Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability System Reform National Budget and Funding Settings

The following documents have been included in this release:

Title of paper: Health and Disability System Reform - national budget and funding settings (SWC-21-SUB-0157 refers)

Title of minute: Health and Disability System Reform: National Budget and Funding Settings (SWC-21-MIN-0157 refers)

Title of minute: Report of the Cabinet Social Wellbeing Committee: Period Ended 22 October 2021 (CAB-21-MIN-0430 refers)

© Crown Copyright, Creative Commons Attribution 4.0 International (CC BY 4.0)

~~[IN CONFIDENCE]~~

Office of the Minister of Finance

Office of the Minister of Health

Social Wellbeing Committee

Health and Disability System Reform – national budget and funding settings

Proposal

1 This paper seeks policy decisions on national budget and funding settings to give effect to the new health system operating model agreed by Cabinet.

Relation to government priorities

2 The Government's manifesto and the Speech from the Throne committed to undertaking a long-term programme of reform to build a stronger public health system that delivers for all, drawing on the recommendations of the independent Health and Disability System Review.

Executive summary

3 In March this year, Cabinet agreed to substantial reforms to the New Zealand public health system in order to address major structural issues and reorient the system toward a more equitable and sustainable future [CAB-21-MIN-0092 refers].

4 This was based on a vision for a new system that focuses on collaboration and cohesion, prioritises the interests of the population above those of individual organisations, avoids duplication, complexity and fragmentation, and operates along clear lines of accountability. The reform programme for achieving this vision is predicated on five major system shifts:

4.1 The health system will reinforce Te Tiriti o Waitangi principles and obligations.

4.2 All people will be able to access a comprehensive range of support in their local communities to help them stay well.

4.3 When people need emergency or specialist healthcare this will be accessible and high quality for all.

4.4 Digital services will mean that many more people will get the care they need in their homes and local communities.

4.5 Health and care workers will be valued and well-trained for the future health system.

96c4635pu7 2022-06-09 12:10:55

Proactively Released

5 As we progress with implementation of the reformed system in advance of legislation coming into effect in July 2022, key decisions need to be made in relation to how the new system will be funded and the mechanisms for financial flows within the operating model. Cabinet has already made decisions for legislating for core accountability documents for the system [CAB-21-MIN-0107 refers].

6 There are significant challenges and inefficiencies across the current health system's budget and funding management settings that were identified by the Health and Disability System Review. Specifically:

6.1 The health system currently poses a significant affordability challenge. As it stands, there are no guiderails for managing long-term costs. Moreover, even in the reformed system, health spending will continue to increase given the country's demographic change, labour costs, technological change and socioeconomic drivers. The challenge is to provide sustainable, long-term cost management without compromising on consistency, quality, and equity in health outcomes, while also providing the Crown with clear transparency and accountability across current and future expenditure.

6.2 There are wider social determinants of health to consider as well, like housing, public transport, and food environments, which have a significant impact on health and wellbeing. Underinvestment in these areas will require a coordinated response across government, but often places a disproportionate burden on Vote Health. Acknowledging this dynamic and achieving cross-government investment an, cost-sharing across Votes to deliver action on these broad determinants will be a key part of meeting the affordability challenge for Vote Health.

6.3 The current budget and system planning cycles are out of step. By the time Budget decisions are taken, most costs for the following financial year are already fixed. There is also little certainty for key decision-makers and planners around future funding increases. All of this makes long-term planning and commissioning a challenging exercise, and favours marginal cost saving initiatives and quick wins over longer-term models of care and 'invest to save' approaches.

6.4 Appropriation structures have come to reflect the inflexibility and fragmentation of the system itself. The large number and inconsistent mix of geographic and service-focused appropriations adds complexity and disincentivises integration of services. Moreover, it adds opacity to how funding flows within the system, making it difficult to track how funding achieves population outcomes and diminishing meaningful Parliamentary authorisation of spending.

6.5 Current mechanisms provide little opportunity for Māori to influence funding decisions and service planning that achieve aspirations for tino rangatiratanga and mana motuhake in health.

96c4635pu7 2022-06-09 12:10:55

Proactively Released

6.6 Funding allocations are not always aligned with outcomes sought through models of care. This often leads to a deprioritisation of equity-focused investments and prevents sustained improvement in outcomes for historically underserved populations like Māori, Pacific, disabled peoples.

Overcoming these challenges will require changes across national funding settings to complement the reformed system's accountability settings

7 National funding settings refer to Budget and funding rules, and system 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.

8 Designing the detail of the national funding settings is a significant and ongoing piece of work. Most of this will progress over the coming months as the system sets up for Day 1 and the future funding allocations and mechanisms are developed. However, with timeframes for Budget 2022 to consider, interim entities will need certainty on national funding parameters and budget holding responsibilities to inform their forward planning in anticipation of July 2022.

9 To provide a level of certainty to these health sector entities, this paper proposes several changes to the national funding settings. This will provide the new system with greater certainty and flexibility than under current settings, as it looks to achieve the ambitions of the reform. In return, I expect these adjustments to support and deliver clearer accountabilities and transparency in relation to ongoing financial sustainability, future growth, and long-term outcomes sought and achieved.

10 This paper details and recommends:

10.1 a shift for Vote Health to a multi-year Budget arrangement from 2024/25, aligned with the first full New Zealand Health Plan as signalled by Cabinet in March [CAB-21-MIN-0092 refers];

10.2 a two-year transitional funding package for 2022/23 and 2023/24 to support the health sector as it embeds the reforms and prepares for its first multi-year Budget; and

10.3 changes to initial funding mechanisms within the new system operating model (i.e. Vote Health appropriation structures, entity budget responsibilities and internal funding parameters).

11 This paper focuses on funding settings relating to the health operating budget. Cabinet will receive subsequent advice on the system's capital and digital funding settings early next year.

Proactively Released

96c4635pu7 2022-06-09 12:10:55

Multi-year approach to health funding from Budget 2024

A multi-year approach will deliver important benefits to the system, especially funding certainty for longer-term planning

12 Over coming years, the health system will face a range of cost pressures which are unavoidable if we want to maintain the same quality and scope of care currently have available. An ageing population, uplifts for providers to ensure sustainability and growth, new technologies and models of care, and a rebalance of funding to reflect needs and socioeconomic drivers, are just some of the ongoing, sustained pressures that the reformed system will face. Domestic and international experience has shown that managing health care expenditure growth in the face of these realities is difficult.

13 The annual Budget process applies a high degree of scrutiny to health sector funding increases. However, in recent years cost growth among District Health Boards has exceeded the increases received through the Budget, and deficits have grown across the system. The current system settings offer few levers to effectively constrain cost growth and the annual cycle limits the ability of the sector to make strategic investments that will support the sustainable management of cost growth over the medium term.

14 The current system also has significant inequities in terms of the investments made and outcomes achieved. Reform, especially in the establishment of the Māori Health Authority and the reorientation of services towards new models of care and population outcomes, will rightly create further pressure to address these inequities. Addressing these inequities is one of the foundational drivers of reform, and will realise gains across several fronts including greater social wellbeing and cohesion, increased economic participation and a reduced burden on the health system over time.

15 Given these cost pressures and drivers, any credible funding path for health will have to strike a balance between providing certainty for long-term planning while maintaining the room to manoeuvre in response to economic shocks or other circumstances. The inflexibility and short horizon of the status quo (fixed nominal baselines and new increases via the annual Budget process) will not continue into the new system. A multi-year Budget arrangement can achieve the requisite balance, if nested within broader system settings designed to support better planning and financial control. This would provide decision-makers and planners with a level of assurance over the longer term, enable a greater focus on outcomes-focused planning and still provide the flexibility to manage a sustainable cost envelope.

Proactively Released

96c4635pu7 2022-06-09 12:10:55

16 A multi-year approach is not entirely risk free. It will enable and incentivise strategic decision making and sustainable cost growth management, only if it is feasible to accurately and reliably forecast costs, plan investments, and identify risks and uncertainties. To be effective as a "hard ceiling" there will need to be a change in expectations and accountability settings. This will be a new way of working for the health system and is likely going to take time to embed and achieve the desired outcomes. Moreover, like the PHARMAC hard budget constraint, the ceiling will be credible only if additional funding, including for new Ministerial priorities, is not provided mid-way through a multi-year funding period.

A multi-year Budget arrangement will support managing spending growth sustainably, while also providing a credible funding path for medium to long-term planning

17 This means shifting away from fixed nominal baselines and the current annual Budget process and instead agreeing up front, and reflecting in the Government's fiscal strategy, a multi-year funding path for Vote Health.[1]

18 In our view, the multi-year Budget arrangement would comprise:

18.1 **a three-year funding commitment** that provides a credible and strongly enforced upper limit on health spending, covering all cost pressures and new investments in health over a three-year period; and

18.2 **a medium-term funding track** from year four onwards to support health sector planning, and to shape investment prioritisation decisions whose impacts fall beyond the three-year funding commitment.

19 This approach should, at a minimum, cover all Vote Health spending under the New Zealand Health Plan (NZHP) so that the funding and planning processes are aligned. This would include Health New Zealand; the Māori Health Authority; PHARMAC; the New Zealand Blood and Organ Service; the Health Quality and Safety Commission and any other entity in scope of the NZHP.

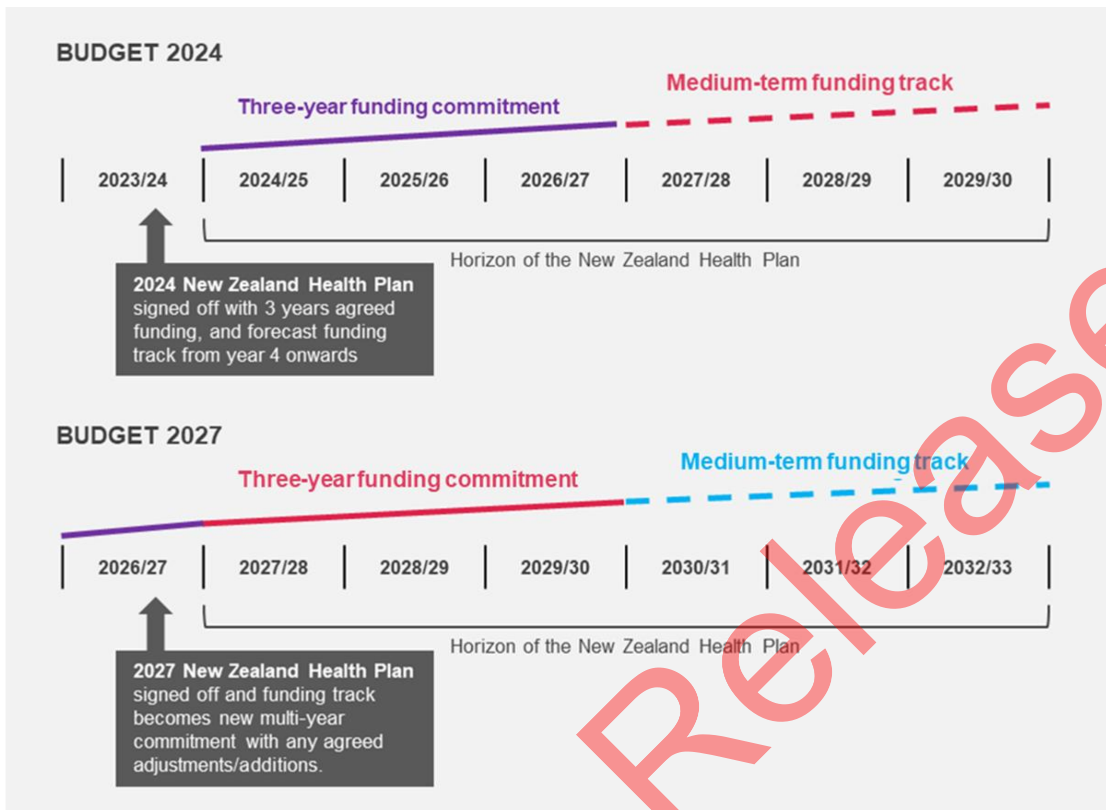
20 The first three-year funding commitment would be agreed at Budget 2024, alongside the first full NZHP, and would apply to the years 2024/25 to 2026/27. In part, the function of the NZHP would be to act as a spending plan for these three years, and outline indicative spending for the following three years based on the medium-term funding track.

[1] This would align Vote Health's fiscal management with parts of Vote Education, Vote Labour Market (ACC) and benefit expenses in Vote Social Development.

96c4635pu7 2022-06-09 12:10:55

Proactively Released

The figure below illustrates how this would work in practice.



21 During this three-year period, work would begin on the 2027 NZHP, using the medium-term funding track from 2027/28 onwards as the basis for planning. If Health New Zealand and the Māori Health Authority considered that additional funding above the funding track was required to meet health system cost pressures and deliver the Government's priorities, they could submit initiatives for consideration through Budget 2027. At Budget 2027, Cabinet would agree the funding commitment for the next three years based on the existing funding track, plus any agreed adjustments to the next three-year funding commitment.

22 While in theory the next government could agree a new multi-year funding commitment that was lower than the indicative funding track, in practice this track will become a minimum funding path from which the next multi-year funding commitment and NZHP will be negotiated. The track will need to be conservative enough to retain investment choices for Ministers, but sufficiently credible to allow the sector to run an effective planning process.

23 Treating the three-year commitment as a hard upper limit will provide a true Budget constraint for the entities. Health NZ, like other Crown entities, would be expected to manage wage and other costs within its overall budget, including setting aside an appropriate level of risk reserves. Where costs were not fully known at the time of a multi-year funding commitment (for example, pay equity), tagged contingencies could continue to be used. There would be a very high bar for adjustments or addendums to the three-year commitment, and exceptions would be reserved for genuinely unforeseeable one-off shocks, such as a pandemic.

Proactively Released

24 This would also leave little room for adjustments between Budget cycles for Ministerial priorities driven by changing political realities. Where these become a necessity, Ministers will be expected to work with entity Boards to identify the scope and appropriateness of repurposing funding from tagged contingencies, out-years, or entity reserves. Where the scale of the shock is so large and so anticipated (e.g. significant and enduring inflationary shocks, a large natural disaster, the emergence of a pandemic) that these methods of cost management are insufficient, Ministers may choose to discuss providing additional funding to the entities.

This approach means that, in effect, there would be one health budget every three years

25 Most funding would continue to be appropriated by Parliament on an annual basis, and announcements relating to policy changes or the roll out of new programmes funded from within the three-year commitment could be made at any time. But no new funding would be allocated for Vote Health on two out of three annual Budget Days.

26 This will change the role of Cabinet and the Minister of Finance in the Budget process, limiting the opportunity for taking decisions on the overall level of health funding to once during the parliamentary term. The Minister of Health would continue to take significant policy decisions to Cabinet throughout the three-year period, as appropriate, but decisions would be funded within the multi-year funding commitment.

27 A key benefit of slowing down the cycle of Budget decisions is that it should take the focus away from annual assessments of dozens of small initiatives and give Ministers and officials more time to properly analyse and tackle significant issues and cost drivers in the health system.

The new funding commitment will be nested within broader system settings designed to support better planning and financial control

28 A new multi-year Budget arrangement will require a robust and comprehensive set of accountability measures that are coherent, reflect system priorities and outcomes, and link long-term strategic direction with service, capacity planning and resourcing. The multi-year Budget arrangement should be contingent on these accountability measures being in place, which would be by Budget 2024. If Ministers are not confident this has been achieved, there will be an option to defer the multi-year arrangement to Budget 2025.

29 These mechanisms, along with reporting and monitoring and intervention powers, will form the full toolkit for setting and monitoring objectives and directly connect Budgets with organisational actions. At a high-level, the key components of this system architecture are:

Proactively Released

96c4635pu7 2022-06-09 12:10:55

29.1 **Expectation and direction-setting** through health strategies, the Government Policy Statement (GPS) and core business rules, underpinned by legislation. These would primarily operate as mechanisms for setting the long-term direction for the health system, including Government priorities and broad funding parameters. The GPS in particular will be a significant new tool for the health system and will allow Ministers to set clear expectations and requirements for how they are monitored.

29.2 **Planning and accountability** through the NZHP and Statements of Performance Expectations and Statements of Intent for the new entities. These documents will be a lynchpin for the system as they will be responsible for giving practical effect to the GPS and health strategies. This will include comprehensive and robust planning around service costs and capacity requirements, and forecasting of anticipated risks. It will take time for the sector to build up the capability required for this. Therefore, an interim NZHP will cover the system for the next two years in anticipation of the first full NZHP and multi-year Budget arrangement coming into effect in 2024/25.

29.3 **Monitoring and reporting** against the priorities and plans above will be achieved through a detailed framework that supports both system and entity-level accountabilities, a focus on improvement and an expectation for public performance reporting. Core national data and information requirements will be the mandate of health entities to ensure regular reporting and transparency. This will cover all population groups regardless of whether funding sits outside of Vote Health (e.g. disability services) to ensure there is transparency across the health system's ability meet needs and address inequities. Significant work is progressing on developing this framework, and initial advice will be provided to the Ministers of Finance and Health later this year.

29.4 **Intervention powers** can be necessary when specific risks or issues are identified, or there is worsening system performance. The starting point for such levers should be relational and reflect the importance of aligned leadership and values across the health system. This includes the soft power of the Minister and Director-General of Health, for example, to convene system leaders, and facilitate and broker solutions to shared problems. Harder, statutory powers may be needed in some circumstances, but this pathway should aim to set thresholds for when certain steps may be trigged. Relevant Ministers will receive proposals related to this for consultation later this year.

30 Cabinet has agreed to the broad accountability arrangements outlined above [SWC-21-MIN-0107 refers]. A high-level diagram on how these arrangements work in concert across the whole system is also provided in Appendix A.

Proactively Released

96c4635pu7 2022-06-09 12:10:55

A transitional funding package at Budget 2022

We recommend a transitional funding package for the first two years from 1 July 2022 to the start of the first three-year funding arrangement

31 Ahead of 2024, the sector should be focused on change management, implementation, and getting all necessary prerequisites in place ahead of Budget 2024. A transitional funding package at Budget 2022 will support the new entities through the transition period. We propose this package:

31.1 rebases the health system to establish the sector on Day One with no deficits and enough funding to stay deficit-free through the two-year reform period;

31.2 provides medium-term funding certainty for Health NZ and the Māori Health Authority to work with the sector on a credible first full NZHP; and

31.3 is sufficiently flexible to allow for the realities of a complex transition process.

32 The two-year funding package would carry an expectation that the sector will not seek new funding through Budget 2023, except for funding that may be required to accommodate unknown and uncontrollable financial risks that materialise through the two-year transition period. The thresholds for coming back for new funding in Budget 2023 will be agreed as part of the Budget process and included in the interim Government Policy Statement.

Rebasing the system in Budget 2022 will set forward expectations for the reform

33 A health system rebase – a significant ongoing funding uplift – is needed 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.

34 We recommend that this rebase occurs at the establishment of the reformed system in July 2022. Deferring this rebase risks establishing an unhelpful precedent that deficits are a normal/acceptable feature of the system. A rebase in Budget 2022 will also signal the Government's commitment to reform and should be provided alongside renewed expectations for financial management and system performance culture going forward.

35 This does not represent a new cost to the system; rather, it is a more transparent way of showing what we know is already being spent by the health system. A significant component of the rebase will be to recognise the costs currently being incurred by district health boards, and will require a funding uplift for the new system that is sufficient to meet these costs and address known cost pressures on the system.

96c4635pu7 2022-06-09 12:10:55

Proactively Released

36 The rebase will represent a significant investment into the health system in Budget 2022 and will need to be communicated in a clear, deliberate manner.

Health reform will be a key consideration in setting parameters for Budget 2022

37 Further work is required to quantify the level of investment needed to deliver a transitional funding package and Cabinet will take final decisions through Budget 2022 [CAB-21-MIN-0349 refers]. Officials from the Ministry of Health, Treasury, and the Transition Unit are working on advice regarding the overall quantum, which will be provided to the Ministers of Health and Finance over the coming months.

Adjustments to health system funding mechanisms

38 The proposed multi-year Budget arrangement is designed to add a level of certainty for long-term planning, give decision makers an incentive to manage cost-pressures, and support the efficient and effective allocation of resources across the health system. However, additional changes are needed to the funding mechanisms by which investments flow to entities and commissioners to improve accountabilities and ensure funding follows and supports outcomes being sought.

39 Most of the desired change will be realised through the design of the new system, including various allocation pathways from appropriations to commissioning and service planning. This work will take time. Meanwhile, this paper proposes some structural adjustments to scaffold the reformed system's funding mechanism design and provide a foundation for interim entities as they plan for the system's go-live date in July 2022. These include:

39.1 shifting the Vote Health appropriation structure to a smaller, more coherent set of appropriations to mirror a system operating model that is less fragmented, and to balance funding flexibility with controls and transparency;

39.2 separate appropriations for hauora Māori and pharmaceuticals. This would mean financial accountability and reporting for related outcomes would sit with the Māori Health Authority and Pharmac, thereby aligning accountability with funding; and

39.3 a set of principles to guide the design and operation of funding allocations within the new system's two lead commissioning entities: Health New Zealand and the Māori Health Authority.

40 The following sections provide further detail on these proposed adjustments.

Proactively Released

Vote Health appropriation structure

Shifting to a smaller but more coherent set of appropriations will reinforce the new system operating model and provide for Parliamentary authorisation at a more meaningful level

41 Appropriations are the basis on which Parliament authorises the incurring of expenses or capital expenditure. Currently Vote Health consists of 54 appropriations, which include geographic appropriations (one for each of the 20 district health boards) and several appropriations for services nationally commissioned by the Ministry of Health.

42 Whilst this many 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.

43 From Budget 2022/23, shifting to a smaller but more coherent set of appropriations in Vote Health will support Parliamentary authorisation at a more meaningful level, mirror a system operating model that is less fragmented, and ensure flexibility to deploy resources to improve population health outcomes.

44 The new structure would include:

44.1 New appropriations for: primary, community, population and public health; hospital and specialist services; hauora Māori (i.e. the Māori Health Authority budget); and pharmaceuticals.

44.2 Maintaining existing appropriations for: monitoring and protecting health and disability consumers' interests (covering the functions of the independent Crown Entities); health capital envelope; COVID-19 vaccine; COVID-19 health system response; and disability support services.

44.3 A new multi-category appropriation that would cover the Ministry of Health's departmental functions.

Separate appropriations are one mechanism to provide control and oversight over the relative resources in each appropriation

45 One of the key priorities for the reforms is to support a rebalancing of the system away from hospital and specialist services towards primary and community care, prevention, and health promotion. The reforms also aim to address the opacity in the current system around resource flows into different areas and the outcomes achieved.

96c4635pu7 2022-06-09 12:10:55

Proactively Released

46 The restructure of Vote Health appropriations supports this in several ways:

46.1 A narrowly defined appropriation for hospital and specialist services separated from primary, community, public and population health will provide additional controls for any funding transfers between the two appropriations, and reinforce the need for Health NZ to manage the funding streams separately. This will be different to the status quo, where DHBs currently have a single appropriation covering both their provider and commissioning arms.

46.2 A separate hauora Māori appropriation aligns financial accountability and reporting responsibilities with the MHA's role in the new system operating model. It also provides greater transparency to Parliament and the public about the Māori Health Authority's budget and additional controls for shifting resources, thereby supporting tino rangatiratanga and mana motuhake.

46.3 A separate pharmaceuticals appropriation, that Pharmac is responsible for reporting against, will align funding and financial reporting responsibilities with decision making and accountability for managing the total budget, and will also improve transparency. This in turn will better support alternative distribution and funding arrangements for high-cost medicines and other products that Pharmac manages, to support more optimal use of the budget. It also reduces some of the administrative and financial complexity for Health NZ and Pharmac.

47 Whilst there is a risk that two separate appropriations for Health NZ's funding will work against the integration of services, the greater risk is that hospital and specialist care continue to dominate over public health, primary and community care. The New Zealand Health Plan will provide clear operational direction about how hospital and specialist and primary and community care are expected to work together. This fragmentation risk will be further mitigated through the flexibility inherent in the locality models, where primary and community care services will be able to work to the top of their scope and integrate with in-community tertiary services wherever possible. There are also the new system's expectation setting, accountability and reporting mechanisms (refer paragraph 28) which will provide a greater level of transparency and coordination across key service areas.

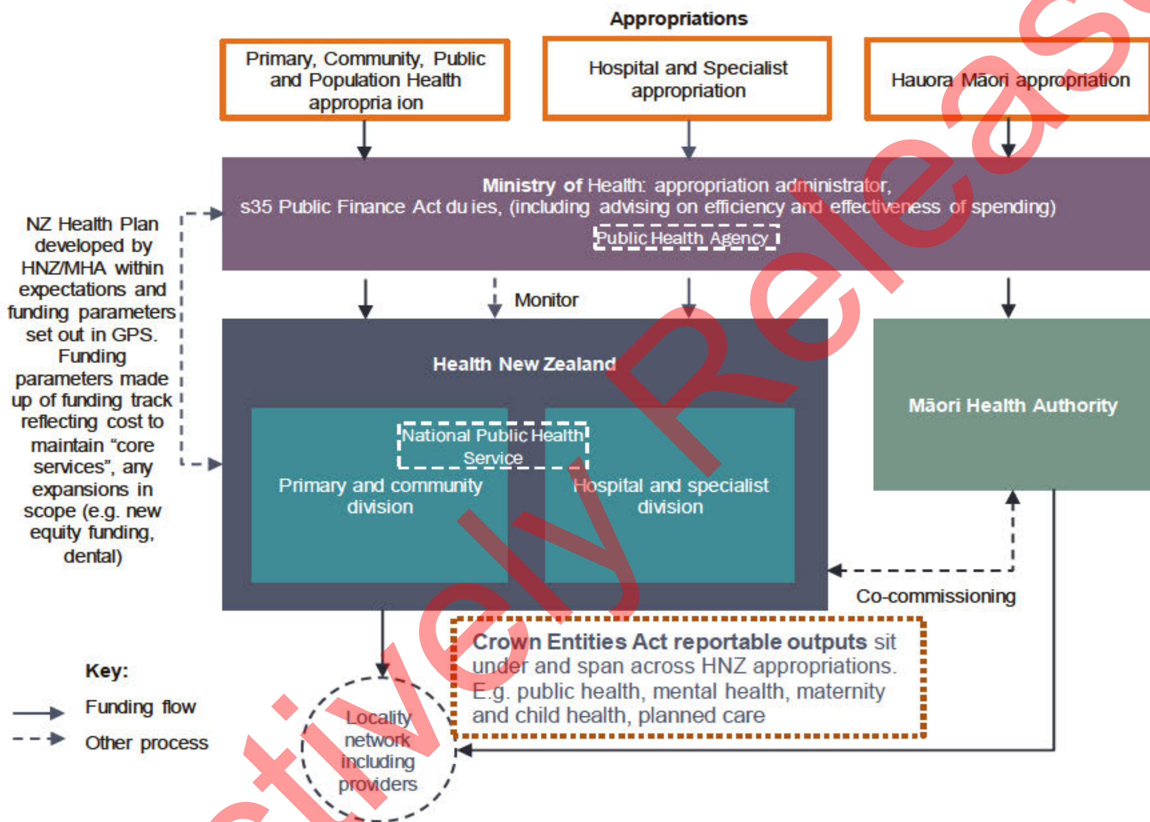
48 Creating a separate pharmaceuticals appropriation risks raising a barrier that impedes substitution between pharmaceutical and non-pharmaceutical treatments, in those conditions where this is an option or in response to new evidence. This barrier also creates risks when PHARMAC's decisions have substantive impacts on other parts of the system as we have seen in recent years with investments in, for example, new cancer medications which require greater clinical oversight. This barrier will be overcome, as it is at the moment, with collaborative working supported by appropriate arrangements, including those that support joint oversight and planning arrangements.

Proactively Released

96c4635pu7 2022-06-09 12:10:55

49 Additional appropriations risk working against the optimal allocation of resources and integration of services and add complexity and administrative burden for limited transparency benefits. In priority areas, alternative mechanisms will be used give transparency and underpin accountability for expenditure and how it is used, including Reportable Classes of Outputs, provided for in the Crown Entities Act. A summary of the rationale for not including separate appropriations for other dimensions of spending is detailed in Appendix B.

The diagram below shows how the appropriations would flow through to entities



Proactively Released

There are some nuances to consider in implementing this appropriation structure

50 To define the hospital and specialist appropriation and the primary, community, public and population health appropriation, a service view will be more effective rather than basing definitions on what is delivered in each of Health NZ's two arms on Day One. This will support a shift towards integrated health promotion, and primary and community care services. It means the "primary, community, population and public health services" appropriation will include some services provided by Health NZ in hospitals and in the community (for example, rural hospital services and district nursing). There is likely to be value in evolving the definitions over time to support the shifting of more activity into primary and community care settings. Officials will provide further advice on definitions to Joint Ministers as part of the next stage of work.

96c4635pu7 2022-06-09 12:10:55

51 Currently, fiscally neutral adjustments (FNAs) between appropriations require joint approval of the Minister of Finance and the relevant Vote Minister [Cab Office circular CP (18) 2 refers]. Given the criticality of the system rebalance towards prevention and primary and community care, we recommend delegating 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 and between other Vote Health appropriations. Any in-year changes would still need to be included in the Supplementary Estimates for that year.

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

52 In addition to the new appropriation structure there needs to be comprehensive and accessible reporting to support decisions at every level of the system and provide transparency. The depth and breadth of reporting will need to develop over time as this is a significant area of work, and it will need to reflect several important perspectives, including:

52.1 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;

52.2 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;

52.3 a spotlight on areas of concern or historic vulnerability (e.g. mental health, public health) and areas of change (e.g. the burden of disease from type 2 diabetes);

52.4 a focus on enablers – workforce, digital and facilities, and Māori and Pacific provider development; and

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

53 Joint Ministers will be receiving initial advice on the reporting framework 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. Initial reporting and accountability mechanisms will need to be in place prior to shifting to the new appropriation structure in 2022/23.

Proactively Released

96c4635pu7 2022-06-09 12:10:55

The new system's accountability and funding arrangements will need to support a clear and sustained focus on priority areas such as mental and public health

54 In general, the best approach to improving health system performance is holding entities accountable for outcomes and giving entities flexibility to determine what allocation of inputs and outputs can best achieve these outcomes. However, in some service areas, outcomes and impacts can be hard to measure; there can be long lags before impacts are measurable, and some are less visible in general. In these cases, it may be relevant to carefully monitor funding in these areas as operational entities may face an incentive to reallocate spending and prioritise service areas with more visible, immediate, and easily measurable impact on outcomes.

55 There has been consideration given to whether separate appropriations for mental health and public health would support a greater system focus in these areas. These are two service areas that have received insufficient focus and funding in the past. The impacts of these services can be especially difficult to measure and can occur with long lags, particularly for public health. As such, monitoring activity on inputs as well as outcomes can be relevant. Separate appropriations can, in theory, address these issues, by ring-fencing funding for these areas.

56 However, while separate appropriations provide additional transparency over spending in a specific area, reportable outputs under the Crown Entities Act and mandatory reporting requirements are just as able to play this role. Separate appropriations also risk working against the integration of services, perpetuating narrow definitions of public and mental health services, and limiting expectations of who delivers them. Finally, separate appropriations provide no guarantee of future funding increases, as illustrated by the flat or falling funding within the separate 'public health services purchasing' appropriation during the early 2010s.

57 Rather than using separate appropriations, the reformed system will have a suite of accountability mechanisms to support a focus on key Government priorities such as mental health, public health and addressing inequities. These are detailed earlier in the paper (refer paragraph 28). These mechanisms would need to be complemented by specific measures related to both system readiness (e.g. pandemic preparedness, technical capabilities) and population outcomes (e.g. vaccine preventable disease rates) to provide a transparent and accurate picture across the priority areas.

58 Spending ringfences (for example setting a spending target in the Government Policy Statement) are another tool that could be used to require a certain amount to be spent on specific areas. Mental health is the only area of DHB funding that currently has a ring-fence. This means that the amount a DHB spends on mental health services must, at least, increase each year to account for demographic and other cost pressures. The mental health ringfence was introduced following the Mason inquiry (1995-96) with the objective of preventing mental health and addiction funding from being reallocated to other service areas in DHBs. Tight rules set as part of the Operational Policy Framework (a set of business rules prepared by Ministry of

96c4635pu7 2022-06-09 12:10:55

Proactively Released

Health and endorsed by the Minister of Health), determine how the ring-fenced funding is to be managed and spent. The rules around the ringfence tend to focus on severe mental health and addiction needs and specialist services, rather than lower acuity services.

59 Ringfences face similar challenges to appropriation boundaries in that they risk shifting the focus to money rather than health and wellbeing, and risk gaming and incentivising lower value spending.

60 Instead, we propose maintaining focus on other accountability tools, including quality reporting. As part of developing the interim GPS and interim entity accountability documents (interim NZHP and Statement of Performance Expectations), we should reconsider whether an explicit mental health ring-fence is needed to support better mental health outcomes. Our initial view is that other accountability tools (refer paragraph 28) are likely to be more effective at supporting a focus on mental health. This could include mandating mental health as a reportable output for the purposes of the Crown Entities Act which would give ex ante and ex post visibility over spending, as well as broader non-financial performance. Fuller advice on whether the current mental health ring-fence should be retained will be developed early next year.

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

61 There will be several changes to funding accountabilities as part of the disestablishment of DHBs and the stand-up of new system entities. Specifically:

61.1 DHB funding and assets transfer to Health NZ and the MHA; and

61.2 non-departmental funding currently managed by the Ministry of Health in relation to services (except Disability Support Services), provider development, workforce training and performance improvement transfers to Health NZ or the MHA.

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

63 However, we suggest Cabinet make some initial decisions at this stage around the MHA's direct budget. These decisions are needed to guide the interim MHA and interim Health NZ, as the decisions will help interim entities plan for Day 1 in July 2022.

96c4635pu7 2022-06-09 12:10:55

Proactively Released

There is a choice about the MHA's direct budget and funding responsibilities

64 The MHA 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 agrees significant national and regional strategies, commissioning frameworks and plans with Health NZ.

65 To provide opportunities for Māori to start the journey towards mana motuhake and rangatiratanga in health, there is an expectation from Māori, including Tā Mason's Steering Group, that the MHA should control a significant share of funding. A recent report undertaken by the 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.

66 There is a choice about the extent of the MHA's direct budget responsibilities for other funding streams, including current DHB funding for kaupapa Māori services 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).

67 We suggest Cabinet agree in principle to the MHA having direct budget responsibility for DHB kaupapa Māori services and other relevant Ministry non-departmental contracts. This means that the funding would sit in the hauora Māori appropriation, and the MHA would have accountability for the use of the funds, including reporting and accounting to Parliament, the Crown and the public. The existing funding is sizeable at potentially around $340 million, especially for a new entity on Day 1 of the reformed system.

68 There is significant further work to be done on the approach to implementation to set the future system and the MHA up for success. Alongside definitional issues around what funding is in scope, and transitional arrangements to provide stability and integration of services, work needs to be done on the design and establishment of regional mechanisms between the MHA and Health NZ to ensure a single, joined-up system.

69 Given this, we propose that Cabinet agree in principle at this stage to the MHA's budget holding role, subject to further advice on implementation from the Transition Unit, the interim MHA's board and the Ministry of Health to Joint Ministers (Minister Little, Minister Robertson, and Minister Henare). It is possible that a staged approach to implementation might be needed.

Proactively Released

96c4635pu7 2022-06-09 12:10:55

Internal funding allocations and mechanisms

70 As agreed by Cabinet in March 2021, in the future system operating model, in general hospital and specialist services will be nationally planned and delivered, and primary and community services will be commissioned from a range of provider organisations. How these services are funded and the mechanisms through which funding reaches the appropriate level of the system will be determined by the internal allocative processes developed by Health NZ and the MHA.

71 As with other Crown Entities, such as ACC, Ministers should not 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 NZHP but would not approve regional funding allocations. For primary and community care, Ministers would set overall priorities via the GPS and approve national standards and measures via the NZHP but would not sign off needs-based funding models for allocating funding within primary and community care.

72 However, while Ministers should not formally approve mechanisms that are the internal responsibility of Health NZ and the MHA, it will be important to ensure that these mechanisms are designed and operated in a way that is consistent with Government's objectives and the system shifts. A lack of alignment could lead to varied or competing priorities that risks delivery of our aims.

73 To ensure alignment and provide some Ministerial direction over the design of internal allocative mechanisms by Health NZ and the MHA, we recommend establishing a set of funding principles for the system. These funding principles are intended to reinforce the key objectives of reform agreed by Cabinet in March and would be set formally for the entities to give effect. Given the strategic importance of the design of funding mechanisms, it would be valuable for these principles to be a permanent Cabinet directive, rather than relying on other tools such as the GPS.

74 **The diagram on the next page proposes a set of funding principles to support the design of internal funding allocations and mechanisms within both Health NZ and the Māori Health Authority.** 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.

Proactively Released

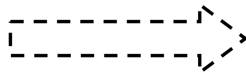
96c4635pu7 2022-06-09 12:10:55

Design principles for Health NZ and MHA internal funding

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

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, children and young people, and other populations that experience inequities, as well as high deprivation geographic areas.
- **Consistent access**: in additional to being pro-equity, funding allocations and mechanisms should fairly distribute funding to support consistent access to effective and quality service and care levels across populations in different geographic areas, recognising that different populations may need access to different services.
- **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 support the efficient allocation of resources including, where appropriate, a shift towards efficient pricing.

75 Consistent with March Cabinet decisions, the Māori Health Authority would need to be involved in and agree significant national decisions on funding allocations and mechanisms.

Financial implications

The proposed multi-year funding approach for health is consistent with the direction of Public Finance System Modernisation

76 The proposed future settings for the health system are well aligned with our current thinking on broader Public Finance System Modernisation (PFSM), including a shift towards multi-year planning and funding cycles, and the piloting of two clusters (the natural resource and justice sectors) through Budget 2022. The key difference with this health proposal is the inclusion of an ongoing medium-term funding track beyond the three-year funding commitment period.

Proactively Released

96c4635pu7 2022-06-09 12:10:55

Health cost pressures and the cost of reform will require significant investment. This should be explicitly factored into the Government's fiscal strategy

77 Health reform will not generate cost-savings in the short term – rather, the intention of these reforms is to reorient the system towards long-term population outcomes and facilitate addressing embedded inequities for population groups like Māori, Pacific and disabled peoples. Aspects of the new national funding settings proposed in this paper will help bend the medium-term cost curve as they will reduce inefficiencies through more transparent and consistent accountabilities and long-term planning.

78 Health is likely to consume most of the current operating allowances over the forecast period. Ministers will have choices about how to manage and communicate these near-term costs, but limited ability to reduce them. Health reform costs will need to be factored into the setting of allowances across the forecast period.

79 We have asked officials to provide advice on a transitional funding package for Vote Health. This will be in time to inform fiscal and Budget strategy advice for the 2022 Budget Policy Statement in December, with a final package being confirmed in Budget 2022.

Legislative implications

80 There are no legislative implications pertaining to the proposals in this paper.

Population implications

81 The proposals in this paper are expected to have significant benefits for disadvantaged populations, especially Māori and Pacific peoples and disabled people, and are not expected to negatively affect any population groups. The proposed shift to a multi-year budget, adjustments to health appropriations, and funding principles for entities will help refocus the health system on improving long-term population outcomes, and the improved accountability mechanisms will drive performance monitoring to this end. This will benefit population groups with embedded inequities.

82 The proposed decisions around the Māori Health Authority's budget will provide a certain foundation for the interim entities and set them up for success in the future system. This is expected to increase Māori access to services and improve health outcomes.

Human Rights

83 The proposals in this paper are consistent with, and advance the purposes of, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

84 The Ministry of Health, the Treasury, and the Public Service Commission have been consulted. Their comments are reflected in this paper. The Department of Prime Minister and Cabinet has been informed.

96c4635pu7 2022-06-09 12:10:55

Proactively Released

Communications

85 The changes to Vote Health's Budget arrangements, and the adjustments to its appropriation structure represent a significant change of the status quo to align with the new system operating model The multiyear funding approach has been applied to other clusters in Budget 2022 (e.g. Justice and Natural Resources) however its combination with a medium-term funding track from year four onwards will be unique to health.

86 This will require a deliberate and consistent communications approach with the wider health sector and beyond. Officials have been asked to develop this advice for Ministers ahead of Budget 2022 announcements.

Proactive Release

87 I intend to release this paper in accordance with the guidance in Cabinet Office Circular CO (18) 4.

Recommendations

The Minister of Finance and Minister of Health recommend that Cabinet:

1. **note** that in March 2021 Cabinet agreed to establish a funding framework for health that provides greater budget certainty for the health system and the Crown, and directed officials to provide further advice on funding and fiscal management settings for health ahead of Budget 2022, including the approach for a multi-year settlement (CAB-21-MIN-0092 refers)

Multi-year health funding

2. **agree** to establish a multi-year funding arrangement for Vote Health from Budget 2024 (at the earliest), to align with the delivery of the first full NZHP

3. **agree** that the multi-year funding arrangement will comprise:

    a. a <u>three-year funding commitment</u> that covers all cost pressures and new investments in health over a three-year period; and

    b. <u>a medium-term funding track</u> from year four onwards to support health sector planning and drive investment prioritisation decisions with impacts beyond the three-year funding commitment

4. **agree** that the first multi-year funding arrangement should only be implemented once Cabinet has confidence that adequate system settings to support improved planning and financial control will be in place

5. **agree** that the multi-year funding arrangement should apply to all Vote Health funding covered by the NZHP, with an option to extend the arrangement to all of Vote Health including the Ministry of Health

6. **agree** that the funding track will be the basis on which each future NZHP is developed

96c4635pu7 2022-06-09 12:10:55

Proactively Released

7. **note** that that the approach set out above is consistent with the direction of the Public Finance System Modernisation (PFSM) reforms, which also proposes multi-year planning and funding, with the key difference being the ongoing medium-term funding track

Transitional funding package at Budget 2022

8. **agree** to provide a transitional funding package at Budget 2022 that supports the health sector through to Budget 2024, providing funding certainty for the health sector for a two-year period

9. **agree** that the health system should be provided with sufficient medium-term funding certainty at Budget 2022 for the sector to start work on the first full NZHP

10. **agree** that at establishment, Health New Zealand should be provided with funding sufficient to establish a starting balance sheet with no deficits, meet its expected costs and should not be forecasting a deficit position on Day One

11. **note** that this will require a significant uplift in ongoing operating funding to rebase the health system in Budget 2022

Vote Health appropriation structure

12. **agree** in principle the overall approach to the appropriation structure for Vote Health from 2022/23 including separate appropriations for:

    a. Primary, community, public and population health services;

    b. Hospital and specialist services;

    c. Hauora Māori, with financial accountability and reporting sitting with the Māori Health Authority;

    d. Pharmaceuticals, with financial accountability and reporting sitting with Pharmac;

    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;

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

    j. Health capital envelope;

96c4635pu7 2022-06-09 12:10:55

Proactively Released

k. Any other appropriations as necessary for implementing the reformed system (e.g. to recognise the transfer of assets)

13. **authorise** Ministers (the relevant appropriation Minister and the Minister of Finance) to jointly finalise the appropriation structure of Vote Health and establish new appropriations as required

14. **authorise** Ministers (the relevant appropriation minister and the Minister of Finance) to jointly reallocate existing funding from the current Vote Health appropriations into the new appropriation structure with effect from 1 July 2022

15. **note** that the relevant associate Ministers of Health will be provided with visibility over the new appropriation structure and how funding is allocated among appropriations

16. **delegate** authority to the Minister of Health alone to approve fiscally neutral adjustments, and associated Imprest Supply changes, from the hospital and specialist services appropriation to the primary, community, population and public health appropriation

17. **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

18. **note** that officials will bring fuller advice on options for the mental health ring-fence early next year.

Budget holding responsibilities across health entities

19. **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

20. **agree in principle**, subject to confirmation with the interim Māori Health Authority Board and advice on the overall implementation approach, 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:

    a. Ministry of Health non-departmental funding currently managed by its Māori Services Directorate, for example, Māori Provider Development Scheme funding;

    b. DHB kaupapa Māori services; and

Proactively Released

96c4635pu7 2022-06-09 12:10:55

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

21. **direct** the Transition Unit, working with the interim Māori Health Authority and Ministry of Health, to provide advice on the overall level implementation approach and associated resource implications to the Ministers of Finance and Health by November 2021

Internal funding allocation mechanisms – funding design principles

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

23. **agree** to a set of funding design principles 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, children and young people, and other populations that experience inequities, as well as high deprivation geographic areas

    c. **Consistent access**: in additional to being pro-equity, funding allocations and mechanisms should fairly distribute funding to support consistent access to effective and quality service and care levels across populations in different geographic areas, recognising that different populations may need access to different services

    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 support the efficient allocation of resources including, where appropriate, a shift towards efficient pricing and resource allocation generally.

Authorised for lodgement

Hon Grant Robertson

96c4635pu7 2022-06-09 12:10:55

Proactively Released

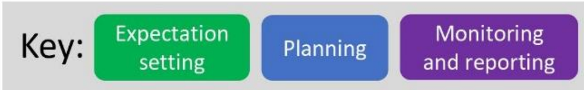
Minister of Finance

Hon Andrew Little

Minster of Health

Proactively Released

Appendix A: Overall accountability settings



This diagram is based on the final state from 2024/25 with the first full NZ Health Plan. The depth and breadth of key components (e.g. reporting) will build over time, with initial elements in place from July 2022.

System wide factors – what is different?

Partnership and co-creation with Māori Health Authority in key expectation setting, planning and accountability and reporting documents

Accountability framework and reform programme supports **culture shift to focus on continuous improvement and innovation**

Consumer voice reflected in design and provision of services.

Easier for **independent voices** to influence and input across accountability cycle e.g. Public Health Advisory Committee, Mental Health and Wellbeing Commission etc

Adaptability of system to respond to emerging challenges and government priorities

What is different?

GPS is a new tool that provides an opportunity to shift to a **more strategic approach** – Ministers set out overall strategic direction, expectations and parameters across a multi-year period, and this is supported via a more comprehensive reporting and monitoring approach

Integrated multi-year planning and budgeting cycle including underpinning funding track, aligns expectations and funding and supports effective negotiation about achieving health objectives in a way that is financially sustainable

Appropriation structure reflects system operating model and provides flexibility to shift resources to where they are most effective at improving population health outcomes, but is complemented by more transparent performance information which aligns with the NZ Health Plan/Statement of Performance Expectations

Transparency and accessibility of key data to enable public and independent scrutiny

Annual assessment of entity's performance against the NZHP and linked SOI and SPEs

Annual reports
All entities

Shows how entities are performing for populations, places and across services. This includes identifying key drivers of any performance issues

Regular Board/Monitor reporting
All Crown entities

Statements of Intent and Statement of Performance Expectations
All Crown Entities

NZ Health Plan
All health entities (except MoH)
Led by HNZ/MHA, signed by Minister

Service and capacity plan. Sets out population health needs, key shifts, what it means for services and capacity, and implications for resource and investment

What is different?

More comprehensive reporting including:

- **Comprehensive service view** to account for financial and non-financial performance, including how performance varies by place
- **Mandatory population reporting** provides accountability for how system is delivering for Māori, Pacific and disabled people
- **Spotlight on areas of concern and change** e.g. mental health

Robust financial model of the sector owned by HNZ but accessible by Monitor/Treasury provides transparency and accountability about financial position

Statutory and non-statutory **intervention powers** will enable a timely and proportionate response to any performance issues whilst empowering a culture of innovation and continuous improvement.

What is different?

High quality coherent planning and accountability framework including NZHP as key long term service and capacity plan covering health system operations

Multi-year budget approach supports long term planning including redesign of models of care – shifts focus away from annual cycle

More useful set of service focused reportable outputs for purposes of the Crown Entities Act to provide a comprehensive accounting for financial and non-financial performance ex ante and ex post

Employment relations settings place operational responsibility on HNZ to manage costs within its overall budget, and provide transparency and accountability via reporting on financial management

Proactively Released

Appendix B: 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 \, 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. Reflects the new system operating model with distributed decision making nationally, regionally and locally. Parliamentary authorisation at geographic level appears to add little benefit and adds complexity and administrative burden. Geographic appropriations are not 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

Proactively Released

96c4635pu7 2022-06-09 12:10:55

Cabinet Social Wellbeing Committee

Minute of Decision

This document contains information for the New Zealand Cabinet. It must be treated in confidence and handled in accordance with any security classification, or other endorsement. The information can only be released, including under the Official Information Act 1982, by persons with the appropriate authority.

Health and Disability System Reform: National Budget and Funding Settings

Portfolios **Finance / Health**

On 20 October 2021, the Cabinet Social Wellbeing Committee:

1 **noted** that in March 2021, Cabinet agreed to establish a funding framework for health that provides greater budget certainty for the health system and the Crown, and directed officials to provide further advice on funding and fiscal management settings ahead of Budget 2022, including the approach for a multi-year settlement [CAB-21-MIN-0092];

Multi-year health funding

2 **agreed** to establish a multi-year funding arrangement for Vote Health from Budget 2024 (at the earliest), to align with the delivery of the first full New Zealand Health Plan (NZHP);

3 **agreed** that the multi-year funding arrangement will comprise:

3.1 a three-year funding commitment that covers all cost pressures and new investments in health over a three-year period; and

3.2 a medium-term funding track from year four onwards to support health sector planning and drive investment prioritisation decisions with impacts beyond the three-year funding commitment;

4 **agreed** that the first multi-year funding arrangement should only be implemented once Cabinet has confidence that adequate system settings to support improved planning and financial control will be in place;

5 **agreed** that the multi-year funding arrangement should apply to all Vote Health funding covered by the NZHP, with an option to extend the arrangement to all of Vote Health including the Ministry of Health;

6 **agreed** that the funding track will be the basis on which each future NZHP is developed;

7 **noted** that that the approach set out above is consistent with the direction of the Public Finance System Modernisation (PFSM) reforms, which also proposes multi-year planning and funding, with the key difference being the ongoing medium-term funding track;

Proactively Released

Transitional funding package at Budget 2022

8 **agreed** to provide a transitional funding package at Budget 2022 that supports the health sector through to Budget 2024, providing funding certainty for the health sector for a two-year period;

9 **agreed** that the health system should be provided with sufficient medium-term funding certainty at Budget 2022 for the sector to start work on the first full NZHP;

10 **agreed** that at establishment, Health New Zealand should be provided with funding sufficient to establish a starting balance sheet with no deficits, meet its expected costs and should not be forecasting a deficit position on Day One;

11 **noted** that the above will require a significant uplift in ongoing operating funding to rebase the health system in Budget 2022;

Vote Health appropriation structure

12 **agreed in principle**, subject to paragraph 13 below, the overall approach to the appropriation structure for Vote Health from 2022/23 including separate appropriations for:

12.1 Primary, community, public and population health services;

12.2 Hospital and specialist services;

12.3 Hauora Māori, with financial accountability and reporting sitting with the Māori Health Authority;

12.4 Pharmaceuticals, with financial accountability and reporting sitting with Pharmac;

12.5 National Response to COVID-19 multi-category appropriation;

12.6 COVID-19 vaccine strategy multi-category appropriation;

12.7 Disability support services (subject to outcome of the machinery of government review);

12.8 A multi-category appropriation for the Ministry of Health departmental functions;

12.9 Monitoring and protecting health and disability consumers interests (covers the functions of the independent Crown Entities);

12.10 Health capital envelope;

12.11 Any other appropriations as necessary for implementing the reformed system (e.g. to recognise the transfer of assets);

13 **authorised** the Minister of Finance and relevant appropriation Minister to jointly finalise the appropriation structure of Vote Health and establish new appropriations as required;

14 **authorised** the Minister of Finance and relevant appropriation Minister to jointly reallocate existing funding from the current Vote Health appropriations into the new appropriation structure with effect from 1 July 2022;

15 **noted** that the relevant associate Ministers of Health will be provided with visibility over the new appropriation structure and how funding is allocated among appropriations;

Proactively Released

16 **authorised** the Minister of Health alone to approve fiscally neutral adjustments, and associated Imprest Supply changes, from the hospital and specialist services appropriation to the primary, community, population and public health appropriation;

17 **noted** that officials will develop a new set of reportable outputs for the purposes of the Crown Entities Act 2004 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;

18 **noted** that officials will develop fuller advice on options for the mental health ring-fence in early 2022;

Budget holding responsibilities across health entities

19 **noted** that 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 2022 technical package, or earlier, as appropriate;

20 **agreed in principle**, subject to confirmation with the interim Māori Health Authority Board and advice on the overall implementation approach, 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:

20.1 Ministry of Health non-departmental funding currently managed by its Māori Services Directorate, for example, Māori Provider Development Scheme funding;

20.2 District Health Board kaupapa Māori services; and

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

21 **directed** the Transition Unit, working with the interim Māori Health Authority and Ministry of Health, to provide advice on the overall level implementation approach and associated resource implications to the Ministers of Finance and Health by November 2021;

Internal funding allocation mechanisms – funding design principles

22 **noted** that Health New Zealand and the Māori Health Authority need to operate within an overall Budget constraint to deliver Te Tiriti o Waitangi obligations, and equitable, effective, sustainable, efficient and acceptable services for people, whānau, iwi, and communities;

23 **agreed** to a set of funding design principles to guide Health New Zealand and Māori Health Authority internal funding allocations and mechanisms:

23.1 Funding should follow allocative decisions made in planning and commissioning: the NZHP will set out key allocative decisions with respect to populations, services and enablers, and place, and funding allocations and mechanisms should support these decisions

23.2 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, which should include Māori as tangata whenua, Pacific people, disabled people, children and young people, and other populations that experience inequities, as well as high deprivation geographic areas;

Proactively Released

23.3 Consistent access: in additional to being pro-equity, funding allocations and mechanisms should fairly distribute funding to support consistent access to effective and quality service and care levels across populations in different geographic areas, recognising that different populations may need access to different services;

23.4 Efficiency: funding allocations and mechanisms should support value for money in service delivery and use of enablers, and where Health New Zealand is the provider, would expect funding allocations and mechanisms to support the efficient allocation of resources including, where appropriate, a shift towards efficient pricing and resource allocation generally.

Rachel Clarke
Committee Secretary

Present:
Hon Grant Robertson
Hon Kelvin Davis
Hon Carmel Sepuloni (Chair)
Hon Andrew Little
Hon Poto Williams
Hon Damien O'Connor
Hon Kris Faafoi
Hon Peeni Henare
Hon Willie Jackson
Hon Jan Tinetti
Hon Dr Ayesha Verrall
Hon Meka Whaitiri
Hon Aupito William Sio
Hon Priyanca Radhakrishnan

Officials present from:
Office of the Prime Minister
Office of the SWC Chair
Officials Committee for SWC

Proactively Released

Cabinet

Minute of Decision

This document contains information for the New Zealand Cabinet. It must be treated in confidence and handled in accordance with any security classification, or other endorsement. The information can only be released, including under the Official Information Act 1982, by persons with the appropriate authority.

Proactively Released

Report of the Cabinet Social Wellbeing Committee: Period Ended 22 October 2021

On 26 October 2021, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 22 October 2021.

SWC-21-MIN-0157	**Health and Disability System Reform: National Budget and Funding Settings** Portfolios: Finance / Health	CONFIRMED

Michael Webster
Secretary of the Cabinet

Proactively Released