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How much Health funding is needed in Budget 2018 to maintain current service levels?

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The health system needs more funding each year just to maintain its current services. This is to cover among other things population growth, inflation - including costs of pharmaceuticals - and salary costs. This does not take account of the additional funding required to meet unmet health need.

This report summarises an analysis of what is needed in operational funding in the Health vote[1] in Budget 2018 to maintain the status quo so that the public can judge whether announced funding is sufficient, whether it will allow for improvements, or whether services are likely to deteriorate. While capital expenditure requirements are a significant issue, they are not analysed in detail in this paper.

Key points

- The Health vote's operational expenses would need to rise by an estimated $805 million (or 5.0 percent), from $16,109 million to $16,913 million, to maintain the current levels of service. The $805 million is simply to keep up with population and cost increases including the existing Care and Support Workers pay equity settlement (but note the proviso below regarding certain other pay increases). Labour allowed for $846 million in its pre-election Fiscal Plan.
- For the Health vote to regain the spending power of the 2009/10 Health vote and pay for the initiatives and additional costs announced over that time, it would need to increase by $2.7 billion in the 2018 Budget to $18.8 billion.
- The DHBs' combined budget needs to rise from $12,683 million to $13,277 million, requiring an increase of $594 million, or 4.7 percent, to maintain the current level of DHB services and cover population and cost increases. Any new or expanded services or costs would be in addition to that. Note that this does not include Care and Support Workers' pay equity funding.

[1] Note that Budget "Health packages" can include items in budget areas outside the actual Health vote itself. Usually these are relatively small compared to the Health vote and are not part of this analysis.

- The appropriations for national health services such as National Child Health Services, Disability Support Services and Mental Health Services (which are funded directly by the Ministry) will need to rise in total by $205 million, or 6.4 percent, to maintain service levels. Any new or expanded services or costs would be in addition to that. Note that this includes the Care and Support Workers' pay equity funding, as approved last year, before distribution to DHBs.

- Funding for the Ministry of Health will need to rise from $198 million to $204 million to meet increased costs.

- In addition, the Government has a number of election commitments and additional costs including pay equity for mental health and addiction care and support workers who were omitted from last year's settlement, which has been accepted but its cost is not finalised[2]. It is not possible to predict which of the election commitments will be funded in Budget 2018 and by how much. Counting those costed by Labour, but allowing significantly less than originally allowed for reducing GP fees, and including the pay equity claim adds a further $216 million. That would mean that the Health vote's operational expenses need to rise by an estimated total of $1,021 million (or 6.3 percent) from $16,109 million to $17,129 million, to meet those new costs and maintain the current levels of service. We emphasise that the precise amount will depend on what is in fact announced.

- These estimates do not take into account outstanding pay negotiations for nurses, allied staff and others. The currently offered 2 percent increase is assumed in the above calculations, but it has been rejected by those workers. The Prime Minister has set up a panel to find a resolution. For each additional 1 percentage point pay increase for nursing and allied staff (for example raising 2 percent to 3 percent) costs an estimated further $32 million per year to DHBs.

- Population pressures are projected to increase costs by 2.3 percent for the year to June 2019. This takes into account health costs of different age groups.

Compounding shortfall

This analysis does not take into account the findings of our previous analyses which were that each year public health services have started the new financial year worse off than they were the previous year. This shortfall has accumulated to billions of dollars since 2010. We have estimated the cost to bring the purchasing power of the 2018 Health vote back to 2009/10 levels, including paying for the various initiatives and added costs (such as the transfer of responsibility for superannuation contributions from the State Services Commission to the DHBs), less "savings" by way of discontinued services. This would require an increase in operational expenses in the Health vote estimated at $2.7 billion, bringing it to $18.8 billion. This estimate uses actual rises in DHB full-time-equivalent employee wage costs, the rises in the Health Care and Social Assistance average wage for other employees, and CPI for other cost increases. Net additional initiatives and costs are added.

On the next page we describe some examples of the unmet needs and pressure points in the health system.

[2] See "Pay equity for mental health and addiction workers", David Clark, Minister of Health, 14 February 2018, available at https://www.beehive.govt.nz/release/pay-equity-mental-health-and-addiction-workers

Examples of Health service pressure points

- The number of people discharged from public hospitals, adjusted for complexity (case-weighted), increased by 16.3% between 2009/10 and 2016/17, much higher than the estimated population growth of 10.2%.[1]
- Over the same period, hospital outpatient visits, including to emergency departments and nurse-led clinics, increased by nearly 105,000 (9%).
- Recent increases in hospital discharges are mostly due to increases in patients in an acute condition. In the months December 2017 to February 2018 acute hospital discharges increased by 3% compared with the same period a year earlier, while the population increased by an estimated 2.1% over the year. The approaching winter months will see 'acutes' rise further.[2]
- The need for mental health services is far exceeding the growth in resources. The number of unique 'clients seen' by Mental Health and Addiction (MHA) services teams grew by 50% in the years 2008/09 to 2015/16, while funding increased by just 16.5 percent in real terms.[3] [4]
- A published peer-reviewed study shows 50% of public hospital specialists report symptoms of burnout, described as 'a state of vital exhaustion'. New Zealand has the 6th-lowest number of specialists-per-population in 33 OECD countries.[5]
- A survey of nurses shows over 50% of those working in DHBs work extra time at least 'several times a week' because of insufficient staff cover, and more than 40% frequently miss meal breaks. Nearly 70% report unsafe care at least once a week, due mostly to inadequate staffing.[6]
- The rise in acute hospital patients is an indicator of poor access to primary health services. The New Zealand Health Survey (NZHS) 2016/17 shows 1 in 7 adults (14%) reported not visiting a GP due to cost in the past year; a further 7% reported not collecting a prescription due to cost.
- Cost barriers to primary health services for children have been reduced through increased subsidies to general practices. However, over 20% of children still experience one or more access barriers, including not being able to get an appointment at their usual medical centre within 24 hours when their parents wanted them to. This was also a major issue for adults.[7]
- A study of health systems in 11 comparable countries ranks New Zealand among the worst for waiting times for elective surgery, waiting times to see a specialist, and waiting times for treatment after diagnosis. New Zealand ranked third-to-bottom on a measure of health equity, and bottom for access to diagnostic tests. An estimated 9% of people requiring hospital treatment are not accessing it.[8] [9]
- Causes of ill-health commonly identified in research include poverty, poor housing and obesity, which are contributing to pressures on the health system.
- In an overall measure of child wellbeing, UNICEF has ranked New Zealand 34th out of 41 developed countries. Children under 5 in lowest socioeconomic groups have 3.5 times the rate of avoidable hospitalisations than those in the highest groups.[10]
- Nearly 100,000 children aged 2-14 years (12.3%) were obese, up from 8.4% in 2006/07. 1.2 million adults (32%) were obese, up from 29% in 2011/12. People who are overweight or obese have a much greater risk of developing serious conditions, including heart disease, type 2 diabetes and bone and joint disease.[11]
- DHBs need more than $14 billion to upgrade their facilities over the next 10 years, due in part to deferred maintenance of hospital buildings during years of funding constraint. This means DHBs will have to pay the government a capital charge of hundreds of millions of dollars over that period from their operating budgets. Last year's capital charges cost DHBs $174 million.[12] [13] [14]

Sources are at the end of this document

Assumptions

Our analysis separately identifies additional expenditure based on Government election commitments, including Labour Party commitments, the Labour-New Zealand First Coalition Agreement and the Labour-Greens Confidence and Supply Agreement. They are quantified only where that is publicly available through being quantified in the Labour Party policies. Other than the mental health services in Canterbury schools, which has already started[3] and an announcement by the Minister of Health that the introduction of increased subsidies for GP visits will be slowed, there has been no firm announcement as to their timing, but their wording in the policies suggests early action. We emphasise that the precise amount will depend on what is in fact announced and its costing.

The commitments affecting Health Vote operation expenditure are as follows:

Possible additional costs identified for 2018/19	**$000**
Mental health and addiction workers' pay equity settlement	25,000
Reducing GP Fees ***(note: refer to text)***	100,000
Primary Mental Health Teams	21,000
Mental health services in schools in Canterbury	10,000
Extend School Based Health Services to all public secondary schools	40,000
Establish a National Cancer Agency	20,000
Total	216,000

The Labour Party's estimate of the funding required for the reduced GP Fees was $259 million per year including $46 million in additional funding to GP practices and $30 million over three years for extra GP training places. We have put the partial implementation of this at $100 million simply as a place holder in the absence of information, in order to indicate some provision. It could be considerably more, or it could be less. We note that the Coalition Agreement includes "Annual Free Health Check for Seniors including an eye check as part of the SuperGold Card", "Teen Health Checks for all Year 9 students", and "Free doctors' visits for all under 14s", any of which could be made part of the Budget announcements on this matter.

A new appropriation for the Auckland Health Projects Integrated Investment Plan, "to fund the development of a Health Sector projects integrated investment plan for the Auckland metro DHBs", was funded $650,000 in the current financial year, though it was set up in the 2016/17 year using existing funding. The 2017/18 funding was a roll-over of some of that funding because the project was not complete. We assume it will not be further funded in 2018/19.

We assume a rise in the CPI of 1.9 percent in the year to June 2019 (the Budget period). This is Treasury's forecast in HYEFU 2017. CPI is the standard price index used for non-labour costs in the

[3] "In-school mental health workers for Canterbury and Kaikōura children, Jacinda Ardern announces", Cecile Meier, 22 February 2018, available at https://www.stuff.co.nz/national/health/101661025/inschool-mental-health-workers-for-canterbury-and-kaikura-children-jacinda-ardern-announces

Health vote. A difference of 1 percentage point in the rise of these costs (such as 2.9 percent or 0.9 percent rather than 1.9 percent) would increase or decrease expenditure by $61 million.

We assume that the pay of doctors will rise by 2.0 percent, which is the rise in the Association of Salaried Medical Specialists collective agreement. For nurses and allied health staff, pay negotiations with the New Zealand Nurses Organisation and the Public Service Association are not settled. The currently offered 2 percent increase is assumed in the calculation of what is needed to maintain current services, but in the circumstances this is an unlikely outcome. It has been rejected by the workers affected and the Prime Minister has set up a panel to find a resolution. There is strong upward pressure on both pay rates and staffing levels. For each additional 1 percentage point increase for DHB nursing and allied staff (for example from 2 percent to 3 percent) there is an estimated $32 million additional increase in expenditure per year.

We assume that the pay of all other employees, with the exception of those benefitting from the care and support workers' pay equity settlements and those at or near the minimum wage (which rose by 4.8 percent from 1 April 2018) will increase on average by 3.2 percent, Treasury's HYEFU 2017 forecast for the increase in the average hourly wage for the year to June 2019. By way of comparison, NZIER's March 2018 consensus forecast was a rise of 3.0 percent in the private sector average hourly wage in the year to March 2019[4]. We note the evident increased wage pressures and, in particular, pay equity cases may have direct and indirect effects. A difference of 1 percentage point in the estimated pay would increase or decrease expenditure by $49 million.

These pay increases do not include the effect of the Care and Support Workers equal pay settlement which benefitted 55,000 low paid carers and will come into its second year. The settlement affects people working for services funded by both DHBs and the Ministry out of its Disability Support Services appropriation. In total this was costed in the settlement at $303 million against the Health vote in the year to June 2018 and $348 million in the year to June 2019 (other costs come from ACC and increased user charges to some people in private care). In the current financial year, only $279 million was provided from the Health vote at the time of Budget 2017, with the Ministry holding the remainder as a contingency. We assume the full $348 million will be made available directly in the 2018/19 year. However, it is not yet clear how the Health vote costs were and will be divided between DHBs and Disability Support Services.

No official estimate is yet available of the similar mental health and addiction care and support workers' claim which the Ministry omitted from the original settlement and the new Minister has agreed to negotiate[5]. We estimate it, we believe conservatively, as proportional to the number of workers in the two groups (3,800 compared to 55,000), at $25 million in the 2018/19 year. There are other pay equity claims whose value we do not attempt to estimate.

Population growth is a significant driver of health costs. We estimate an increase of 2.34 percent during the year to June 2019, including both an increase in the population (1.65 percent) and the increased expenditure requirements due to the ageing of the population. These were calculated

[4] See https://nzier.org.nz/publication/nzier-consensus-forecasts-revises-up-growth-outlook-march-2018

[5] See "Pay equity for mental health and addiction workers", David Clark, Minister of Health, 14 February 2018, available at https://www.beehive.govt.nz/release/pay-equity-mental-health-and-addiction-workers

using the latest (2017) Ministry of Health demographic projections and 2015 age, sex and ethnicity cost weights. We believe the Ministry is updating its cost weights but has not provided them to us in time for this analysis.

How reliable are our estimates of funding needs?

Our estimates of funding needs are consistent with estimates made by the Ministry of Health and Treasury prior to Budget-setting in previous years, when they have been published. On average our post-Budget estimates of funding shortfalls for the full Vote, based on the same methodology as our pre-Budget estimates, are very close to those of the Ministry, but for the part that refers to DHBs our estimated shortfalls have been consistently lower than the Ministry's. It is possible we are underestimating the pressure on DHBs because of transfers of responsibility ('devolution') from central services to DHB which are not well documented, and because some of the national services are carried out by DHBs but not fully funded. In recent years, Treasury has not released such estimates.

A Treasury response to our analyses[6] does not question our methodology but differs on some matters of interpretation. It claims health spending has "increased in real (CPI adjusted) terms and real per capita terms in most years, albeit at a lower rate and with occasional reductions". However, it acknowledges "There are other measures of health inflation [than CPI] that may be higher", and its figures do not include demographic factors such as ageing, "that could tend to increase costs per capita". Ministry of Health data shows that the effect of these factors is significant. Treasury also concedes:

> *Ministry of Health figures (based on historical cost weights by age, ethnicity and deprivation) generally suggest that health spending growth has kept pace with demographic cost pressures, but has only made a contribution to other cost pressures, although this analysis does not include funding for new initiatives.*

In other words, the Ministry's figures indicate health funding has not kept up with total costs, including the increasing costs of technology, growing health need and, to some extent, personnel costs, let alone total costs plus new initiatives. On this interpretation, new initiatives have in effect not been funded.

An Excel spreadsheet showing the calculations and assumptions is available from http://www.union.org.nz/category_media/health-working-papers/.

[6] NZ Treasury. District Health Board Financial Performance to 2016 and 2017 Plans, February 2017.

Notes providing sources to *Examples of Health service pressure points*

[1] Ministry of Health. Caseload Monitoring Reports. https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/district-health-board-data-and-stats/caseload-monitoring-reports

[2] Ibid

[3] NZCTU. *Budget 2017 mental health funding 'boost' a cut in real terms*. https://www.union.org.nz/so-called-budget-mental-health-funding-boost-is-a-cut-in-real-terms/

[4] Ministry of Health. Mental Health and Addiction: Service Use – Series, 2014/15.

http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/mental-health-and-addiction-service-use-series

[5] C Chambers, C Frampton. 'Tired, worn-out and uncertain': Burnout in the New Zealand public hospital senior medical workforce (2016). ASMS. https://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf

[6] L Walker. *NZNO Employment Survey 2017: Our Nursing Workforce: Resilience in Adversity*, NZ Nurses Organisation 2017. https://www.nzno.org.nz/LinkClick.aspx?fileticket=s8btvTGtiFk%3D&portalid=0

[7] NZ Health Survey 2016/17. https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey

[8] K Davis, S Stremikis, et al. *Mirror, Mirror on the Wall: How the performance of the US health care system compares internationally,* Commonwealth Fund, June 2014. Updated 2017. http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017

[9] Bagshaw P, Bagshaw S, Frampton C, Gauld R, Green T, Harris C, et al. Pilot study of methods for assessing unmet secondary health care need in New Zealand. *New Zealand Medical Journal*. 2017; 130(1452):23–38. https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1452-24-march-2017/7193

[10] UNICEF**.** *Building the Future: Children and the Sustainable Development Goals in Rich Countries*. Innocenti Report Card 14: Children in the Developed World**.** https://www.unicef-irc.org/publications/890-building-the-future-children-and-the-sustainable-development-goals-in-rich-countries.html

[11] NZ Health Survey 2016/17.

[12] Hon G Robertson. Response to Parliamentary Oral Question No. 1, 29 November 2017. Hansard, 2017.

[13] Ministry of Health. Information received under the Official Information Act, 9 March 2018.

[14] Ministry of Health. Schedule 3: DHB Provider Arm Financial Performance for the period ending 30 June 2017 (audited).