

**OFFICE OF THE
MINISTER OF HEALTH**

**MEMORANDUM TO THE CABINET SOCIAL POLICY AND HEALTH
COMMITTEE**

**DISTRICT HEALTH BOARD FUNDING: APPROPRIATIONS FOR DISTRICT
HEALTH BOARDS**

Paper 2 of 3

PROPOSAL

1. I propose that from 2001/02 onwards there should be one appropriation - a Non-Departmental Output Class (NDOC) - for each district health board (DHB) for funding health and disability support services.

EXECUTIVE SUMMARY

2. HFA funding is currently made up of NDOCs which are defined by region and by service. Since there will be 21 DHB districts, defining DHB NDOCs in a similar way would result in a large and unwieldy number of NDOCs, many of which would be very small.
3. I propose, therefore, that from 2001/02 onwards there should be one NDOC for each DHB for funding the health and disability support services that DHBs are responsible for. Where particular service areas or initiatives need to be protected or encouraged, this will be achieved through ring-fences created in the funding agreements between the Minister of Health and DHBs. The proposed arrangements for NDOCs do not affect the ability to ring-fence funding, but instead allow ring-fences to be more innovative and flexible.
4. DHBs will be required to report monthly, quarterly and annually on their expenditure in different areas and the details of these reports will be determined in the funding agreements. Also, in order to provide national service-level expenditure information, the Minister of Health will table in Parliament each year a report of consolidated DHB expenditure, based on the DHBs' annual reports.
5. The current provider development scheme should, however, remain a separate appropriation. Any further Maori health funding ring-fences can be created within funding agreements.

APPROPRIATIONS AND NDOCS

6. Any spending of public money must be in accordance with an appropriation made by Parliament. A separate appropriation is made for each class or

category of public expenditure. Funding must be used for the purposes set out for each appropriation and appropriations cannot be overspent.

7. Over 95 percent of Vote Health is made up of appropriations for purchasing health and disability support services. These appropriations are in the form of Non-Departmental Output Classes (NDOCs). NDOCs which the HFA currently has available in 2000/01 to purchase health and disability support services are shown in Table 1. For example, the HFA can only spend a maximum of \$1,615 million on personal health services for people in the Northern region. The size of these NDOCs is voted by Parliament in each year's Appropriations Act, on the advice of the Minister of Health (the Vote Minister) and the Minister of Finance.

Table 1. HFA NDOCs, 2000/01

NDOC	\$ million	% of Vote Health
Personal Health Services: Northern	1,615	23%
Personal Health Services: Midland	979	14%
Personal Health Services: Central	1,145	16%
Personal Health Services: Southern	1,087	15%
Disability Support Services: Northern	576	8%
Disability Support Services: Midland	348	5%
Disability Support Services: Central	428	6%
Disability Support Services: Southern	399	6%
Public Health Service Purchasing	129	2%

Notes:

1. *Figures are taken from the 2000 Estimates of Appropriations.*
2. *The four regions to which personal health and DSS funding is appropriated are the former regional health authority regions.*
3. *The Estimates also included a separate NDOC of \$109 million to fund HHSs for the capital charge. This has since been transferred into the nine NDOCs shown in this Table.*
4. *The Public Health Service Purchasing NDOC also includes a portion of funding administered by the Ministry of Health.*
5. *The HFA also receives funding of \$89 million for its own management.*

8. After the passing of the New Zealand Public Health and Disability Bill, the HFA will cease to exist and 21 DHBs will be formed. For the remainder of the 2000/01 year the NDOCs in Table 1 will continue to apply.
9. In this paper I propose an NDOC structure to apply to DHB funding from 2001/02 onwards. This NDOC structure will apply to those health and disability support services which the DHBs have responsibility for planning and funding. It will not apply to those services which the Ministry of Health will have responsibility for.

DSS APPROPRIATIONS

10. A report is due to the Committee by 28 February 2001 on the administration of DSS funding, that is, whether, or which parts of, DSS funding will be devolved to DHBs, rather than being administered centrally through the Ministry of Health (or another organisation) [CAB (00) M 23/2B(4) refers].
11. The recommendations of the current paper make no assumptions about the devolution of DSS funding. Whatever DSS funding goes to DHBs will be included in the DHB appropriations. DSS funding has been used in the paper as an example of DHB funding, however, since it is currently part of HFA funding.

PROPOSED NDOC STRUCTURE

12. I propose that from 2001/02 there should be one NDOC for each DHB for funding health and (any) disability support services. Such an NDOC structure does not affect the ability to ring-fence funding, however. Where particular initiatives or service areas need to be protected (public health services, for example) then this can be achieved through the funding agreements with DHBs, and can be achieved in an innovative and flexible way.
13. Details of any ring-fences which may apply to DHB funding through the funding agreements, and how these ring-fences are constructed, will be dealt with as part of the usual funding agreement cycle. Funding agreements will be signed by the Minister of Health and, at least initially, by the Minister of Finance.
14. Apart from my preferred option, there are two other options for a DHB NDOC structure:
 - i. define NDOCs by both district and service, following the principle of the current HFA NDOC structure (as shown in Table 1)
 - ii. define NDOCs by service only, that is, have an NDOC for each service group such as personal health, DSS and public health. Since personal health is currently 75 percent of Vote Health it would need to be broken down into smaller NDOCs (NDOCs are not expected to be larger than 30 percent of the total Vote). Other service groups such as mental health and Maori health might also be considered.
15. These options are discussed below.

Defining NDOCs by both district and service

16. Defining NDOCs by HFA region and service (as shown in Table 1) is currently manageable because there are only four regions to divide funding between. In the new environment, however, there will be 21 DHB districts. Defining NDOCs by both district and service (option i from para 14) would

therefore create 63 or 84 or 105 NDOCs (or another multiple of 21 depending on how many service areas were 'NDOCed'). Dealing with this number of appropriations would be unwieldy and overly-bureaucratic.

17. It is also the case that many of the resulting NDOCs would be very small. The West Coast DHB, for example, can expect a total budget of less than one percent of available funding and this budget would be broken down even further into NDOCs. One percent of current HFA funding is about \$70 million. Having a number of rigid sub-budgets created by service NDOCs would reduce the DHBs' ability to manage demand variability and financial risks, as they would not be able to balance 'unders and overs' across their total budget. The sub-budgets would be rigid because for a DHB to shift any funding between its NDOC sub-budgets would require the approval of Parliament. DHBs may find that there is an incentive to re-categorise their spending in some areas to keep within NDOCs.

Defining NDOCs by service

18. In defining NDOCs by service only (option ii from para 14) the most important funding consideration would be to determine the size of the service-based NDOCs, that is, the total amount of funding to be spent across the country in different service areas, such as primary care or mental health. Each NDOC would then be split into 21 DHB allocations, according to a separate population-based funding formula for each service NDOC.
19. In their funding agreements with the Minister of Health, DHBs would be required to keep strictly to these allocations. For a DHB to shift any funding between allocations would require the approval of Parliament, since this would involve moving funding between service-based NDOCs. Funding could more easily be shifted between DHBs, within the same NDOC, but DHBs are unlikely to be willing to give up their funding to balance overspending in another DHB.
20. Funding allocations therefore have effectively the same properties as the individual district-based and service-based NDOCs in option (i). In most respects, therefore, option (ii) has the same weaknesses as option (i).

Reasons for favouring my proposed approach

21. Under my proposed approach there would be one NDOC for each DHB. The size of each NDOC would be determined by applying a single population-based funding formula to the total amount available for DHBs.
22. Where NDOCs are defined by DHB district, issues of protecting funding for particular services or initiatives would be addressed through the funding agreements that each DHB will have with the Minister of Health. In these agreements there will be a number of ways the Minister can direct or influence the DHBs' spending, including:

- i. **Creating ring-fences.** The Minister could direct a DHB to spend a certain amount of its funding on a specific programme or in a particular service area.
 - ii. **Agreeing to purchasing intentions.** As part of the funding agreements, DHBs will indicate their intended spending in different areas and this will be monitored by the Ministry of Health and DHBs will have to explain any variations from their budget. Large variations will become a performance issue for the Board.
 - iii. **Making service coverage requirements.** DHBs will be subject to service coverage requirements, such as the level of subsidies to pay to primary care providers. Service requirements will affect how much the DHBs can spend in different areas and how much funding they will be able to shift at the margins.
23. Funding agreement ring-fences can be set up to protect particular service areas (in much the same way as NDOCs do), to protect certain initiatives, and to reflect Government priorities for the health and disability sector. Funding agreement ring-fences can be more innovative than NDOCs, however (although they do not have to be), to address the problems of small sub-budgets. Such ring-fences could, for example, require DHBs to spend a minimum amount of funding on each service area, where the sum of the minimum funding amounts adds up to less than the DHBs' total budget. The remainder of the budget could then be spent in those areas the DHB determined to be appropriate. Alternatively, ring-fences could require DHBs to spend an amount within, say, five percent each side of a particular sum.
24. Funding agreement ring-fences are also more flexible than NDOCs. Under my proposed approach, ring-fences can be constructed differently for different DHBs. Adjustments to a DHB's ring-fences could also be negotiated with the Minister of Health and would not need to go before Parliament. Finally, it is easier to change or modify ring-fences over time. NDOCs tend to get 'ingrained' and become hard to change. For example, NDOCs based on the four former regional health authority (RHA) regions are still being used despite the RHAs being disestablished in 1997.
25. Defining NDOCs by district as I have proposed reflects a population-based funding approach under which the most important consideration is to allocate funding to DHBs to meet the needs of particular populations. Each DHB receives an NDOC with which to do this. The next consideration is what this funding is spent on, and this is addressed through the funding agreements.

HOMOGENEITY OF DISTRICT-BASED NDOCS

26. NDOCs are supposed to be groupings of homogeneous outputs. It is arguable, however, whether district-based NDOCs are sufficiently homogeneous, or in fact whether these NDOCs are concerned with

purchasing specific *outputs*. DHBs will be funded - as the HFA is currently funded - to ensure that there are services in place to meet the needs of people to a specified degree. Particular goods and services, in terms of outputs, are not always specified.

27. I acknowledge that district-based NDOCs do not perfectly fit this class of appropriations. However, given that the current HFA NDOCs are also far from homogeneous, and that there is currently no better alternative appropriation class, I consider that DHBs should also be funded in this way.

REPORTING ON EXPENDITURE

28. Spending against NDOCs is regularly reported in the Estimates of Expenditure. Since there will be only one NDOC for each DHB, accurate and timely financial information on DHB expenditure will be necessary in order to monitor the use of resources within the DHBs and across the whole country.
29. Cabinet has previously agreed that DHBs will be required to report in detail on their expenditure in different areas. DHBs will submit regular performance reports, including monthly financial and quarterly performance reports against their Annual Plan, to the Minister of Health. They will also be required to submit an Annual Report, including audited financial statements, to be tabled in Parliament. All financial statements that the DHBs produce will be required to clearly and separately detail each of the dimensions of DHB performance, namely funding of health and disability services; management of the DHB; and management of Crown-owned hospital and associated health services [CAB (00) M 15/10 refers].
30. DHBs will also be required to report on expenditure in a number of service or population areas, including, but not limited to, any ring-fenced areas. This could, for example, include reporting on estimated expenditure on Maori. Reporting requirements will be specified in each DHB's funding agreement.
31. The categories against which DHBs will be required to report will be determined in the funding agreements which the DHBs will have with the Minister of Health. In addition to the DHB annual reports, I propose to table in Parliament each year a consolidated report on DHB expenditure, built up from the individual reports. Comparing DHB expenditure in different areas, and aggregating them in an overall report will of course require that consistent service definitions across all of the DHBs are developed.

MAORI HEALTH RING-FENCE

32. Cabinet has asked for a report on whether there should be a Maori health funding 'ring-fence' [CAB (00) M 11/1A(4) refers]. In this paper I have proposed a structure whereby there will be only one NDOC for each DHB. Therefore only DHB districts will be ring-fenced at the level of appropriations.

33. Even under an alternative appropriation structure, it would not be feasible to construct an NDOC for all health and disability support services provided to Maori (or, for that matter, for services provided to any particular demographic group). This is because most services are integrated and no distinction is made between Maori and non-Maori patients.
34. Funding for developing Maori providers is, however, already ring-fenced as a separate appropriation. Provider Development is an appropriation of \$11.4 million which is used for the development of health providers, including workforce development. Almost all of this fund - over \$10 million - is used for the development of Maori health providers. It is currently administered by the HFA and makes up about a quarter of the total funding administered by the HFA's Maori Health Operating Group. Provider Development should continue as a separate appropriation from the DHB NDOCs (for "Other Expenses to be Incurred by the Crown"). It is likely that this fund will be administered, at least initially, by the Ministry of Health.
35. It would also be possible, with the structure of one NDOC for each DHB, to ring-fence funding within funding agreements for services provided specifically for Maori, or by Maori providers, or both (the 'by-Maori-for-Maori' services). As discussed earlier in this paper, decisions about ring-fences in funding agreements will be made as part of the usual funding agreement process.

CONSULTATION

36. The Treasury, the Health Funding Authority, Te Puni Kokiri, the Department of the Prime Minister and Cabinet, the Ministry of Pacific Island Affairs, the Ministry of Agriculture and Forestry (Rural Affairs) and the Office of the Controller and Auditor-General have been consulted on this paper.

FINANCIAL IMPLICATIONS

37. This paper has no financial implications.

LEGISLATIVE IMPLICATIONS

38. This paper has no financial implications.

HUMAN RIGHTS ACT 1993

39. This paper has no Human Rights Act 1993 implications.

REGULATORY IMPACT STATEMENT

40. A regulatory impact statement is not required.

PUBLICITY

41. Any publicity on matters related to this paper is being managed as part of the Communications Strategy that forms the wider work on health sector change.

AT THE MEETING ON 18 DECEMBER 2000, FOLLOWING REFERENCE FROM THE CABINET SOCIAL POLICY AND HEALTH COMMITTEE, CABINET:

CAB (00) M 42/5 B

DISTRICT HEALTH BOARD FUNDING: APPROPRIATIONS

- a **noted** that Health Funding Authority funding is currently made up of Non-Departmental Output Classes (NDOCs) that are defined by region and by service, but that this structure would not be feasible for 21 District Health Boards;
- b **agreed** that from 2001/02 onwards there will be one NDOC for each DHB, for funding the health and disability support services for which that DHB will be responsible;
- c **agreed** that where particular services areas or initiatives need to be protected or encouraged, this will be achieved through ring-fences created in the annual funding agreements between the Minister of Health and DHBs;
- d **noted** that the proposed funding structure does not affect the ability to ring-fence funding and that ring-fences in this structure can be innovative and flexible;
- e **noted** that DHBs will be required to report monthly, quarterly and annually on their expenditure in different areas (including, but not limited to, any ring-fenced funding) and that the details of these reports will be determined in funding agreements;
- f **agreed** that each year, commencing from the end of the 2001/02 year, the Minister of Health will table in Parliament a report of consolidated DHB expenditure, based on the DHBs' annual reports;
- g **agreed** that Provider Development (used for the development of health providers) should remain a separate appropriation from the DHB NDOCs;
- h **noted** that on 3 April 2000 Cabinet directed officials to advise on whether there should be a Maori health funding ring-fence [CAB (00) M 11/1A(4) refers];
- i **noted** that it is not feasible to have a separate NDOC for all health and disability support services provided to Maori, but that the Provider Development appropriation constitutes a ring-fence around Maori health funding, and that ring-fences can be created within funding agreements as part of the annual funding agreement process.

