NEW ZEALAND COUNCIL OF TRADE UNIONS
Te Kauae Kaimahi

Working Paper on Health

Number 10, 30 May 2013

Did the 2013 Budget provide enough for Health?

Bill Rosenberg, Policy Director/Economist, NZCTU Te Kauae Kaimahi

Contents

Summary

The following are the main conclusions of a comparison of the 2013 Budget with the analysis the CTU carried out prior to the Budget[1] which found that $445 million was required to just keep operational expenditure up with rising costs, population growth, and ageing.

- The Health Vote in the 2013 Budget was an estimated $238 million behind what is needed to cover announced new services, increasing costs, population growth and the effects of an ageing population.
- While the Budget listed services that will receive more funding, these come at the cost of cuts in other services.
- District Health Boards (DHBs) are underfunded by an estimated $111 million.
- Centrally managed national services such as Child Health Services, Emergency Services, Māori Health Services and Public Health services received $123 million below what they needed.
- The Ministry of Health itself was underfunded by $4 million.

[1] "How much funding is needed in Budget 2013 to avoid the condition of the Health System worsening?" by Bill Rosenberg, Working Paper on Health No. 9, 15 May 2013. Available at http://union.org.nz/news/2013/health-budget-track-100m-shortfall.

The analysis the CTU carried out prior to the Budget assumed that CPI would rise by 1.8 percent in the year to June 2014, wages would increase by 1.8 percent (1.6 percent in the DHBs), and an increase of 1.42 percent for the growing and ageing population. See the report on that analysis for further details.

Treasury's Budget forecast of inflation in the year to June 2014 is 1.9 percent compared to our estimate of 1.8 percent. That would increase the shortfall from $238 million to $243 million.

How much did the Health Vote increase?

The Health Vote increased by only $298 million in operational funding overall between Budget 2012 and Budget 2013 (from $13,836 million to $14,135 million). This is $146 million short of the $445 million required just to keep up with costs without providing for new and improved health services. However the Budget in addition provided for $91 million in "new policy initiatives" in 2013/14[2], bringing the total needed to $536 million. The total shortfall is therefore $238 million. If the Treasury inflation forecast is used, the shortfall increases by $5 million to $243 million.

This was offset by "savings" totalling $39 million including $22.6 million that are not explained, plus reductions in the provision for DHB deficits ($5.0 million) and for risks such as epidemics or natural disasters ($11.9 million). We can only assume that those among the $22.6 million, because they are not identified, come largely from reductions in service or pressures for as yet unknown additional user charges. The reduction in provision for risk is essentially an accounting entry: if those risks become a reality, the funding will have to be found from somewhere in the government's finances even if it is not provided for in Health. It can be best read as an intention to first tell Health to find the money by stopping spending on something else.

The reduction in funding for DHB deficits responds to their reduced deficits, but those in turn represent increased pressures on the DHBs which do not appear as a funding reduction but have a similar effect. The Ministry of Health lists among "Cost Pressures and New Initiatives", $30 million per year in deficit reduction[3]. The Minister of Health in one of his Budget media statements[4] said that "Prudent management of the health budget, including DHBs reducing their deficits from $150 million four years ago to around $25 million (excluding Canterbury), has allowed the Government to invest more money into new health initiatives." Perhaps the money went into "new health initiatives", but it was money the DHBs formerly had available to them. "Prudence" has taken the form of significant pressure on DHBs to conform. For example, Professor Don Matheson of the Centre for Public Health Research at Massey University has investigated the deficit reduction process in the Capital and Coast DHB, concluding contributions from within the DHB to cutting the deficit "appear to have been made in response to the financial situation without any prior analysis of different strategic options to tackle the deficit, which

[2] "Health Sector – Information supporting the estimates 2013/14", p.11-13, excluding $250 million for DHB Cost Pressures and Demographics, and a further $38 million in similar provisions identifiable in National Disability Support Services, National Elective Services, Public Health Services Purchasing. The document is available at http://www.treasury.govt.nz/budget/2013/ise/v6/.

[3] Vote Health Four-year Budget Plan, 8 February 2011 (dated 6 June 2012 in footers), p.6. Available at http://www.treasury.govt.nz/publications/informationreleases/budget/2012/pdfs/b12-2265841.pdf.

[4] "Health receives the largest Budget increase", Tony Ryall, 16 May 2013, available at http://www.beehive.govt.nz/release/health-receives-largest-budget-increase.

limited thinking about the system as a whole"[5]. The DHB "became increasingly focused on the Minister of Health's targets" with negative consequences for both equity and efficiency.

As we remarked last year, "savings" appear to be increasingly difficult to find: the $39 million in the 2013 Budget is less than the $47 million last year which in turn was less than half the $109 million listed in the 2011 Budget.

District Health Boards

Health services provided or funded through DHBs gained an apparent $285 million in funding in the Budget (from $10,819 million to $11,104 million). However the Minister announced this as an increase of $250 million, which is what the DHBs had been told several months prior to the Budget. The difference appears to be a result of a transfer of responsibility for $35.1 million in vaccine funding from the national Public Health Service Purchasing appropriation to the DHBs during the 2012/13 financial year. So while their funding appears to have increased by $35 million, so have their costs. While the $250 million is described as a "new policy initiative", it is in fact a "contribution to cost pressures" ($97 million) and for "demographics" ($153 million). It was a 22 percent reduction on last year when DHBs received $320 million for these purposes (though in fact they received less because they were expected to take the proceeds – and the risks – of the reduced expenditure from the rise in prescription charges and the reduced asset value threshold for support for people going into residential aged care).

The $250 million increase in the vote for the DHBs compares to the $351 million that we estimated that they needed just to cover increased costs, population and ageing. They are therefore underfunded by $101 million. However on top of that, they are expected to provide $9 million in the year towards "initiatives" announced by the Minister in Aged Care and Dementia, and in Cardiovascular Disease and Diabetes. Their total shortfall therefore comes to $111 million.

National services

The centrally managed national programmes such as Child Health Services, Emergency Services, Māori Health Services and Public Health, in total gained $12 million in operational funding (rising from $2,799 million to $2,811 million), which is $43 million below what is needed to stand still on cost, population and ageing pressures alone (after allowing for the transfer to DHBs of $35.1 million for vaccines noted above). In addition, however they have to pay for $81 million in "initiatives", bringing the total shortfall to $123 million. That is offset by $39 million in "savings" which we have described above. We cover this area in more detail below.

The Ministry, capital funding and the total appropriation

In addition, the Ministry of Health itself received $191 million which is just $0.2 million more than last year despite needing a $4 million increase to cover increased costs. The Ministry has had sharp cuts in its funding over several years: it received $217 million in the 2009 Budget for the year to June 2010 for example. Other operational expenses (international health organisations, legal expenses and provider

[5] "From Great to Good; how a leading New Zealand DHB lost its ability to focus on equity during a period of economic constraint", Don Matheson, 22 February 2013, p.15, available at http://www.hiirc.org.nz/page/38148/.

development) gained $1.1 million to $28.5 million, though the full increase went to Provider Development for Pacific Providers and the remaining areas received zero increase.

Capital funding rose sharply: from $289 million in Budget 2012 to $520 million in Budget 2013. However this is not necessarily an accurate guide to actual capital expenditure because approval is often obtained to convert unspent operational funding to capital for various purposes, and some is not spent. For example, in the year to June 2013, $289 million was originally budgeted, $554 million was provided after supplementary appropriations, but only an estimated $363 million will be spent.

The total Vote therefore rose from $14,125 million to $14,655 million or by $530 million between the 2012 and 2013 Budgets.

Effects on DHBs

The pressure on DHBs will lead to some combination of service deterioration, reductions in services, new or increased user charges and other forms of revenue, increased DHB deficits, or searching for new efficiencies and productivity improvements. It is difficult to document these responses systematically because DHBs have been unforthcoming with information, and many of the changes do not attract media attention because they may be individually small and affect parts of the population with little access to the media.

DHB plans to cope with the financial stringencies have tended to focus on their "funded" provision of medicines and services in the community rather than their "provided" services, largely in hospitals, which Government targets tend to focus on, whose actions are easier to identify and which affect influential sections of the population. There is a pattern of DHBs running their "provider" (largely hospital) operations at a deficit, and their "funder" operations at a surplus. The "funder" arms provide funding to a wide range of non-DHB services including aged care, community services, primary care, mental health and preventative health services. In other words, DHBs are spending more than budgeted on hospitals and less than budgeted on (broadly speaking) community health. Similarly Matheson, in the paper quoted above, noted that Capital and Coast DHB's "hospital sector expenditure grew relative to the primary health care sector" and that it had "shrinking 'purchasing power' over the primary health care sector... Although nominally in control of the sector, most of the decisions are being taken elsewhere."

DHB revenue-gathering activities may be rational from their own viewpoints but win-lose from a national viewpoint. One city-based DHB for example was looking to gather more revenue from sharpening up its administration on its provider side to make more claims to ACC and the Ministry of Health, and to ensure it charged its services to other DHBs wherever possible. It was also looking at encouraging more private use of its facilities to increase revenue, decreasing outsourcing of services to reduce costs, and some genuine increases in efficiency such as by reducing waste and improving procurement practices. Staffing cuts and use of lower skilled staff were also under consideration. In its funded services it was looking at discontinuing services it was not required to provide, reducing funding for services which had not used their funding in the past (including in Māori and Pacific health), reductions in above-base funding to Primary Healthcare Organisations which increased access to services and recovery of more costs from them, widespread reviews of contracts with private and community providers to transfer the financial

pressure onto them, and service reviews. On the positive side it was looking at programmes to improve prescribing practices.

We have previously noted news media reports of cuts and deterioration in services in a large number of areas including home help for the elderly and sick, residential care for the elderly, eye operations, services for mental health and addictions, community health services, public health, hospital care, cancer treatment, primary health organisations and GPs, and diabetes services. There are growing concerns from providers, clinicians, caregivers, health professional associations, unions and independent observers at the low wages and lack of training in residential care services[6], which both provide essential care to elderly and disabled people and potentially reduce the use of costly hospital services.

Services providing low cost access to high need populations have faced funding cuts and may be unable to continue to provide the needed service. Examples are the Newtown Union Health Service and the Hutt Union and Community Health Service whose patients include refugees, state and council housing residents and which have experienced severe funding cuts resulting in staffing and service reductions. User charges cannot be increased because of the low incomes of their patients[7]. An Auckland primary health care group, ProCare, complained in June 2012 that it would have to start charging for sexual health consultations in central Auckland for people under 22 years old because the Auckland DHB had cut funding to other than young Maori and Pacific people, and those who live in the poorest fifth of localities[8]. In November 2012 a report to the Capital and Coast DHB identified poor dental health as being "the biggest cause of avoidable hospital admissions for young children in the Wellington region". Dental health for children is the responsibility of the DHBs. There was an increase in children not having free scheduled dental examinations on time[9]. Added pressure on DHB funding is likely to worsen the situation which will tend to increase the use of more expensive hospital services as a result of lower cost early intervention primary health services being under-resourced.

Stresses are also indicated in a recent case where the major private mental health provider, Richmond Services, ordered its staff to overstate the hours they spent with clients in order to avoid returning public funds adds to the picture of stress in these contracted care sectors. Former staff, including one who resigned over client care standards, said "staff were overstretched and clients neglected"[10].

We have also noted reports of staff shortages and cuts in hospitals including in the Waikato[11], Northland, and Auckland DHBs[12]. In our pre-Budget report we pointed out a blow-out in provision of hospital staff provided through agencies (called "outsourced services" in the DHB accounts) in the year to June 2012,

---

[6] E.g. "Caring counts: Report of the Inquiry into the Aged Care Workforce", Human Rights Commission, May 2012, available at http://www.hrc.co.nz/eeo/caring-counts-report-of-the-inquiry-into-the-aged-care-workforce; "Disability carers face training woes", Sunday Star Times, 17 June 2012, p.A9, available at http://www.stuff.co.nz/national/health/7116635/Disability-carers-face-training-woes.

[7] "Newtown midwives made redundant", by Bronwyn Torrie, *Dominion Post*, 1 October 2012.

[8] "Fears for youth as free sex advice cut", by Martin Johnston, *New Zealand Herald*, 18 June 2012, p.A5.

[9] "Dental woes putting kids in hospital", by Bronwyn Torrie, *Dominion Post*, 7 November 2012, p. A3.

[10] "Mental health workers 'falsified hours'", by Ben Heather, *Sunday Star Times,* 31 March 2013, p.A7, available at http://www.stuff.co.nz/national/health/8491242/Mental-health-workers-falsified-hours.

[11] Waikato DHB, Memorandum to All Staff from Craig Climo, 22 May 2012: "Financial outlook for 2012-13 and beyond".

[12] "Nurses forced to supply own thermometers", *Sunday Star Times*, 3 June 2012, p.A6, available at http://www.stuff.co.nz/national/health/7036222/Nurses-forced-to-supply-own-thermometers.

suggesting stress in staffing levels (probably mainly in nursing) in the DHBs. The Association of Salaried Medical Specialists, representing senior doctors in the hospitals, has become increasingly concerned at their staffing levels and retention of existing staff, warning that it may lead to service reductions and concerns as to safety[13]. Similarly the New Zealand Nurses Organisation in its biennial employment survey has reported significant loss of nursing leadership positions and increases in workload and patient acuity in the face of continuing restructuring and fiscal restraint[14].

However pressures on different DHBs will not be identical. They have different cost structures and face somewhat different demographic pressures. Some need to pay other DHBs for services; for others a significant proportion of their services are funded by other DHBs; both are faced with the unders and overs of nationally set prices for such services.

Effect on national services

The Budget documents for Health itemise new or increased levels of national services worth $81 million. Given that not even increases in costs and population are fully covered by the increase in the Vote, the cost of these items must be met by stopping or reducing other services, increasing user charges, or productivity improvements. Some of this is achieved through a $39 million saving described above which occurs in the Health Services Funding appropriation[15].

There has been restructuring of these appropriations during the year. In the new financial year there is a new "national service" called "National Personal Health Services". During the current (2012/13) financial year, it was created with $71.3 million from National Contracted Services – Other, which had a total of $97.6 million moved from it to Monitoring and Protecting Health and Disability Consumer Interests ($13.0 million), National Mental Health Services ($4.5 million) and Public Health Service Purchasing ($8.9 million). In addition, as noted above, Public Health had $35.1 million devolved to the DHBs for vaccines.

All of the sixteen national services except Health Workforce Training and Development, National Contracted Services – Other, National Personal Health Services, and Problem Gambling Services have been underfunded for existing cost pressures and the additional "initiatives" expected of them. The table below summarises the situation. However, it should be borne in mind that while our methodology is a reasonable approximation for the Health Vote as a whole and for substantial subsections of it, at increasing levels of detail there are special circumstances such as one-off costs or other changes between appropriations that cannot be taken into account.

---

[13] "Entrenched public hospital specialist shortages becoming increasingly unsafe", 3 February 2013, Ian Powell, ASMS, available at http://asms.org.nz/Site/News/Media_Statements_2013/03_Feb_2013.aspx

[14] "NZNO Biennial Employment Survey 2013: Our Nursing Workforce: 'For Close Observation'", L. Walker and J. Clendon (in press).

[15] This appropriation covers several purposes including providing for risks (such as natural disasters or epidemics, and DHB deficits), DHB pay settlements, and Ministerial initiatives not defined at Budget time. Unspent money is often used to fund Ministerial initiatives, converted to capital for various purposes or rolled forward into the next year. Treasury commented in 2010 that "the majority of risk reserve provisioning over the last two years has been used (or requested) for new initiatives, not for alleviating or managing risk within Vote Health" and recommended that the Minister not be allowed to request additional funding from the general contingency fund during the year unless he had first used up the risk reserve and found further savings in the Health Vote ("Treasury Report: Vote Health Budget 2011 Package", report number T2010/2278, p.12, 14, available at http://www.treasury.govt.nz/downloads/pdfs/b11-1948935.pdf).

National Services 2013/14

Comparison of funding required to meet cost and population pressures compared to actual appropriation, additional spending and "savings"

Shortfalls are in red italics (positive); funding exceeding cost pressures is in black (negative).

Note caveats in the text.

	Required	Appropriation	*Shortfall* on costs	Initiatives	*Shortfall* after initiatives	"Savings" identified
			$000			
Health Services Funding	120,540	90,222	*30,318*	0	*30,318*	-39,437
Health Workforce Training & Development	172,550	173,495	-945	0	-945	0
Monitoring and Protecting Health and Disability Consumer Interests	27,629	26,596	*1,033*	750	*1,783*	0
National Advisory and Support Services	347	340	*7*	0	*7*	0
National Child Health Services	85,920	80,482	*5,438*	3,118	*8,556*	0
National Contracted Services - Other	14,918	28,846	-13,928	0	-13,928	0
National Disability Support Services	1,088,968	1,103,234	-14,266	23,300	*9,034*	0
National Elective Services	283,954	277,406	*6,548*	12,000	*18,548*	0
National Emergency Services	93,339	93,009	*330*	2,509	*2,839*	0
National Māori Health Services	7,897	7,635	*262*	0	*262*	0
National Maternity Services	148,012	144,212	*3,800*	0	*3,800*	0
National Mental Health Services	69,077	59,927	*9,150*	3,998	*13,148*	0
National Personal Health Services	73,695	93,921	-20,226	13,813	-6,413	0
Primary Health Care Strategy	181,992	178,936	*3,056*	6,450	*9,506*	0
Problem Gambling Services	17,534	17,739	-205	0	-205	0
Public Health Service Purchasing	465,528	434,559	*30,969*	15,363	*46,332*	0
Totals	**2,851,900**	**2,810,559**	***41,341***	**81,301**	***122,642***	**-39,437**

National Disability Support Services, which also appeared underfunded in the last two years, continues to show signs of being under pressure. While it is never easy to draw a clear connection between financial pressures and service failures, recent serious cases of repeated abuse of disabled people in residential care, which have aroused widespread public concern and a call by the Disability Rights Commissioner Paul Gibson for a new oversight body[16], must lead to questions as to whether the Ministry of Health has adequate capacity to properly monitor the growing private provision of services to vulnerable people, and is doing so.

The $23,300 in "initiatives" in Disability Support Services consists of $0.3 million for the "Enabling Good Lives" programme and $23.0 million for family carers of disabled adults ("Family Care Givers" in the Budget documents). The latter is the Government response to a Court of Appeal decision that family carers of disabled adults are entitled to payments to remove discrimination against them. This response has been highly controversial for two reasons. The legislation for it was passed with urgency along with other Budget legislation and included an unprecedented provision preventing any challenge to

[16] "Abuse leads to call for overhaul of services for disabled", by Kirsty Johnston, *Dominion Post*, 25 May 2013, p.A6.

government policy on eligibility to the funding on the grounds that it remained discriminatory, through the courts or Human Rights Commission. Carers were also disappointed at the level of funding itself. Commenting on the Court decision in June 2012, the Minister stated that, depending on Government decisions on eligibility, the cost could be anywhere between $17 million and $593 million[17]. The Government has capped it at the bottom of the range, ensuring that the minimum number of carers can access this funding, and at a very low level of payment.

Also in the National Disability Support Services appropriation was a $12.0 million provision for the Sleepover case which found that carers providing mental health and disabilities 24 hour care should be paid at least the minimum wage. In the next three years it reduces to $10.0 million per year. In 2011, the Government announced that "it is committing $27.5m to assist Crown funded employers in the health and disability sector to settle valid back wage claims and up to $90m over three years to support employers phase in the minimum wage for employees who work sleepovers"[18]. The provision made appears considerably less than this.

Other pressures

Private health insurers are complaining about declining numbers of people covered by private health insurance – and particularly comprehensive insurance – as a result of rapidly rising premiums and the economic situation. The insurers' industry body, the Health Funds Association, says the number of people covered by private health insurance has fallen by 3 percent or 45,000 people since 2009. This means the pressures on the public system could be rising faster than population increases indicate. In addition, private insurers are facing rapidly rising costs. Premiums rose 5.3 percent in the 2012 calendar year, with claims up at the same rate[19]. This suggests that the cost pressures on the public health system may well be underestimated by the CPI plus age-adjusted population increases. An increasing response by insurers is to offer limited cover insurance, and to limit client choice by requiring them to use specified service providers which are contracted to provide health services (such as elective surgery) at a lower cost. This will further accentuate the long-existing situation of leaving more costly and complex procedures and treatments to the public health system.

Cuts in ACC entitlements and tougher attitudes to applying the rules governing those entitlements have contributed to lowering ACC claims costs, but are also likely to have moved further costs onto health services.

[17] "50,000 families with disabled adult children eligible for claims", Vernon Small, *Dominion Post*, 13 June 2012, p.A4, available at http://www.stuff.co.nz/dominion-post/news/7091961/50-000-families-with-disabled-adult-children-elig.

[18] "Sleepover Wages (Settlement) Bill passed", Tony Ryall, 6 October 2011, available at http://www.beehive.govt.nz/release/sleepover-wages-settlement-bill-passed.

[19] "Health insurance industry picks up", Eloise Gibson, Dominion Post, 12 February 2013, p.B7.