the wider suite of mechanisms for expectation setting, planning and accountability, and reporting. This includes a more useful set of service-focused reportable outputs for the purposes of the Crown Entities Act (e.g. public health, mental health, maternity and child health, planned care), and more comprehensive and accessible reporting including mandatory population reporting for Māori as tangata whenua, and Pacific and disabled people. Reportable outputs under the Crown Entities Act are a means of providing a comprehensive account to Parliament on ex ante and ex post non-financial and financial performance. Initial advice on a reporting framework will be provided in November, alongside advice on the detailed appropriation structure.

7. s9(2)(f)(iv)

IN CONFIDENCE

s9(2)(f)(iv)

Budget and funding responsibilities across entities

8. Whilst budget and funding responsibilities across entities are largely pre-determined by Cabinet's March decisions on the system operating model (refer CAB-21-Min-0092), decisions are needed on the nature and scope of the MHA's direct budget responsibilities and where the pharmaceuticals budget sits. This paper proposes:

   a) **A separate hauora Māori appropriation with accountabilities and responsibility for reporting against it sitting with the MHA**. This will include funding provided through Budget 2021, any funding provided through Budget 2022, and Ministry of Health non-departmental funding currently managed by its Māori Services Directorate, for example Māori Provider Development Scheme funding.

   b) s9(2)(f)(iv)

   c) Out of scope of request

   d) s9(2)(f)(iv)

Internal funding allocations and mechanisms

9. Most of the work on funding will come over the coming months in designing Day 1 and future funding allocations and mechanisms. **This paper proposes a set of draft funding design principles to set the parameters within which Health NZ and the MHA decisions on funding allocations and mechanisms must be made.** Officials propose testing and refining them with external experts and asking Cabinet to sign them off in a paper at the end of September. Officials also recommend including the draft principles in Letters of Expectations to interim entities, ahead of formal Cabinet agreement. Setting up the funding allocations and mechanisms will be an iterative process; officials recommend checking that the proposed design principles are still fit for purpose when the first full NZ Health Plan has been developed.

IN CONFIDENCE

10. The Transition Unit is preparing advice for incoming Boards on internal funding allocations focused on the first two years of Health NZ and the MHA. A high-level explanation of how internal funding flows might work for Health NZ is included in Appendix B.

Recommendations

Purpose of paper

1. **Note** this paper seeks decisions on national level funding settings that need to be taken in September to meet Budget 2022 timeframes and to provide clarity for interim entities in setting internal budgets. These decisions include:
    a) in-principle agreement to the overall Vote Health appropriation structure
    b) agreeing budget responsibilities across entities including noting where further work is needed
    c) seeking your feedback on a set of funding design principles to set the parameters within which Health New Zealand and Māori Health Authority decisions on funding allocations and mechanisms must be made

Vote Health appropriation structure

2. **Note** officials recommend shifting to a more coherent set of around ten appropriations for Vote Health to reinforce system shifts, and to balance the need for operational flexibility for Health New Zealand and the Māori Health Authority with the expectation of Parliamentary authorisation and transparency in a meaningful way
3. **Note** separate appropriations for "primary, community, public and population health services" and "hospital and specialist services" will provide control and oversight over the relative resources in each appropriation and support a rebalancing of the system towards health promotion, prevention and primary and community care
4. **Note** that, given the central role of public and population health services in the key reform shifts, further advice will be provided about mechanisms to protect funding for these services, which have historically been deprioritised in the face of immediate demands
5. **Agree in principle** the overall approach to the appropriation structure for Vote Health including separate appropriations for:
    a) primary, community, public and population health services, with further advice coming on the best mechanism for protecting public health funding
    b) hospital and specialist services
    c) hauora Māori
    d) pharmaceuticals
    e) National Response to COVID-19 multi-category appropriation
    f) COVID-19 vaccine strategy multi-category appropriation
    g) disability support services (subject to outcome of the machinery of government review)
    h) a multi-category appropriation for the Ministry of Health departmental functions

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i) monitoring and protecting health and disability consumers interests (covers the functions of the independent Crown Entities)

j) health capital envelope

Yes / No	*Yes / No*	*Yes / No*
Minister of Finance	**Minister of Health**	**Associate Minister of Health**

6. **Note** officials will develop a new set of reportable outputs for the purposes of the Crown Entities Act to provide ex ante and ex post reporting, and there is an opportunity to shift this to a more useful set of service-focused categories, such as public health, mental health, maternity and well child, and planned care, that support and align to the agreed appropriations and accompanying performance measures

Budget holding responsibilities across health entities

7. **Note** further advice on detailed functional roles of future entities, and associated resource implications and funding transfers, will be provided to Ministers in the coming months and included as part of the Budget technical package, or earlier, as appropriate

Māori Health Authority direct budget responsibilities

8. **Agree** that in addition to funding provided through Budget 2021 and any potential funding provided through Budget 2022, the Māori Health Authority will be responsible for managing funding and reporting against a hauora Māori appropriation containing Ministry of Health non-departmental funding currently managed by its Māori Services Directorate, for example, Māori Provider Development Scheme funding

Yes / No	*Yes / No*	*Yes / No*
Minister of Finance	**Minister of Health**	**Associate Minister of Health**

9. **Note** that officials will provide further advice alongside a draft Cabinet Paper in early September on the approach to Māori Health Authority direct budget holding responsibilities for:

a) DHB funding for Māori providers

b) other non-departmental Vote Health non-devolved funding currently administered by the Ministry which has a Māori component (for example, mental health and workforce development)

10. s9(2)(f)(iv)

Pharmaceuticals budget

11. Out of scope of request

12.

Yes / No	*Yes / No*	*Yes / No*
Minister of Finance	**Minister of Health**	**Associate Minister of Health**

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Pacific commissioning function

13. **Agree** to the establishment of a dedicated Pacific commissioning function in Health New Zealand that is led by senior leadership and broadly incorporates:

    (a) Responsibility for Pacific provider and workforce development, and sector innovation

    (b) Direct commissioning capability for national and regional Pacific services; and

    (c) Accountability mechanisms for Pacific-specific funding across Health New Zealand

Yes / No	***Yes / No***	***Yes / No***
Minister of Finance	**Minister of Health**	**Associate Minister of Health**

14. **Note** that, contingent on your agreement to recommendation 13, officials will provide you with detailed advice on the implementation approach for this commissioning function along with options for new investments for addressing Pacific inequities

15. s9(2)(f)(iv)

Internal funding allocation mechanisms – funding design principles

16. **Note** Health New Zealand and the Māori Health Authority need to operate within an overall Budget constraint to deliver Te Tiriti o Waitangi dynamic, equitable, effective, sustainable, efficient and acceptable services for people, whanau, iwi, and communities

17. **Note** officials have developed an initial draft set of funding design principles for future Cabinet endorsement to guide Health New Zealand and Māori Health Authority internal funding allocations and mechanisms:

    a) **Funding should follow allocative decisions made in planning and commissioning:** The New Zealand Health Plan will set out key allocative decisions with respect to populations, services and enablers, and place. Funding allocations and mechanisms should support these decisions.

    b) **Pro-equity**: Funding allocations and mechanisms should fairly distribute funding to enable effective culturally responsive services and use of enablers to address current and future inequities across populations. This should include Māori as tangata whenua, Pacific people, disabled people, and other populations that experience inequities.

    c) **Consistent access**: Funding allocations and mechanisms should fairly distribute funding to support consistent access to effective and quality service and care levels across populations.

    d) **Efficiency**: Funding allocations and mechanisms should support value for money in service delivery and use of enablers. Where HNZ is the provider, would expect funding allocations and mechanisms to shift towards efficient pricing and resource allocation generally.

18. **Note** the funding design principles sit alongside a broader set of commissioning principles (refer diagram on page 20)

IN CONFIDENCE

19. **Indicate** if you have any feedback on the design principles in recommendation 17

Yes / No	***Yes / No***	***Yes / No***
Minister of Finance	**Minister of Health**	**Associate Minister of Health**

20. **Agree** that the final version of the design principles referred to in recommendation 17 should be agreed by Cabinet in an upcoming paper in September on funding

Yes / No	***Yes / No***	***Yes / No***
Minister of Finance	**Minister of Health**	**Associate Minister of Health**

Next steps

21. **Note** officials will develop a Cabinet paper on funding and budget settings for the future system operating model that covers key decisions from this paper and the earlier Treasury led paper on multi-year funding arrangements for Vote Health (refer DPMC-2021/22-40)
22. **Note** the Transition Unit will report back to Joint Ministers at the end of August summarising how the governance and accountability framework for the new system operating model will work
23. **Note** the Ministry of Health, in consultation with the Treasury and the Transition Unit, will report back to Joint Ministers in November 2021 with advice on the detailed appropriation structure and indicative appropriation splits
24. **Note** the Transition Unit, in consultation with the Ministry of Health and the Treasury, will report back to Joint Ministers in November 2021 with initial advice on the overall approach to the reporting framework.

Stephen McKernan **Director** **Transition Unit**	Dr Ashley Bloomfield **Director-General of Health** **Ministry of Health**	Jess Hewat **Manager, Health & ACC** **The Treasury**

Hon Grant Robertson **Minister of Finance**	Hon Andrew Little **Minister of Health**
…../…../….	…../…../….

IN CONFIDENCE

Hon Peeni Henare
Associate Minister of Health

…../…../….

Contact for telephone discussion if required:

Name	Position	Telephone	1st contact
Stephen McKernan	Director, Health Transition Unit	s9(2)(k)	X
Dr Ashley Bloomfield	Director-General of Health Ministry of Health		
Jess Hewat	Manager, Health and ACC, The Treasury		

Minister's office comments:

- ☐ Noted
- ☐ Seen
- ☐ Approved
- ☐ Needs change
- ☐ Withdrawn
- ☐ Not seen by Minister
- ☐ Overtaken by events
- ☐ Referred to

IN CONFIDENCE

HEALTH REFORM: APPROPRIATIONS, BUDGET RESPONSIBILITIES AND FUNDING DESIGN PRINCIPLES

Purpose

1. This paper seeks decisions from you on some overall national level funding settings for the new system operating model, to inform a September Cabinet paper. The paper:
   - outlines the role of funding settings in supporting the key health reform system shifts
   - seeks in principle agreement to the overall appropriation structure for Vote Health
   - outlines further work needed on the direct budget responsibilities of the Māori Health Authority (MHA) and seeks agreement to where the pharmaceuticals budget should sit
   - seeks feedback on an initial set of funding design principles to guide internal Health New Zealand (Health NZ) decisions on funding allocations and mechanisms.

2. The September Cabinet Paper will also include your decisions on a recent Treasury led paper on a multi-year funding approach for health (refer DPMC-2021/22-40). Cabinet decisions are needed in September in order to meet timeframes for Budget 2022 and provide clarity for interim entities in setting internal budgets for July 2022. Officials will provide separate advice on digital and capital funding settings over the coming weeks, including a Cabinet Paper in October.

3. **This paper does not cover planning and commissioning which refers to how services are planned, purchased and monitored.** Key decisions needed for legislation have been taken on planning and accountability settings, but further work is needed on the detailed design. A high-level overview of how planning and funding settings relate to each other, including using illustrative examples, is included in **Appendix A**.

The role of funding settings

Current funding settings are not fit for purpose and changes are needed to support the health reform system shifts

4. Funding settings refer to Budget and funding rules and funding allocations and mechanisms. Well-designed funding settings working alongside well-functioning and complementary institutional arrangements can support and incentivise equity, value for money, efficiency, and sustainability.

5. Changes to funding settings are needed to support key reform shifts and objectives, including:

   (a) **Reflecting and embedding Te Tiriti o Waitangi**. The Health and Disability System Review (The Review) found that tino rangatiratanga and mana motuhake of hauora Māori are not sufficiently recognised and provided for in the current system.

   (b) **Aligning budget and funding responsibilities with accountabilities**. The Review found that commissioners do not always have the funding flexibility they need to make strategic decisions to tailor responses to population health needs.

(c) **Ensuring funding follows and supports allocative decisions made through planning and commissioning** with respect to populations, services and place. This includes directing funding towards need and rebalancing the system towards health promotion, prevention and primary and community care. The Review found that allocations and use of funding has not always reinforced outcomes being sought through models of care.

(d) **Ensuring an allocation of funding that supports and promotes improvements in equity**. One of the key findings of the Review was that population-based funding for primary and community services needs to be better weighted according to need and relevant ethnicity weightings need to be included.

(e) **Providing certainty to support longer term planning and commissioning**, including addressing structural issues, such as redesigning models of care, that require a multi-year approach. The annual budget cycle and disconnect between planning and Budget decisions was a key issue identified by the Review.

This paper focuses on agreeing some overall national level funding settings needed for Budget 2022 and Day 1

6. Taken together, this paper, an earlier Treasury-led paper on a multi-year funding approach to health funding (refer DPMC-2021/22-40) and upcoming advice on digital and capital funding settings, set the overall national level funding settings for the system operating model. The proposals across these papers reinforce the system operating model, enable effective planning and commissioning, align budget and funding responsibilities with accountabilities, and set funding design principles that support the reform objectives.

7. Most of the work on funding will come over the coming months in designing Day 1 and future funding allocations and mechanisms. This paper sets out some initial draft funding design principles to set the parameters within which Health NZ and the MHA decisions on funding allocations and mechanisms must be made. Officials propose testing and refining them with external experts and getting Cabinet to sign them off in a Cabinet Paper at the end of September on funding.

8. The Transition Unit is preparing advice for incoming Boards on internal funding allocations focused on the first two years of Health NZ and the MHA. A high level explanation of how internal funding flows might work for Health NZ is included in Appendix B for illustrative purposes.

In this paper, funding allocations and mechanisms refer to how funding is allocated within Vote Health and is distinct from commissioning

9. Commissioning is the process by which health services are planned, organised, funded and monitored to achieve the most equitable outcomes in the most efficient, effective and sustainable way. The commissioning process determines funding for services. Funding allocations and mechanisms are the means by which funding flows to entities, commissioners, budget holders and service providers within Health NZ, for example, via appropriations and needs-based funding models to regional commissioning arms of Health NZ.

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Vote Health appropriation structure

The current Vote Health appropriation structure will not be fit for purpose for the new health system operating model

10. Appropriations are the basis on which Parliament authorises the incurring of expenses or capital expenditure. The current Vote Health appropriation structure is not fit for purpose. It consists of 54 appropriations, which include geographic appropriations (one for each of the 20 district health boards) and a number of appropriations for services nationally commissioned by the Ministry of Health (the Ministry), such as mental health. Whilst a large number of appropriations might in theory create a sense of control and transparency, the mix of geographic and service-focused appropriations does not provide a useful framework for providing transparency to Parliament about how the Government intends to use public money. It also creates unnecessary barriers to the integration of services and an administrative burden when Ministers and departments need to reallocate funding.

11. **A new appropriation structure needs to be seen alongside the wider suite of mechanisms for expectation setting, planning and accountability, and reporting**. Currently these mechanisms are not working well together to ensure that the system is performing and being held to account. There are **significant opportunities for improvement in the new system, where in general Health NZ should have funding flexibility and certainty in return for clear accountabilities** and **comprehensive reporting.** This is so that resources can be allocated by Health NZ (acting with the MHA for key national and regional plans) to where they are most effective at improving population health outcomes. It relies on the Government Policy Statement (GPS) being strategic and focused on key directions and expectations, the NZ Health Plan being a high-quality service and capacity plan that delivers against the GPS, and more comprehensive and meaningful reporting than exists currently.

12. This section focuses on where the appropriation structure should be used as a control and transparency mechanism to support reform objectives. Appendix A uses an illustrative example to show how planning, accountabilities, reporting and funding settings work together, including the role of appropriations as part of that system.

We propose shifting to a smaller but more coherent set of appropriations to reinforce system shifts and provide for Parliamentary authorisation at a more meaningful level

13. A good appropriation structure needs to balance controls and transparency around the distribution of funding across key outputs, with flexibility to deploy funding to where it can best be used to improve population health outcomes. It needs to be consistent with the delegations implied by health system operational leadership by a Crown entity. It should support Parliamentary authorisation of spending at the “right level”.

14. This section proposes shifting to a smaller but more coherent set of appropriations in Vote Health to support Parliamentary authorisation at a more meaningful level, to support rebalancing of the system to prevention and primary and community care, to mirror a system operating model that is less fragmented, and to ensure flexibility to deploy resources to improve population health outcomes.

15. New Vote Health appropriations would include: primary, community, population and public health services; hospital and specialist services; hauora Māori (ie the MHA budget); and pharmaceuticals. Appropriations would remain for: monitoring and protecting health and disability consumers interests (covers the functions of the independent Crown Entities); health capital; COVID-19 vaccine; COVID-19 health system response; and disability support services. A new multi-category appropriation would cover Ministry departmental

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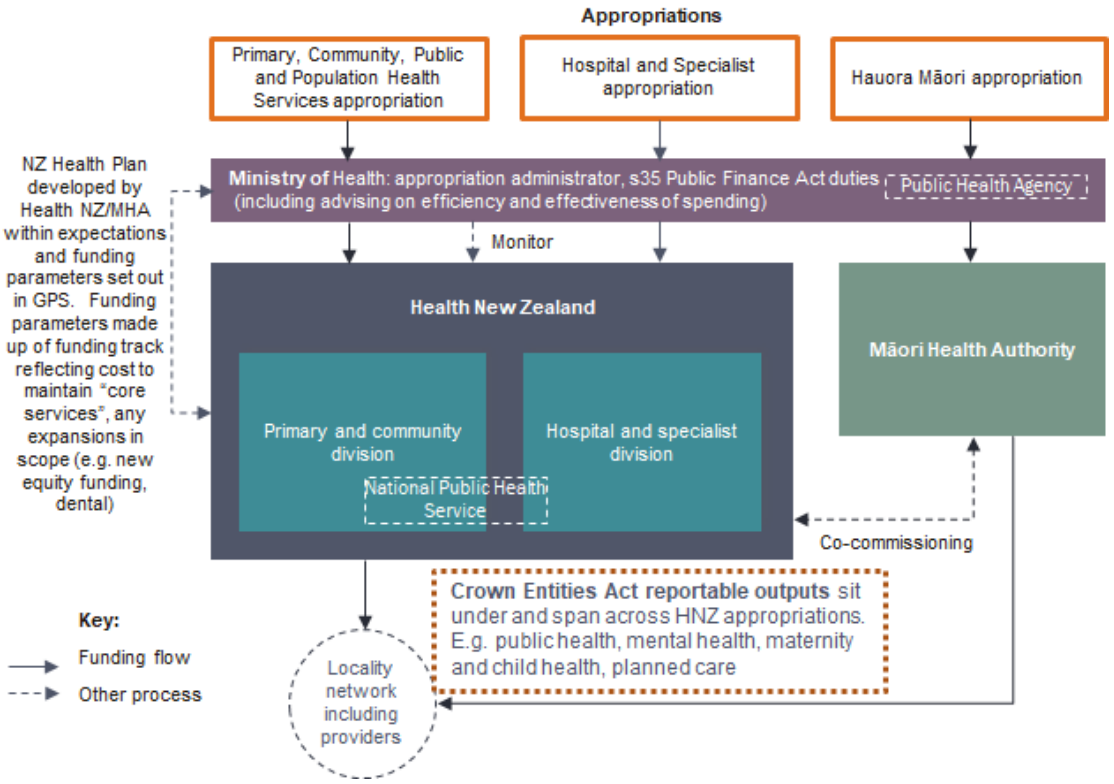
functions. The diagram below shows how the appropriations for Health NZ and the MHA would flow through to entities.



16. Officials will provide further advice at the beginning of September, alongside a draft funding Cabinet Paper, on the most effective suite of mechanisms to protect public health funding and other areas of Ministerial priorities, such as mental health. This includes expectation setting in the GPS, mandating public health as a reportable output class for the purposes of Statement of Performance Expectation accountability requirements, and appropriation structures including performance measures in the information supporting the Estimates.

17. Once the appropriation structure has been agreed officials will develop a new set of reportable outputs for the purposes of Health NZ's Statement of Performance Expectations. Reportable outputs under the Crown Entities Act are a means of providing a comprehensive account to Parliament on ex ante and ex post non-financial and financial performance. Currently DHBs have four centrally reportable outputs[1], but they do not reflect how DHBs run their operations and are not conducive to supporting a meaningful performance story. Further work is needed on the design of the reportable outputs, but there is an opportunity to shift to a more useful set of service focused categories (e.g. public health, mental health, maternity and well child, planned care) to account for spending, activity and outcomes and how this varies by population and place.

[1] Prevention, Early Detection and Management Services, Intensive Assessment and Treatment Services, Rehabilitation and Support Services

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Separate appropriations for "primary, community, public and population health services" and "hospital and specialist services" will provide control and oversight over the relative resources in each appropriation

18. One of the key system shifts is to support a rebalancing of the system away from a reliance on hospital and specialist services towards population health improvement through health protection, health promotion, screening, early intervention and comprehensive primary health care services. Separate appropriations for "primary, community, public and population health services" and "hospital and specialist services" provide greater transparency to Parliament about the balance of resources in each, additional controls around shifting funding, and reinforce the need for Health NZ to manage the funding streams separately. This control does not exist in the current system, with each DHB having a single appropriation covering both the provider and funder arms.

19. Currently, joint Ministerial approval is required for fiscally neutral adjustments (FNAs) between appropriations. To encourage the reform objective of rebalancing resources across the system, officials recommend exploring the option to delegate authority to the Minister of Health alone to approve FNAs (and associated Imprest Supply changes) from the "hospital and specialist services" appropriation to the "primary, community and public health" appropriation. Joint Ministerial approval would continue to be required for FNAs out of the "primary, community and public health" appropriation. Any in-year changes would still need to be included in the Supplementary Estimates for that year.

20. Given the central role of public and population health services in the key reform shifts which have historically been deprioritised in the face of immediate demands, officials have considered a separate public and population health appropriation. While an appropriation would give visibility of the volume of public health funding at a Vote level, separate appropriations risk working against the integration of services and adding complexity. As discussed in paragraph 9, officials propose providing advice at the beginning of September 2021 on the most effective suite of mechanisms to protect public health funding.

21. To define the appropriations we propose taking a service view rather than basing it on what is delivered in each of Health NZ's two arms to support a shift towards health promotion, prevention and integrated primary and community care services. This means the "primary, community, population and public health services" appropriation will include services provided by Health NZ in hospitals or in the community (for example, rural hospital services, district nursing). There may be value in evolving the definitions over time to support the shift of more activity into primary and community care settings. Officials will provide further advice on definitions as part of the next stage of work.

22. Whilst there is a risk that separate appropriations work against integration of services in primary/community settings and hospitals, the greater risk is that hospital and specialist services continue to dominate over population health, primary and community care. Expectation setting, planning, and reporting can mitigate the risk around integration of services.

Separate appropriations for hauora Māori commissioning and pharmaceuticals will provide transparency over key features of the operating model including the level of budget responsibility for the MHA and Pharmac

23. We recommend a separate hauora Māori commissioning appropriation to provide greater transparency to Parliament and the public about the MHA budget and additional controls around shifting resources, thereby supporting tino rangatiratanga and mana motuhake. It does risk being seen as the entire spend on hauora Māori, so careful messaging will be

needed, along with significantly improved population level reporting. The next section provides advice on the scope of the MHA budget.

24. Officials also recommend a separate appropriation for pharmaceuticals to provide greater transparency to Parliament around a key feature of the pharmaceuticals model – a fixed budget constraint. Paragraphs 37 to 42 below recommend that accountabilities and reporting for this appropriation should sit with Pharmac.

The new appropriation structure needs to be complemented by comprehensive and accessible reporting

25. Much more important than the appropriation structure will be comprehensive and accessible reporting to support decisions at every level of the system, and provide transparency. The depth and breadth of it will need to develop over time, and it will need to reflect a number of important perspectives including:

    a) a population view – what the system is delivering for Māori as tangata whenua and priority populations such as Pacific and disabled people, and how it varies by place. This needs to align with wider population frameworks across Government, for example the All of Government Pacific Wellbeing Strategy

    b) a service view – accounting for spending, activity and outcomes, and how this varies by population and place. This should meet the requirements for reportable outputs for Statements of Performance Expectations in the Crown Entities Act

    c) a spotlight on areas of concern (e.g. mental health) and areas of change (e.g. the burden of disease from type 2 diabetes)

    d) a focus on enablers – workforce, digital and facilities and equipment

    e) an organisational perspective – performance of Health NZ and the MHA.

26. Initial advice on the overall approach to the reporting framework will be provided to Joint Ministers in November 2021, including a proposed set of reportable outputs for the purposes of Health NZ's Statement of Performance Expectations. Performance measures will be developed for the Information Supporting the Estimates early next year.

Concerns around large appropriations providing limited transparency and accountability are better addressed via accountability documents and reporting

27. The "primary, community, public and population health services" and "hospital and specialist services" appropriations will be over $7 billion each. Whilst in theory larger appropriations provide less control and transparency, in reality the new structure would actually give more meaningful control and transparency for two of the key system shifts: rebalancing the system to prevention and primary and community care, and reinforcing a Te Tiriti o Waitangi partnership.

28. Additional appropriations risk working against the optimal allocation of resources and integration of services and add complexity and administrative burden for limited transparency benefits. Instead for other areas, planning and reporting should be the key mechanism for providing transparency and accountability. It should set out what services will be (or have been) delivered to meet population needs, and how that varies by place. At the level of overall services (e.g. mental health), the Crown Entities Act requirement for reportable outputs in Statements of Performance Expectations are a more useful tool to provide transparency and accountability to Parliament, without the downsides of appropriations.

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29. The table below sets out a summary of why appropriations are not the right tool for providing controls and transparency across other spending "dimensions", including services, geography, outputs delivered for populations, and digital and facilities (operating).

Table 1: Rationale for not using appropriations across other "dimensions"

Dimension	**Current state:** are there separate appropriations at the moment?	**Recommended approach:** role of appropriations in supporting system operating model agreed by Cabinet in March?	**What other tools should be used?**
Services e.g. mental health	Mixed. DHBs have a single appropriation per DHB, but Ministry commissioned services are organised by service.	No separate appropriations for services. Not consistent with intent of system operating model – holding Health NZ to account for maximising population health and delivering on the GPS/NZ Health Plan, but providing funding flexibility to support the best allocation of resources. Risks working against the integration of services and stifling innovation, particularly for low acuity services (e.g. counselling, behavioural services). Adds complexity and administrative burden for limited benefits.	Accountabilities, planning and reporting. This includes a more meaningful set of reportable outputs for the purposes of Crown Entities Act requirements. Initial thinking is that these should be service focused e.g. maternity and child health, mental health, public health.
Geography e.g. regions	Mixed. 20 separate DHB appropriations, but Ministry commissioned services do not have geographic appropriations.	No regional or geographic appropriations. Undermines the ability to dynamically rebalance allocations to achieve equity outcomes and Te Tiriti o Waitangi obligations. Adds complexity and administrative burden, for limited benefits. Parliamentary authorisation at geographic level appears to add little benefit. Geographic appropriations are not be used in other areas (e.g. education, welfare).	Accountabilities, planning and reporting with a focus on understanding and addressing the "postcode lottery".
Outputs delivered for populations	In two cases where output delivered for a population – Disability Support Services (DSS), National Māori Health Services.	Separate appropriations for DSS and hauora Māori to provide transparency and accountability to Parliament. Does risk being seen as entire spend on that population. Appropriations cannot be the key mechanism for control or transparency on spending on particular populations because appropriations need to be output expenses[2] and mutually exclusive. This means they cannot, for example, cover the entirety of spending on Pacific people.	Focus on accountabilities, planning and reporting, including building in mandatory reporting for Māori and priority populations including Pacific and disabled people. This should include population level reporting measures against appropriations.
Digital, facilities and equipment (operating funding)	Appropriation exists for new Crown capital.	No change to status quo. No separate operating appropriation. Definitional/boundary issues e.g. some digital investments part of broader investments so separate appropriation risks working against integration of services and adding complexity and administrative burden for limited benefits.	Accountabilities, planning and reporting. Consider the case for spending ringfences/targets in upcoming capital settings paper

[2] they must relate to final goods and services that are purchased

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Budget holding responsibilities across entities

Cabinet's March decisions on roles and responsibilities of entities in the future system operating model have implications for budget and funding responsibilities

30. At a high level, key changes to funding accountabilities include:

    a) DHB funding and assets transfer to Health NZ; and

    b) non-departmental funding currently managed by the Ministry for services (except Disability Support Services), provider development, workforce training and performance improvement transfer to Health NZ or the MHA.

31. Further advice on detailed functional changes, and associated resource implications and funding transfers, will be provided to Ministers in the coming months and included as part of the Budget technical package (or earlier, as appropriate).

There is a choice about the Māori Health Authority's direct budget and funding responsibilities

32. The Māori Health Authority will be responsible for a direct commissioning budget for hauora Māori made up of an initial budget provided through Budget 2021 ($37 million per annum), any funding provided in Budget 2022 or future Budgets and any non-departmental funding currently managed by the Māori Services Directorate in the Ministry (e.g. Māori Provider Development Scheme funding). The MHA will also have a co-commissioning role, meaning it co-develops and signs off significant national and regional strategies, commissioning frameworks and plans of Health NZ.

33. In addition to this, there is a choice about the extent of the Māori Health Authority's direct budget responsibilities for other funding streams including current DHB funding for Māori providers and other relevant Ministry non-departmental contracts (e.g. workforce funding with a Māori element). Initial estimates from the Ministry suggest that funding to Māori health providers by the Ministry and DHBs might be around $340 million per annum (2019/20 figures, further work needed on the quantum).[3]

34. Officials will provide further advice on options on the Māori Health Authority budget and funding responsibilities alongside a draft Cabinet Paper in early September. We are considering a range of options including the Māori Health Authority having direct budget responsibility, as well as the design of its co-commissioning levers. If the Māori Health Authority has direct budget responsibilities and accountabilities, there is an option to operationalise it via a formalised national and regional co-commissioning mechanism agreed between the Māori Health Authority and Health NZ, as part of ensuring a single, joined-up system.

New investment

35. To provide opportunities for Māori to achieve aspirations for mana motuhake and rangatiratanga in health, there is an expectation from Māori, including Tā Mason's Steering Group that for the MHA to be successful it needs control of a significant share of funding. A recent report undertaken by independent research group Sapere, suggests that $1 billion of additional investment per annum is needed to provide comprehensive 'by Māori for Māori' primary care to all Māori. Officials will provide you with further advice on options for the Māori Health Authority investment through Budget 2022.

[3] Excludes Disability Support Services and capitation payments

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36. s9(2)(f)(iv)

Out of scope of request

37. Out of scope of request

38.

39.

40.

41.

[4] Out of scope of request

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42. Out of scope of request

s9(2)(f)(iv)

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s9(2)(f)(iv)

Internal funding allocations and mechanisms

Officials have developed an initial draft set of funding design principles to guide design of funding allocations and mechanisms within Health NZ and the Māori Health Authority

49. As agreed by Cabinet in March 2021, in the future system operating model, hospital and specialist services are nationally planned, and primary and community services are commissioned. **The diagram below sets out our initial draft design principles to support the design of internal funding allocations and mechanisms within both Health NZ and the Māori Health Authority (grey box)**, alongside a set of commissioning principles. As discussed in paragraph 9 internal allocations refer to how funding is allocated to commissioners, budget holders and service providers within Health NZ and is distinct from commissioning which determines funding for services by external providers.

50. The design principles are intended to reinforce the key objectives of reform agreed by Cabinet in March. Given the strategic importance of such a decision, we think it is valuable for these design principles to be a permanent Cabinet directive, rather than relying on other tools such as the GPS. Officials recommend including the draft principles in Letters of Expectations to interim entities.

51. Officials have tested these draft principles with Tā Mason's Steering Group, and plan to test them further with key experts, including DHB Planning and Funding General

Managers and Chief Financial Officers, ahead of finalising them for a September Cabinet Paper.

52. In designing funding mechanisms and allocations there will be tensions and trade-offs across the principles. Accountability documents, plans and reporting will need to be transparent about the key trade-offs across the principles, as well as judgements underpinning the trade-offs.

Figure 1: Initial draft design principles for Health NZ and MHA commissioning and internal

Health NZ and the MHA need to operate within an overall Budget constraint to deliver Te Tiriti dynamic, equitable, effective, sustainable, efficient and acceptable services for people, whānau, iwi, and communities.

Commissioning design principles

- **Te Tiriti dynamic** - services recognise Te Tiriti o Waitangi obligations
- **Equitable** – services actively recognise the inequities experienced by priority populations
- **Effective** – quality services are responsive and can demonstrate improved health outcomes
- **Sustainable** – services are clinically, financially and environmentally sustainable
- **Efficient** – services provide value for money
- **Acceptable** – services are acceptable to iwi, patients, whānau and community.

Funding should follow allocative decisions made in planning and commissioning

This includes encouraging and supporting new models of care and a shift towards health promotion, prevention and primary and community care.

Funding allocation and mechanism design principles

- **Funding should follow allocative decisions made in planning and commissioning:** The NZ Health Plan will set out key allocative decisions with respect to populations, services and enablers, and place. Funding allocations and mechanisms should support these decisions.
- **Pro-equity**: Funding allocations and mechanisms should fairly distribute funding to enable effective culturally responsive services and use of enablers to address current and future inequities across populations. This should include Māori as tangata whenua, Pacific people, disabled people, and other populations that experience inequities.
- **Consistent access**: Funding allocations and mechanisms should fairly distribute funding to support consistent access to effective and quality service and care levels across populations.
- **Efficiency**: Funding allocations and mechanisms should support efficient service delivery and use of enablers. Where Health NZ is the provider, would expect funding allocations and mechanisms to shift towards efficient pricing.

53. Consistent with the approach to other Crown Entities, such as ACC, we do not propose Ministers have a routine role in signing off internal funding allocations or mechanisms. By way of example, this would mean for planned care Ministers would approve access and equity targets in the NZ Health Plan, but would not approve regional funding allocations. For primary and community care, Ministers would set overall priorities via the GPS, approve national standards and measures via the NZ Health Plan, but would not sign off needs based funding models for allocating funding within primary and community care. Consistent with March Cabinet decisions, the MHA would need to be involved in and sign off significant national decisions on funding allocations and mechanisms.

54. The Transition Unit is preparing advice for incoming boards on internal funding allocations, focused on the first two years of Health NZ and the Māori Health Authority. These funding allocations will need to work within the parameters of the funding design principles above. Setting up the funding allocations and mechanisms will be an iterative process. A high level explanation of how internal funding flows might work within Health NZ's two appropriations is included in **Appendix B** for illustrative purposes.

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Next steps

55. Subject to your feedback on the proposals, we will prepare a Cabinet paper that provides an overview of your key decisions from this paper, as well as seeking agreement to your decisions on the recent Treasury led multi-year funding approach paper (refer DPMC-2021/22-40).

56. Ministers will receive further advice over coming months from the Transition Unit, the Ministry and Treasury on a number of issues relating to funding and accountability settings.

    a) Summary of how the governance and accountability framework for the new system operating model will work (Joint Ministers, end of August)

    b) Mechanisms to protect public health funding (early September)

    c) Capital funding settings (initial advice to Joint Ministers end August, Cabinet Paper October)

    d) Detailed appropriation structure, initial appropriation splits (Joint Ministers November), final splits (Budget Technical Package), performance measures for Estimates (early 2022)

    e) Initial advice on the overall approach to the reporting framework (Joint Ministers November)

    f) Direction and expectation setting documents – Letters of Expectations to interim entities (September), and interim GPS (first draft in December)

    g) Budget 2022 – as outlined in DPMC-2021/22-40 Ministers will also receive further advice over the coming months on a Budget 2022 transitional package.

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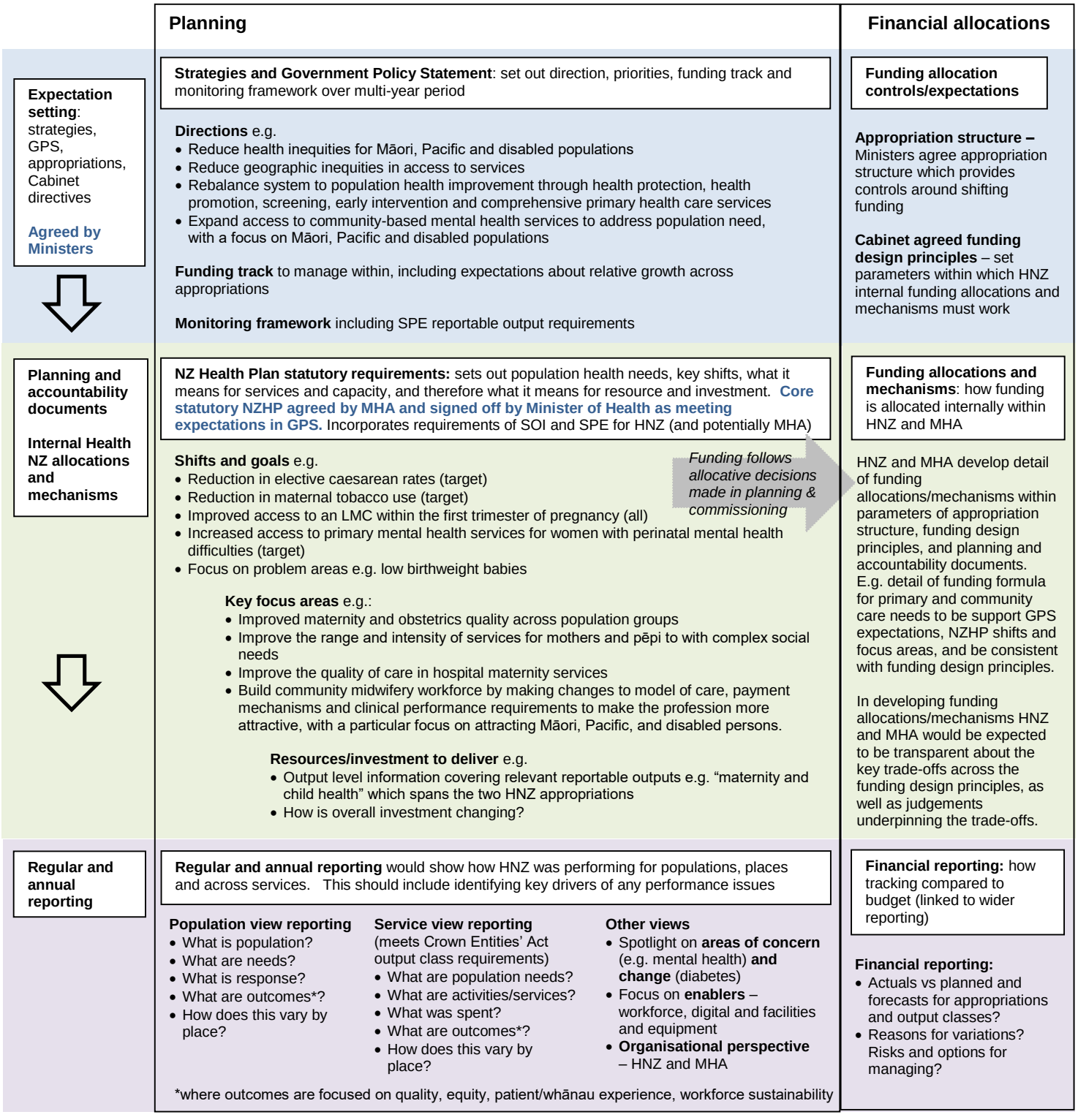
APPENDIX A: PLANNING AND FUNDING SETTINGS

1. For an area like maternity and child health there would be a number of controls to ensure funding was allocated appropriately. Collectively, the aim of these would be to operate at a strategic level, and to support the Board's accountability for delivering equitable, consistent and sustainable maternity and child health outcomes for all mothers and pēpi, within an overall budget constraint.

2. The diagram below provides an illustration of how expectation setting, entity plans and reporting cascade and relate to each other for both planning and allocative funding decisions. It is illustrative only and not intended to be comprehensive, and is based on the final state (from 2024/25 with the first full NZ Health Plan).



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APPENDIX B: HEALTH NZ DAY 1 BUDGET ALLOCATIONS

1. Day 1 budget allocations for Health NZ will need to make the best use of current information and mechanisms, but there is an opportunity for Health NZ, working with the MHA, to approach Day 1 budget setting in a way that signals the direction of travel and supports the key health reform shifts.

2. In the new system operating model hospital and specialist services will be planned nationally by Health NZ to improve the allocation of resources across the country. Health NZ will be better placed to drive performance improvement if funding allocations are linked to the funding design principles, performance expectations and a clear performance management approach. In the early implementation period, existing hospital price and volume schedules could be used to explore and benchmark the relative efficiency of different hospitals, with rapid deployment of Health NZ's performance function to identify drivers of variability, share best practice and actively work to reduce variations. Differentials in equity, access and quality could also be explored in a similar way. In its first two years, significant work will be required by Health NZ to improve data, develop efficient pricing frameworks and build capability. Ministers would set expectations for Health NZ to demonstrate progress towards efficient prices in the GPS, and approve measures via the NZ Health Plan, but they would not set prices or pricing methodologies.

3. In the new system operating model primary and community services will be commissioned through regional arms and delivered through new locality networks of providers. We envisage needs based funding models being used to set regional commissioner budgets, to set guidance budgets for locality planning and to set capitation funding for providers and groups of providers within a locality. This is analogous to the current arrangements where the population-based funding formula is used to set DHB budgets while the PHO capitation formula is used to fund PHOs. This approach requires thinking about needs based funding as operating across different groupings of services at different levels in the system. Developing this requires further refinement of the design work for primary and community services, as well as quite complex technical work. We therefore recommend that the full implementation of this is done for the 2024 year.

4. s9(2)(f)(iv)

5.

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TE TAI ŌHANGA
THE TREASURY

Treasury Report: Disability System Transformation Cabinet Paper – Treasury Advice

Date:	16 September 2021	**Report No:**	T2021/2292
		File Number:	SH-3-7-1

Action sought

	Action sought	Deadline
Hon Grant Robertson **Minister of Finance**	a. **agree** to provide the Ministerial consultation feedback to the Minister of Health and the Minister for Disability Issues as attached in Annex A b. **refer** this report on to the Minister of Health and the Minister for Disability Issues. c. **indicate** whether you would like requirements for prioritisation of MSD's work programme and scaling options for the EGL approach included in Minister Sepuloni's Budget 2022 invite letter	20 September 2021

Contact for telephone discussion (if required)

Name	Position	Telephone		1st Contact
Keegan Taylor	Analyst, Welfare and Oranga Tamariki	s9(2)(k)	N/A (mob)	✓
Keiran Kennedy	Manager, Welfare and Oranga Tamariki	N/A (wk)	s9(2)(g)(ii)	

Minister's Office actions (if required)

Return the signed report to Treasury.

Note any feedback on the quality of the report

Enclosure: No

Treasury Report: Disability System Transformation Cabinet Paper – Treasury Advice

Executive Summary

Disability System Transformation has been progressing for over a decade, but recent decisions made as part of the Health and Disability Reforms require decisions on the future of Disability Support Services to be made by the end of September 2021.

The Disability System Transformation Cabinet paper seeks agreement to establish a new Ministry for Disabled People as a departmental agency hosted by the Ministry of Social Development (MSD) and to implement the Enabling Good Lives (EGL) approach to Disability Support Services nationally. The disability community has been engaged throughout the development of these proposals.

While Treasury is broadly supportive of the proposals, there are several material risks that will require careful attention to ensure they are mitigated. Cabinet decisions to be made shortly will affect MSD's capacity to deliver, specifically progressing the Te Pae Tawhiti (TPT) transformation. Budget 2022 decisions will require tough trade-offs by Budget Ministers as progressing these initiatives remains contingent on Budget 2022 funding.

Recommended Action

We recommend that you:

a. **note** that to remain aligned with the Health and Disability Reforms, Cabinet decisions on the future home of Disability Support Services are required by the end of September 2021

b. **note** that upcoming Cabinet decisions such as progressing MSD's TPT transformation will have significant impacts on the Ministry of Social Development's capacity to deliver existing and new initiatives

c. **note** that progressing work on a several large initiatives including the national implementation of the EGL approach is contingent on Budget 2022 funding meaning adherence to allowances will require challenging prioritisation

d. **agree** to provide the Ministerial consultation feedback to the Minister of Health and the Minister for Disability Issues as attached in Annex A

Agree/Disagree
Minister of Finance

e. **refer** this report on to the Minister of Health and the Minister for Disability Issues.

f. **indicate** whether you would like requirements for prioritisation of MSD's work programme and scaling options for the EGL approach included in Minister Sepuloni's Budget 2022 invite letter, and

g. **indicate** whether you would like to discuss this matter further with officials.

Keiran Kennedy
Manager, Welfare & Oranga Tamariki

Hon Grant Robertson
Minister of Finance

Treasury Report: Disability System Transformation Cabinet Paper – Treasury Advice

Purpose of Report

1. This report provides advice to support your feedback on the draft Disability System Transformation Cabinet Paper which has been circulated for Ministerial consultation by the Minister of Health and the Minister for Disability Issues. The paper is due for consideration at the Social Wellbeing Cabinet Committee (SWC) on 29 September 2021 along with other papers on the Health and Disability Reforms.

Links between Health and Disability reforms

2. Government provides a range of disability supports and services, with policy and operational responsibility sitting across different agencies. The Ministry of Health (MOH), supported by the MSD, is leading the work on Disability System Transformation which has been ongoing for more than a decade. This work is underpinned by the vision of Enabling Good Lives for all disabled people and their families to have greater choice and control over their supports and lives.

3. In order to align with the Health and Disability Reforms and to provide clarity for MOH through the transition, a Cabinet decision is required on where responsibility should sit for commissioning Disability Support Services. In the reformed system, MOH will continue its role as steward of the health system responsible for policy, strategy and legislation, with the majority of its operational functions shifting to Health New Zealand or the Māori Health Authority from 1 July 2022 (i.e. the management of national contracts for provision of some health services). While MOH could retain the responsibility for Disability Support Services, it would be the only direct commissioning responsibility they retained following the reforms.

4. In considering the health system reforms in March 2021, Cabinet noted advice would be provided in September 2021 on the future model and governance of Disability Support Services. Since then the Minister of Health and the Minister for Disability Issues have received advice on potential machinery of government structures as well as the national implementation of the Enabling Good Lives approach.

5. Disability Support Services represents a significant amount of expenditure. It is an appropriation managed by the Disability Directorate in MOH which currently employs 128 FTE. Funding for 2020/21 totalled approximately $1.7 billion with services delivered through approximately 975 service providers under 1,500 contracts. 75% of Disability Support Services expenditure is based on claims under a fee-for-service model (contracted organisations invoice MOH for services provided) with the processing and paying of these claims representing a substantial task (90,000 – 100,000 claim items are processed each month). The other 25% of the expenditure is mostly paid for through bulk-funded or capacity contracts.

6. Around 43,300 people are provided with long-term support such as assistance with daily activities including getting up and going to bed, cleaning and washing. In addition, around 100,000 other people receive support in other ways through this appropriation such as with equipment or the modification and provision of hearing aids.

7. While Cabinet agreed that the initial focus of Disability System Transformation should be people eligible for MOH-funded Disability Support Services [SOC-17-MIN-0007

refers], the Minister of Health and the Minister for Disability Issues have sought advice from officials on a broader scope for change.

Outline of the Disability System Transformation Cabinet paper

8. The Health and Disability Reforms requires a decision on the future home for Disability Support Services. This Cabinet paper proposes the establishment of a new departmental agency hosted by MSD.

9. In deciding where Disability Support Services should be located, consideration needs to be given to how services might evolve. The paper therefore also seeks a decision on the national implementation of the Enabling Good Lives approach.

Proposal to establish a Ministry for Disabled People

10. The scope of Disability System Transformation is a key consideration in determining the best machinery of government structure. In addition, potential structures were assessed against six criteria including strategic fit and alignment, ease of implementation and relative cost.

11. **The recommended machinery of government structure is a new departmental agency hosted by MSD.** The departmental agency structure is preferred as it would provide scope for bringing together key, cross-government disability functions and provide for a more dedicated focus on the outcomes of disabled people.

12. Having MSD as the host department is consistent with recognising disability as a social and whole-of-life issue and creates opportunities for alignment with MSD's leadership role in social sector commissioning. In addition, MSD currently provides financial assistance to disabled people and has experience with hosting a range of independent and semi-independent entities.

Costs

13. The paper proposes setting up a dedicated transition team (up to 30 people including an interim chief executive of the new Ministry) and seeks the cost of the team in 2021/22 ($5 million) to be charged against the Between-Budget Contingency. This will enable establishment of the new Ministry within the required timeframes, While the number of FTEs is high, we consider this acceptable as it will support agencies to mitigate implementation risk and ensure the provision of services is not disrupted by the transition.

14. The costs of establishing a new departmental agency hosted by MSD and ensuring its ongoing operation are estimated to be **$85.0 million** over the forecast period. The majority of this funding will be sought through Budget 2022. The costs are made up of the following:

    a **One-off costs of $28.4 million** primarily for the transition team, fitout and IT systems.

    b **Ongoing operating costs of $56.6 million** primarily for corporate overhead and 20 additional FTE to support the new Ministry. The estimate does not include (i.e. is in addition to) the approximately $21 million per annum of funding currently provided to MOH for 128 FTE (Vote Health departmental funding). The estimate assumes that the $21 million will be transferred to the new entity.

15. These costs are rough estimates and details of what will be transferred from Vote Health still need to be worked through. Previous splits with Oranga Tamariki and the

Ministry of Housing and Urban Development have underestimated the cost of transition particularly regarding losses in economies. To minimise the risk of this occurring, MSD has taken a conservative approach to estimating costs including assuming no overhead will be transferred from Vote Health. While we are supportive of this approach as it provides Cabinet with greater certainty that costs will not increase further, the Treasury will work with MSD to understand the costings more and identify any scope to scale the costs.

Proposal to implement the Enabling Good Lives approach nationally

16. The Cabinet paper seeks agreement to implement the Enabling Good Lives approach nationally and endorsement of an implementation plan covering three phases (design and development, staged transition, stabilisation) over four years. Progressing this decision would be contingent on Budget 2022 funding.

17. This approach seeks to support disabled children and adults and their families to have greater choice and control over their supports and lives. There are three pilots located in Christchurch, Waikato and Mid-Central which received permanent funding through Budget 2021.

18. The national implementation seeks to leverage the learnings from the existing Enabling Good Lives prototypes including how to integrate funding which may not have alignment in eligibility. Proposed eligibility and scope (including existing funding in scope) of the national implementation is broadly the same as was agreed for the MidCentral prototype, Mana Whaikaha, in 2018 with some minor differences.

Costs

19. Budget 2021 provided funding to undertake Phase One and early modelling indicates an additional $160 million – $180 million per annum would be required for full implementation. The modelling was undertaken based on the Mana Whaikaha prototype, and there are a number of assumptions in the model that the Treasury will work with MOH to determine their validity ahead of a likely Budget 2022 submission. Decisions on the pace of implementation will impact the phasing of costs.

Risks

20. The Treasury is broadly supportive of the Cabinet paper's proposals, but we see several significant risks: MSD capacity, complex connections between work programmes, and tight timelines. **We recommend that you raise these with your colleagues in your feedback as part of ministerial consultation and at the SWC meeting of 29 September 2021.** We have prepared speaking points in the attached Annex B.

MSD capacity

21. MSD is delivering on a busy work programme which includes other significant transformations such as the Welfare Overhaul and the Te Pae Tawhiti organisational transformational programme. MSD's capacity challenges have been heightened by the impacts of COVID-19. Challenging sequencing and trade-off decisions will be required to ensure MSD is able to deliver its work programme as planned. A decision to proceed on this work will mean other new initiatives will need to be deferred

22. These programmes will require significant resource for implementation over several years meaning a consistent focus on delivery will be required to implement them successfully. There is also a risk that MSD may face difficulties recruiting at pace for an

establishment team given the pressures on policy resource in the context of other significant reforms programmes across government.

23. **You may wish to request that Minister Sepuloni, in her response letter to you for Budget 2022, demonstrates how she has taken steps to prioritise MSD's work programme, outlining how she will phase other work on welfare reform to accommodate this transformation and manage delivery risk.** This will assist in ensuring MSD is supported to deliver on this work and provide space for them to continue to play their important crisis response role.

Complex connections between work programmes

24. The national implementation of the Enabling Good Lives approach represents a significant change to how Disability Support Services are delivered. This change is proposed to occur at the same time as there is a change in the provider of Disability Support Services. Furthermore, the number and complexity of changes being delivered in the health and disability space increases the risk of misalignment and poor sequencing of decisions. Careful consideration will be necessary to mitigate these risks and ensure proposals are delivered as planned.

25. It will be important that through transition (and beyond) careful consideration is given to the impact of these changes on the third-party providers of disability support services. These providers already face challenges engaging with different government agencies and the variability of their approach to contracting and commissioning. The risk that these changes create additional complexity may be exacerbated by the Health Reform proposals, which seek to transform the health sector approaches to commissioning.

26. You should note that this Cabinet paper does not propose to apply a multi-year approach to providing funding for the Disability Support Services. This contrasts with the proposals that will be before Cabinet in October that seek a multi-year Budget approach for the health system (T2021/1579 refers). We think this inconsistency is appropriate at this point in time, as further work would be required to establish the policy case for providing ongoing funding certainty for the Disability Support Service funding. Multi-year funding arrangements may be considered as part of the wider Public Finance Modernisation work programme.

27. There are clear connections between the Health and Disability Reforms and Disability System Transformation. **We recommend you emphasise the need for the Health Reform Transition Unit, the proposed Disability Support Services Transition Team, MOH and MSD to work closely together to ensure work is aligned and communications with the disability community are coordinated and consistent.**

28. Further, the Accelerating Accessibility work which seeks to introduce a new system to take a progressive approach to identifying, preventing, and removing accessibility barriers has close ties with Disability System Transformation. A Cabinet paper seeking decisions is scheduled for the 29 September 2021 meeting of SWC. Given the delivery risks outlined above, **we recommend deferring the Accelerating Accessibility work programme until the establishment and national implementation work is being safely delivered.** To date, MSD have not articulated what is driving the timing of Accelerating Accessibility.

Timelines

29. The timeframes outlined in the Cabinet paper for both the transition and Enabling Good Lives national implementation are very ambitious particularly prior to the 1 July 2022 establishment date. This risk is further exacerbated by the complexity and timing of other reforms according concurrently. There remains a strong likelihood that agencies will not be able to adhere to the proposed timeframes.

30. Because of its alignment with the Health Reforms, the establishment of the departmental agency has limited discretion to delay timelines. However, the national implementation of the Enabling Good Lives approach provides more options for the pace and scale of implementation. **We recommend you communicate to your colleagues the need to provide options for scaling the Enabling Good Lives implementation in their Budget 2022 submissions with clear explanations of the consequences of each option.** Providing options would serve to manage implementation risk as well as assist in adhering to Budget allowances.

Next Steps

31. Feedback is due from Ministerial consultation by 20 September 2021. The paper is due for consideration at SWC on 29 September 2021 where, in addition to decisions on disability matters, decisions on the Health Reforms will also be made.

32. Subject to Cabinet agreement, agencies will look to stand up the transition team as soon as possible.

33. Budget bid(s) will likely be submitted as part of Budget 2022 to cover the fiscal impact of establishing a new Ministry for Disabled People ($80 million across the forecast period) and implementing the national roll out of the Enabling Good Lives approach ($160 - $180 million per annum).

34. The Minister of Health and the Minister for Disability Issues intend to report back to SWC by March 2022 with further detail on establishing the new Ministry and the next steps for Disability System Transformation.

Annex A: Feedback for Ministerial Consultation

- MSD is undertaking several significant work programmes including the Welfare Overhaul and the Te Pae Tawhiti transformation programme. Because of this, we see significant implementation risk associated with the paper's proposals. Therefore, it should be demonstrated (both in this Cabinet paper and more generally) that steps are being taken to manage and prioritise MSD's work programme.
- Progressing the national implementation of the Enabling Good Lives approach is contingent on Budget 2022 funding. There are a number of significant pressures on Budget 2022 allowances which mean challenging trade-offs will need to be made. To support this, should the Enabling Good Lives national implementation initiative be invited, options for scaling the pace and scale of the implementation should be included with explanations of their respective consequences.

Annex B: Talking Points for 29 September 2021 SWC

MSD Capacity

- MSD is undertaking several significant work programmes including the Welfare Overhaul and the Te Pae Tawhiti transformation programme. What prioritisation processes do MSD have in place to ensure that they are focusing their resource where it is most needed?
- Given MSD's significant work programme, I expect your response letter for Budget 2022 to demonstrate how you have worked with MSD to prioritise MSD's work programme.

Timelines

- I recognise there is limited discretion for deferring the establishment of the new entity to house Disability Support Services. However, I expect, if a bid is submitted for the Enabling Good Lives national implementation in Budget 2022, it should consider MSD and MOH capacity and provide a variety of options for the pace and scale of the implementation.
- What will be the impacts of the Enabling Good Lives national implementation receiving no or scaled funding through Budget 2022?

Complex connections between work programmes

- There are connections and overlaps between the work being undertaken by MSD, MOH, the Health Transition Unit and the proposed Disability Support Services Transition Team. I expect them to work together to ensure all work is aligned.
- Taking into account capacity and implementation risks, what do you (Minister Sepuloni) see as a workable sequencing of Accelerating Accessibility, the establishment of a Ministry for Disabled People and the national implementation of the Enabling Good Lives approach? What are your relative priorities?

TE TAI ŌHANGA
THE TREASURY

Treasury Report: Vote Health – Budget 2022 Transitional Package

Date:	8 October 2021	Report No:	T2021/1992
		Treasury File Number:	SH-1-6-14-3

Action sought

	Action sought	Deadline
Minister of Finance (Hon Grant Robertson)	**Agree** to the recommendations in this report. **Provide feedback** on the attached letter.	Ahead of 14 October 2021

Contact for telephone discussion (if required)

Name	Position	Telephone		1st Contact
Jess Jenkins	Analyst Health & ACC	s9(2)(k)	s9(2)(g)(ii)	✓
Justin Alsleben	Graduate Analyst Health & ACC		N/A	
Jess Hewat	Manager Health & ACC		s9(2)(g)(ii)	

Minister's Office actions (if required)

Return the signed report to Treasury.

Enclosure: Yes (attached)

1) Draft invitation letter to the Minister of Health

Treasury Report: Vote Health – Budget 2022 Transitional Package

Executive Summary

1. This briefing is provided alongside the Budget 2022 letter you have received from the Minister of Health, dated 23 September 2021. It advises you on possible strategy and fiscal management options for Vote Health for Budget 2022 and seeks your view on a draft response letter to the Minister.

2. The Minister of Health has submitted a list of initiatives totalling $21.2 billion operating over four years and $2 billion capital – likely to be one of, if not the, largest Budget submission ever received. We consider that the list of initiatives submitted does not sufficiently indicate the relative priority, deliverability, or degree of discretion involved in funding each initiative, or the link between investments and the evolving health system reform and health system readiness strategies. In particular, we note system-wide capacity constraints that will continue to be exacerbated by COVID-19.

3. We do not have enough information to recommend specific initiatives for invitation from the submitted list. In order to advance the necessary prioritisation, **we recommend that, in your Budget 2022 invitation letter to the Minister of Health, you set out your key priorities for new investment in health and request the Minister submit three packages (high, medium and low) within specified funding envelopes** for new investment (including critical reform costs, such as change management and digital investment, and other Government priorities). Based on a bottom-up assessment of the Minister's letter and consideration of affordability we suggest high, medium, and low package scenarios of $300, $600, and $900 million average operating per annum.

4. **Across the Budget 2022 Health package we consider the first priority should be to 'rebase' the system and provide certainty that the current level of health services will be adequately resourced over the initial two-year transition period.** Accordingly, the rebase and non-discretionary cost pressure initiatives should be submitted and considered outside of the described envelopes, but with a very high bar set to meet this definition.

5. **The fiscal picture, following this approach, would therefore currently present as follows, noting these figures remain indicative:**

Priority	Operating ($m)					Capital ($m)
	2021/22	2022/23	2023/24	2024/25	2025/26	
Rebase/cost pressure package	-	1,800	2,900	2,900	2,900	TBD
New investment (High package)	-	900	900	900	900	TBD
Health Capital Envelope	-	-	-	-	-	1,500
COVID-19 Response	TBD	1,500-2,000	-	-	-	TBD
Total impacts:						
Budget allowances	**-**	2,700	3,800	3,800	3,800	>1,500
CRRF	**TBD**	**1,500-2,000**	**-**	**-**	**-**	**TBD**

6. We recommend you restate your expectation that the Budget 2022 package provides sufficient funding for the next two years and therefore you do not expect health to submit any initiatives in Budget 2023. **Given the package is intended to provide sufficient funding for two years, you have options for managing the uplift across Budget 2022 and Budget 2023 allowances.** You will shortly receive advice on your fiscal strategy for Budget 2022, and we recommend that the Vote Health transitional funding package should be a key consideration in the development of your Budget 2022 and Budget 2023 allowance settings.

Recommended Action

We recommend that you:

a) **note** that the Minister of Health submitted a list of initiatives totalling $21.2 billion operating and $2 billion capital, likely to be among the largest Budget submissions ever received;

b) **note** there are significant capacity constraints in the health sector that limit what can be delivered through new investment;

c) **note** a portion of the requested funding will cover the health system rebase and cost pressures, to be submitted outside envelopes discussed at recommendation f) below;

d) **note** further funding will be required for the COVID-19 public health response, 2022 immunisation programme and health system readiness, which will be drawn from the COVID-19 Response and Recovery Fund, and can be managed as requirements become clear;

e) **note** that the Minister of Health's letter contains a significant number of bids that appear to be discretionary investment proposals;

f) **agree** to request that the Minister of Health provides a series of discretionary investment packages, within envelopes of $300, $600, and $900 million in order to progress prioritisation of this investment and understand trade-offs at different investment levels;

Agree/Disagree

g) **agree** that capital funding requirements should be primarily managed through the submission of an initiative to top-up the Health Capital Envelope;

Agree/Disagree

h) **agree** that disability initiatives invited to Budget 2022 should be submitted by the appropriate Vote Minister (Social Development or Health) in line with recent Cabinet decisions on Disability Support Services functions, and that these initiatives will be considered outside of the process outlined in recommendation f);

Agree/Disagree

i) **provide feedback** on the enclosed draft letter at Appendix 1;

j) **indicate** whether you would like to discuss this advice or feedback on the enclosed draft letter at the Finance Priorities Meeting scheduled for 12 October 2021;

Yes/No

k) **note** you will receive the following further advice:

- on 22 October 2021, the "roadcheck" fiscal strategy advice for Budget 2022;
- in late October 2021, advice on the management and communication of cluster and health reform decisions against Budget 2022 and 2023 allowances;
- advice on investment in the COVID-19 public health response, immunisation programme, and health system readiness, and on the alignment between this and Budget 2022 investment as requirements become clear and requests are received;
- following final package submission and Treasury assessment, advice on Budget initiatives for Vote Health, including on the costs of the rebase and cost pressure package;
- in coming months, advice on:
  - an indicative funding signal from 2024/25;
  - contingency options to manage unforeseen costs that arise between Budgets 2022 and 2024;
  - options to establish Health New Zealand's opening balance sheet, and any associated cash injection;

l) **note** the appointment of interim Health New Zealand and Māori Health Authority boards presents an opportunity to discuss with them your expectations around financial management in the reformed health system;

m) **indicate** whether you would like the Treasury to draft initial written communications, potentially through a Letter of Expectations, to the new boards.

Yes/No

Jess Hewat
Manager, Health and ACC
The Treasury

Hon Grant Robertson
Minister of Finance

Treasury Report: Vote Health – Budget 2022 Transitional Package

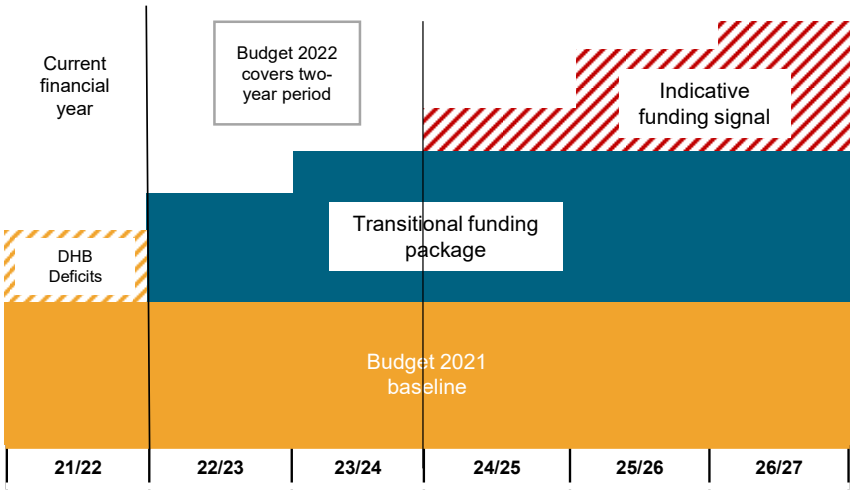
Purpose

1. We are providing this stand-alone report on Budget 2022 investment in health in recognition of Cabinet's decision to prioritise investment in a multi-year funding package to embed health system reforms through Budget 2022 [CAB-21-MIN-0349 refers], and the considerable quantum required for such a package.

2. This report provides advice on possible strategy and fiscal management options for Vote Health for Budget 2022 and should be read alongside the Minister of Health's Budget 2022 submission letter. It also seeks your feedback on a draft response letter to the Minister of Health, emphasising the need for a clear reform investment strategy as we move into the next phases of the Budget process (see Annex 1).

Context

3. You and the Minister of Health will shortly seek Cabinet's agreement to a multi-year funding approach for health from Budget 2024 and to progress a transitional funding package in Budget 2022 that provides two years of funding certainty for the health system (2022/23 – 2023/24).



4. We have previously advised that funding requirements for this two-year transitional package are likely to be significant – both because the package covers a period of two years, and due to the need for a substantial increase in funding to support reforms and address long-standing challenges to sustainability in health (T2021/1579 refers).

5. The Minister of Health has submitted a list of initiatives for your consideration totalling $21.2 billion operating over four years, and $2 billion capital. While we are supportive of the need for a significant funding uplift for the system, this level of investment is not affordable and does not recognise significant delivery constraints facing the health system in 2022. It is not clear that a prioritisation process on investment has occurred, and, at this stage, the letter does not align with any other over-arching reform strategic objectives, such as those to be set out in the initial Government Policy Statement.

6. In mid-October you will provide a response letter to the Minister of Health. For most Votes these response letters will invite specific initiatives to be submitted for Budget 2022 consideration. However, for Vote Health we recommend that the response letter instead focuses on setting expectations for the health sector and provides a top down constraint within which a two-year package of new investments should be prioritised. A draft response letter is appended for your feedback at Appendix 1.

System-level considerations

7. While ambitions for reform are rightly high, expectations for what can be delivered over the next two years should recognise:

    a. **The ongoing and uncertain impact of COVID-19** which will increasingly place significant additional pressure on the health system leaving little reserve capacity. The Reconnecting New Zealand (DPMC) and Health System Readiness (MoH) work programmes will have implications for system capacity and funding requirements for the COVID-19 public health response beyond June 2022.

    b. **Workforce shortages and other health sector capacity constraints** (including construction sector capacity constraints and the availability of specialist skills and expertise), which mean the system will continue to have limited capacity in the near to medium term to deliver any new programmes or investments. Change fatigue will also be a factor in the system's ability to deliver.

    c. **The need to support a 'refresh' of planning and financial management in the health sector** in order to prevent deficits and support financial sustainability of health system expenditure over coming years. Key to this will be ensuring that the funding provided through Budget 2022 provides certainty that non-discretionary activity will be adequately resourced over the initial two-year period.

    d. **Transition over the reform period will generate new pressures**. While we expect that over time, the structural changes will yield some efficiencies, in the short term any efficiencies gained are likely to be masked by the costs of reform. We should also expect risks to materialise and unforeseen costs to emerge across the two years.

Recommended approach to prioritisation for Budget 2022

8. The invitation letter from the Minister of Health outlined 75 initiatives (totalling $21.2 billion), of which a significant number appear to be discretionary investment for new initiatives or related to costs of reform that were not identified at Budget 2021. From the 75 bids provided, the relative priority, deliverability, or relation to the overall reform investment strategy is unclear. The Minister acknowledges that further phasing and scaling will be required.

9. It is difficult to overstate the task ahead for the health system: the system will need to continue to adapt to the changing COVID-19 environment whilst implementing much-needed reform. Alone this will be a significant challenge, and we consider there is little scope for the system to also deliver additional programmes associated with new investment. As such, we recommend your priorities for the transitional health package at Budget 2022 should be to:

    a. 'Rebase' the health system and provide certainty that the current level of health services will be adequately resourced over the initial two-year transition period**;**

b. Fund critical reform costs, including enablers such as change management and digital investment, with a focus on supporting the early stages of reform implementation; and

c. Noting workforce and other capacity constraints, you may also wish to make some additional investment in Government priorities, including manifesto commitments and the five "system shifts" envisaged through reform.

10. Each of these priorities are discussed as package components in the following sections.

11. To support the development of a cohesive and affordable transitional package for Budget 2022, we recommend that your response letter to the Minister of Health sets out your key priorities for the health package and requests that the Minister submit three packages (a low, medium and high package) for new investments within specified funding envelopes. Similar to the Budget 2020 priority process, the exercise of preparing three packages will help expose key trade-offs and choices for Ministers. We would recommend that the rebase and non-discretionary cost pressures are submitted and considered outside these packages.

12. Any investment in the health system through Budget 2022 should align with investment in the COVID-19 public health response, 2022 immunisation programme, and health system readiness. We will provide further advice on this as additional funding requests are received across the year.

13. We also recommend that you restate your expectation that the Budget 2022 package should provide sufficient funding for the health system for the next two years and, therefore, you do not expect the Minister of Health to submit any initiatives in Budget 2023. However, to manage unforeseen costs between now and Budget 2024 it may be necessary to set aside a small contingency from the Budget 2022 Health allocation. We will provide further advice on this in coming months.

A) Rebase and cost pressure package

14. As you and the Minister of Health have previously agreed (T2021/1579 refers), a significant ongoing funding uplift is needed through Budget 2022 to redress historic underfunding and set a clear and reasonable expectation that the system will operate within allocated funding while continuing to provide at least the current level of health services.

15. The Minister's letter provides an estimated quantum for an operating uplift through Budget 2022 as several bids, including various cost pressure bids and a "rebase" bid to address historic deficits. The table below summarises the key initiatives we would consider to be part of a rebase/cost pressure package, and indicative costs.

Priority	Component	Operating ($m)					Capital ($m)
		2021/22	2022/23	2023/24	2024/25	2025/26 and outyears	
Adequately resource current level of health services	'Rebase' to address historic deficits	-	800	800	800	800	-
	Uplift to address remaining cost pressures across Vote Health	-	1,000	2,100	2,100	2,100	-
	Establishment of Health NZ balance sheet	-	-	-	-	-	TBD
Sub-total			**1,800**	**2,900**	**2,900**	**2,900**	**TBD**

16. The estimated costs across the initiatives in the Minister's letter align with our expectations based on Treasury's own modelling, and we consider that, on the whole, the right approach has been taken to estimating costs; however, further work is required to document the methodology, refine the costings, and provide assurance that the amounts will be sufficient for the new system. The costs indicated above provide a reasonable order of magnitude, however you should expect these numbers to move.[1] We will provide you with further advice in coming months, including on key judgements and choices underpinning the cost estimates, as well as the likely impacts for a future indicative funding signal from 2024/25.

17. We expect it will also be necessary to provide a cash injection (capital) to strengthen Health New Zealand's (HNZ) opening balance sheet. The Minister's letter includes a balance sheet initiative but provides no quantum at this stage. s9(2)(j) [redacted] Further advice will also be provided on this.

18. We note that the Minister submitted five bids relating to the disability system. Cabinet has recently agreed to establish a new Ministry for Disabled People as a departmental agency within the Ministry of Social Development (MSD) and for relevant Disability Support Service functions to be transferred to it. Accordingly, we recommend that the Minister for Social Development and the Minister of Health coordinate to ensure these initiatives are considered through the appropriate Vote (Social Development or Health) in line with where funding is likely to be appropriated as of 1 July 2022. Regardless of the Vote it will fall within, initiatives relating to disability should be considered outside of the envelope process outlined below to recognise these functions are in the process of being transferred to a new agency, and that funding for disability services will not be part of the multi-year funding track for health.

[1] We note that these figures account for current estimates of ongoing Holidays Act liabilities and foreseeable MECA settlements, but they do not include the large impacts of pay equity or pay parity settlements.

B) And C) New Investments

19. The Minister of Health's requests collectively represent significant ambition for the health system over the next two years. In order to progress further prioritisation and to provide a clearer picture of trade-offs, while retaining flexibility as your fiscal strategy develops, we recommend you provide three envelopes within which the Minister of Health should develop packages for discretionary investment. We recommend these are initially set as $300, $600, and $900 million average operating per annum.

20. The proposed size of the above envelopes takes into account currently understood investment need relative to other known Budget 2022 pressures based on a bottom-up assessment of the Minister's letter, as well as considerations of affordability. We consider these amounts sufficient to support an effective prioritisation discussion while avoiding options that risk undermining confidence in reform or encouraging scaling beyond minimum viable options. The specific envelope figures can be adjusted according to the level of prioritisation that would support your Budget decision-making process as the strategy develops.

Priority	Component/Offset	Operating per annum ($m)		
		Low	*Med*	*High*
Resource critical reform enablers	Embedding the new system operating model	300	600	900
	Data & digital capability			
Government priorities	Investment in system shifts			
	Manifesto commitments			

21. Based on our initial high-level review of the Minister of Health's submission, we think the following initiatives, as 'critical reform enablers', should be high priority within these packages:

    a. **Digital and IT infrastructure**: The submission letter seeks more than s9(2)(f)(iv) in data and digital investment, most of which is operating funding. This is in addition to the $400 million data and digital contingency provided at Budget 2021. While we expect significant investment will be required, this should be prioritised and sequenced factoring in capacity constraints to deliver digital projects. We will focus our advice on deliverability.

    b. **Ministry of Health capability**: The submission letter seeks s9(2)(f)(iv) operating to strengthen the Ministry of Health. A strong and well-functioning Ministry is a critical component of the governance and accountability framework, and for ensuring success of the future health system. s9(2)(f)(iv) Our view is that at this stage, **this bid should be prioritised**, as it is a key enabler for the work-programme to build, and work to strengthen, the Ministry as the steward of the health system currently underway.

    We recommend you request that the Minister of Health retain this bid in his envelopes to allow further work to occur on new departmental arrangements for the Ministry of Health from 1 July 2022.

c. **Workforce development**: Given known workforce constraints, and the reliance on workforce for implementing and realising the benefits of reform both in the short and medium term (as well as increasing health system capacity in line with the Reconnecting New Zealand work programme), we also suggest recommending to the Minister of Health that workforce initiatives - particularly those centred around increasing supply - are prioritised as critical reform enablers in line with a clear workforce strategy and the implications of re-opening borders.

Health Capital Envelope

22. Recent Budgets have included the provision of unallocated capital funding to 'top up' the Health Capital Envelope (HCE), with Joint Ministers' approval required to allocate funding and make drawdowns from the appropriation.

23. There is considerable pressure on the HCE from existing and planned projects and we expect pressures to increase as further information on the state of District Health Boards' assets is gathered in preparation for transfers to HNZ. We consider it prudent to top up the envelope again at Budget 2022 as a contribution to future health capital costs. The request for $1.5 billion over two years is broadly consistent with recent Budget allocations to the HCE ($750 million at Budget 2020 and $700 million at Budget 2021).

Priority	Component	Capital ($m)
BAU capital investment	Health Capital Envelope top-up	1,500

24. The Minister's letter includes a separate request for s9(2)(f)(iv) apital funding for the Southern Digital Transformation Programme, consistent with the Indicative Business Case recently considered by Cabinet [CAB-21-MIN-0391 refers]. The Detailed Business Case is currently being prepared. We recommend inviting a separate initiative for this programme.

25. The submission letter also seeks around s9(2)(f)(iv) for other initiatives. We recommend that these initiatives are not invited, and that funding for these initiatives be prioritised against other calls on the HCE.

Funding for continuation of the COVID-19 response (CRRF funded)

26. You have also received a letter from the Minister for COVID-19 Response with impacts for Vote Health. The Minister seeks over $1 billion for the Public Health response in 2022/23, in addition to $1-1.5 billion for continuation of the vaccine programme. This funding indication represents an extension of the current programmes (testing, tracing, PPE etc.) and references the need for unquantifiable investment in workforce, capital and infrastructure.

27. As you may expect, these costs remain high level as further work progresses on the design of the broader vaccine rollout in 2022, public health settings under the Reconnecting New Zealand framework, and on Health System Readiness. While the funding need here is clear, further work is occurring on the scale, timing, and model of funding requirements for the next 12-18 months. It is expected that most, if not all, of this funding will be drawn from the CRRF. We continue to work closely on this with the Ministry of Health and other associated agencies and advice will be provided in due course.

28. This investment, likely to exceed $2 billion in the coming 12-18 months, represents significant activity taking place across the sector. We will be mindful of this in assessing new investment in the system through Budget 2022.

Priority	Component/Offset	Operating ($m)					Capital ($m)
		2021/22	2022/23	2023/24	2024/25	2025/26 and outyears	
Continuing the COVID-19 Response	Immunisation Programme	TBD	1,000-1,500	-	-	-	-
	Public Health Response	-	1,000	-	-	-	TBD
	Health System Readiness	-	TBD	-	-	-	-
Total impact on CRRF		**TBD**	**1,500-2,000**	**-**	**-**	**-**	**TBD**

Total impacts and fiscal management options

29. The next 12-24 months will see considerable funding directed to the health sector, through rebasing and addressing other business-as-usual costs, reform investment, COVID-19 related pressures, pay equity and MECA settlements, and eventual Holidays Act payments. You have already made some provisions for these, such as the s9(2)(j) and the forecast provision for pay equity, which will cushion the fiscal impact as these costs materialise.

30. The combined impact of the components detailed in this paper, assuming a high package for critical reform enablers and manifesto commitments, would result in a significant Vote Health baseline operating uplift from 2023/24 onwards of $3.8 billion, plus at least $1.5 billion provided for capital expenditure. The medium and low scenarios would represent options to scale or defer investment in reform enablers and manifesto commitments which would reduce the overall uplift. However, the cost of the rebase/cost pressure package included below could also increase.

Priority	Operating ($m)					Capital ($m)
	2021/22	2022/23	2023/24	2024/25	2025/26 and outyears	
Rebase/cost pressure package	-	1,800	2,900	2,900	2,900	TBD
New investment (High package)	-	900	900	900	900	TBD
Health Capital Envelope	-	-	-	-	-	1,500
COVID-19 Response	TBD	1,500-2,000	-	-	-	TBD
Total impacts:						
Budget allowances	**-**	**2,700**	**3,800**	**3,800**	**3,800**	**TBD**
CRRF	**TBD**	**1,500-2,000**	**-**	**-**	**-**	**TBD**

31. Importantly, this package is intended to provide sufficient funding for two years – or the equivalent of two Budgets' investment. You will shortly receive advice on your fiscal strategy for Budget 2022, and we recommend that the Vote Health transitional funding package should be a key consideration in the development of your Budget 2022 and Budget 2023 allowance settings. We also recommend that new spending on the critical reform enablers and manifesto commitments should be part of the broader Budget 2022 prioritisation process and traded off against new spending in other portfolios. You will also shortly receive advice on how to manage and communicate multi-year packages (including clusters) against allowances at Budget 2022.

Engagement with new interim HNZ and Māori Health Authority boards

32. As you are aware, the new boards for the interim entities were recently appointed and announced. The boards will have an obvious interest in Budget 2022, and its impacts for both service provision and expectations for planning and financial management in coming years.

33. There is an opportunity for you to engage early to set out your expectations and explain the Government's vision for the new multi-year funding framework and associated planning refresh in health. A Letter of Expectation may be a useful tool for initial engagement, and the Treasury can provide draft communications for your feedback should you have interest in such engagement.

Next steps

34. We will integrate any feedback on the proposed approach to prioritisation and the draft response letter ahead of the Treasury Report on final response letters planned for 15 October. Should you wish to discuss feedback, we will attend the Finance Priorities Meeting scheduled for 12 October.

35. You will receive further advice as follows:

    - on 22 October 2021, the “roadcheck” fiscal strategy advice for Budget 2022;
    - in late October 2021, advice on the management and communication of cluster and health reform decisions against Budget 2022 and 2023 allowances;
    - as requirements become clear and requests are received, advice on investment in the COVID-19 public health response, immunisation programme, and health system readiness, and on the alignment between this and Budget 2022 investment;
    - following final package submission and Treasury assessment, advice on Budget initiatives for Vote Health, including on the costs of the rebase and cost pressure package;
    - in coming months, advice on:
        - an indicative funding signal from 2024/25;
        - contingency options to manage unforeseen costs that arise between Budgets 2022 and 2024; and
        - options to establish HNZ’s opening balance sheet, and any associated cash injection.

Annex One is refused under section 18(d) of the Official Information Act as it is publicaly available here:https://www.treasury.govt.nz/sites/default/files/2022-09/b22-inv-health-4535950.pdf