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How much funding is needed in Budget 2014 to avoid the condition of the Health System worsening?

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Summary

- In total, the operational expenses portion of the Health vote will need to rise by 3.5 percent or $499 million from $14,135 million to $14,633 million to maintain the current levels of service. The $499 million is simply to keep up with population and cost increases. To provide for additional services and new treatments and allow for productivity at the rates suggested by Treasury would require 4.7 percent or $670 million, taking the total to $14,805 million.

- The DHBs' combined budget will need to rise from $11,104 million to $11,503 million, requiring an increase of $399 million or 3.6 percent to maintain the current level of DHB services. Allowing for reasonable additions to services and new treatments plus productivity increases would require DHB funding of $11,640 million, an increase of 4.8 percent or $536 million.

- Last year, Vote Health's operational funding increased $298 million on the previous year's Budget. DHBs received $250 million of the new funding. If that occurred again this year, it would be $149 million short for DHBs and $201 million for the whole vote, or $372 million taking new services and productivity into account.

- We estimated a total shortfall of $220 million for the 2010 and 2011 Budgets, which was very similar to the Ministry of Health's estimate. However, the Ministry's estimated shortfalls for the 2012 Budget ($376 million) and the 2013 Budget ($343 million) - which had to be met by cuts and efficiencies – were substantially higher than ours. This means that the DHBs and national health services are starting the new financial year considerably behind where they were one to three years ago.

- The appropriation for national health services other than the DHBs (which are funded directly by the Ministry) will need to rise 3.4 percent or $96 million to maintain service levels, taking it from $2,811 million to $2,906 million. With the above allowance for additional services, new treatments and productivity increases, an additional 4.6% or $130 million would be required, a total of $2,941 million.

- Funding for the Ministry of Health will need to rise from $191 million to $195 million.

- If the full amount is not funded, New Zealanders will face some combination of deterioration of services, inability to access new treatments and more or increased user charges.

Background

The health system needs more money each year just to maintain its current standards and services: the population increases and ages and general costs rise, pharmaceutical and salary costs rise. If we want improvements in the health system, to make use of new treatments and technology if they are more expensive, or to address existing problems such as persistent deficits in District Health Boards (DHBs) and loss of some services, further increases in funding are required over and above these. The following estimates a baseline of what is needed in the Health vote[1] in the Budget on 15 May 2014 to maintain the status quo so that the public can judge whether increases in funding are sufficient to make real improvements in their health services, or whether services are likely to deteriorate.

In the last four years, we carried out a similar analysis for the Budgets in those years. Our estimate of the increase needed simply to keep up with costs and inflation was within 1 percent of that provided by the Ministry of Health in 2010 and 2 percent in 2011 (we estimated that $564 million was required, compared with the Ministry's estimate of $576 million).

In 2012 we estimated $506 million was needed before providing for extra treatments and $573 million after allowing for those. The Ministry of Health[2] however estimated the total "pressures" to be $692.2 million, or $726.2 million after new initiatives, compared to $350 million provided. Their 2013 estimate was also higher than ours. Their estimate was that the total shortfall for the four years to 2015/16 would be $1.8 billion, consisting of $2.9 billion in "pressures" offset by a planned $1.1 billion in additional funding if it was cut from $350 million to $250 million per year from

[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.

[2] Source: 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.

2013/14, which is close to what has happened. (Similar information for Budget 2013 has been suppressed from the documents released.)

Our estimates are therefore conservative: they tend to underestimate the needs of Vote Health. Our methodology this year is similar to last year, but it is important to emphasise that even the increases that we indicate are the minimum required to "stand still" would leave the Health system with significant underfunding compared to community needs from both the current year and from accumulated underfunding over several years.

Assumptions

Our findings are based on a number of assumptions. Sensitivity to other assumptions is tested below.

We assume a rise in the CPI of 2.1 percent in the year to June 2015 (the Budget period), which is the NZIER consensus mean forecast for the year to March 2015. The Reserve Bank forecasted 1.9 percent in the year to March 2014 and 1.9 percent to June 2015 in its March 2014 Monetary Policy Statement, while Treasury forecasted 2.4 percent percent for the year to March 2015 and 2.0 percent in the year to June 2015 in the December 2013 Half Year Economic and Fiscal Update (HYEFU).

For wages we have treated DHB "provider" activities (largely hospitals) and "funder" activities (services a DHB funds but does not provide itself) slightly differently. For DHBs, many of the general increases in wages and salaries have been settled in collective employment agreement negotiations. Though we do not have complete information and it is difficult to estimate changes due to staff turnover and performance, we have estimated an increase of 1.5 percent for medical salaries (including both senior and junior doctors), 1.5 percent for nursing salaries, and 1.6 percent for others. Note that these increases are significantly below forecast CPI inflation and are at a time when there are expectations of increasing wage pressures. For staff in the funded services we assume the Reserve Bank's forecast for the increase in the Labour Cost Index (LCI) for the year to March 2015 of 2.1 percent.

In 2013 Budget papers, the Ministry of Health describes "the Government's expectations for Pay and Employment Conditions in the State Sector" as resulting in the DHBs imposing a maximum 1.5 percent "Annual Cost of Settlement". The above wage and salary estimated increases, though not for the same years as this policy, are within that limit. Given that average wage increases in the work force generally are of the order of 2.5 to 3 percent, and the Ministry notes pressures resulting from the need to recruit internationally, with skill shortages in a number of areas and high turnover and growing demand for aged care workers, it is unlikely that this is sustainable.[3]

Wages and salaries are assumed to be 62.5 percent of expenditure, based on DHB provider arm data. For DHBs, this includes 19 percentage points for medical staff, 24 percentage points for nursing staff and 20 percentage points for other staff, according to DHB consolidated accounts for the year

[3] Vote Health Four-Year Plan 2013-14 to 2016-17, 20 December 2012, pp. 16, 17, 55, available at http://www.treasury.govt.nz/downloads/pdfs/b13-info/b13-2659847.pdf

ended June 2013. Medical staff costs represent 11 percent of total DHB expenditure and nursing staff 13 percent.

We note but do not specifically account for the fact that staffing is also provided through agencies (called "outsourced services" in the DHB accounts). In both the years to June 2012 and June 2013 this accounted for 6.2 percent of DHB expenditure – equivalent to 10 percent of the personnel costs. These are higher than the 2011 year, suggesting stress in staffing levels in the DHBs.

Population growth is a significant driver of health costs. We assume an increase of 1.64 percent during the year, provided by the Ministry of Health, which includes both an increase in the population and the increased expenditure requirements due to the ageing of the population. For simplicity we refer to this as the "population increase" factor in the following. (The Ministry notes New Zealand Institute for Economic Research estimates that demand growth will be significantly higher than the Ministry's population based estimate.[4]) Other population changes are estimated by using recent Statistics New Zealand's national population estimates and births data: a 2.0 percent decrease for births, and a 0.2 percent decrease for children (0-14 year olds). This compares with falls in live births of 4.0 percent in the year to December 2013 and 0.4 percent the previous year, and in the number of 0-14 year olds of 0.2 percent in the year to December 2012 June 2013 and the previous year.

Savings are being sought through Health Benefits Ltd (HBL). Its Statement of Intent 2013/14-2015/16, updated in June 2013, showed actual savings of $55 million in 2010/11, $60 million in 2011/1 and $99 million in 2012/13. These however do not take account of costs required to make the savings which totalled $58 million for the three years to 2012/13.

It forecasts further gross savings, including savings made by DHBs independent of HBL's programme, of $144 million in 2013/14 ($68 million less than previously forecast), $165 million in 2014/15 and $241 million in 2015/16. Total operating and capital costs are estimated at $66 million in 2013/14, $57 million in 2014/15 and $67 million in 2015/16.

The facts that these are still forecasts, that costs are significant and that projects are taking considerably longer than projected to go out for proposals, let alone implementation, cast considerable uncertainty over them. In addition, DHBs are concerned as to where the costs will fall and whether they will see the benefits of the savings or whether they will be taken away in reductions in their appropriations (as has occurred with a Pharmac pharmaceutical saving). While in the overall picture that may well be attractive to the government, it would not offer relief to DHB budgets or incentivise them to participate in HBL's national procurement arrangements. In addition, a recent media report indicated South Island DHBs would actually be paying more under HBL's plans for changes to DHBs' finance, procurement and supply chains (FPSC) in order for North Island DHBs to pay less.[5]

[4] Vote Health Four-Year Plan 2013-14 to 2016-17, 20 December 2012, p. 13, available at http://www.treasury.govt.nz/downloads/pdfs/b13-info/b13-2659847.pdf

[5] "Reforms will 'harm CDHB'," *The Press*, 3 May 2014.

Further, the Auditor General has observed[6] that at least one of the more ambitious proposals "involves significant change for the sector", including "changes in staff responsibilities, organisational capability, financial or procurement processes, accounting and reporting, and relationships with suppliers" with consequent on-going risks. The Audit General commented that "the reporting of savings is based on (unaudited) returns that DHBs submit to HBL", that "these savings have not been the subject of any quality assurance review by HBL" and recommended improvements in the way HBL collected and verified the savings. The Auditor General raised the same matter in a more recent report, which was also critical of the Ministry of Health and DHBs for a lack of information on costs and intended savings relating to regional services planning.[7]

Given all these risks, costs and uncertainties, rather than factor the savings into our estimates, we simply state the potential savings.

Findings

In the 2013 Budget, the Health vote amounted to $14,135 million for operational expenses, plus $520 million for capital expenditure, a total of $14,655 million.

Of that, $191 million was for the operation of the Ministry of Health, and a further $28 million was for "other" expenses such as New Zealand's membership of the World Health Organisation. We assume these will need an increase in funding as a result of inflation of 2.1 percent, and, for all but the International Health Organisations membership, increased wage costs, taking them to $195 million and $29 million respectively.

The biggest portion of the Health vote was $11,104 million to fund District Health Boards (DHBs) and $2,811 million to fund national health programmes such as provision of clinical training, disability support, public health (such as anti-smoking, healthy eating and immunisation campaigns) and other national health services.

Hospital funding is the responsibility of the DHBs, and a significant pressure on hospital costs can be salaries of health professionals. However there was less pressure from wage and salary increases in the last two years and as noted above they appear to be contained in the coming year, though this is unlikely to be sustainable. We estimate that they will rise only 1.5 percent overall, which is less than our estimated CPI increase and a little less than last year and the previous year. Other costs are assumed, in line with standard health funding formulas, to rise by CPI (2.1 percent).

Services provided directly by DHBs (mainly hospitals) take approximately 55 percent of their funding. The remainder is used to fund a wide range of other services. We base our cost increases for these on labour costs increasing by 2.1 percent. We note however that there has been a history of very low wage increases in some of these services, for example as documented in the investigation into employment equity in aged care by the Equal Employment Opportunities Commissioner, Dr Judy

[6] "Health sector: Results of the 2011/12 audits", Office of the Auditor-General, April 2013, p.40-41, available at http://www.oag.govt.nz/reports/health

[7] "Regional Services Planning in the Health Sector", Office of the Auditor-General, November 2013, available at: http://www.oag.govt.nz/reports/health

McGregor.[8] This is likely to be contributing to the high turnover noted above. The matter is an ingredient in the current breakdown in negotiations between the Aged Care Association and government on contracts for residential care provision; an Equal Pay case before the courts relating to workers in this sector may also force pay rises; and there are discussions regarding payment to carers for the extensive time some are required to spend in travel to and from home-based clients. Other costs are assumed to increase 2.1 percent.

Labour costs in the whole funded Health sector are estimated to rise 1.8 percent on average. On top of these cost increases we apply the 1.64 percent population increase noted above.

This would take the DHBs' combined budget from $11,104 million to $11,503 million, requiring an increase of $399 million or 3.6 percent which needs to be met in the 2014 Budget to maintain the current level of DHB services for each New Zealander.

However there is also a demand for new services and treatments, which Ministers respond to. In its long-term projections, Treasury made a 1.5 percent allowance for this[9]. We can also factor in an expectation of productivity increases which offset needs for increased funding. Treasury allowed for a 0.3 percent productivity increase. Together these give an indication of an expected increase required of the Health budget which would take the DHBs' combined budget requirement to $11,640 million, an increase of 4.8 percent or $536 million.

For national health services other than the DHBs which are funded directly by the Ministry, we assume that, in the main, labour costs will rise by 2.1 percent and other costs at the rate of CPI (2.1 percent) and that in most cases, the population increase (1.64 percent) will require a further increase in their funding. We estimate that the total appropriation for these services will need to rise 3.4 percent or $96 million to maintain service levels, taking it from $2,811 million to $2,906 million. With the above allowance for additional services and productivity increases, an additional 4.6 percent or $130 million would be required, a total of $2,941 million.

It should be recalled however that we estimated that DHBs were $111 million short of their needs in Budget 2010. In Budget 2011, movements between the DHB and national health service funds made it difficult to estimate the exact effect on the DHBs, but the DHBs and the national health services together received $108 million less than their needs. The corresponding shortfall in 2010 was $120 million. We estimated the shortfall in Budget 2012 to be $88 million and the Ministry of Health estimate was considerably more. In 2013 we estimated the DHB and national services' shortfall to be $234 million and, again, the Ministry's estimate was considerably more. This means that the DHBs and national health services are starting the new financial year considerably behind where they were one to four years ago.

Budget papers from 2013 describe the public health system's situation as very challenging. A Treasury assessment says: "Departments were asked to identify savings options equivalent to 5% of current expenditure in their plans – which may have been an inappropriately high target for Vote

[8] "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.

[9] Called "non-demographically-driven growth". See "Health Projections and Policy Options: Background paper for the 2013 statement on the long term fiscal position", July 2013, p.20.

Health." It states that significant change is needed in the sector to achieve the savings and priorities the Government is expecting, with "considerable savings" required in future Budgets, and this may be difficult to achieve: "Given the complexity and scale of change required to achieve these and Government's expectations / priorities will require considerable sector support and careful management of resources and costs over the four year period."

> Sustainability of the health system is described as requiring service model changes and productivity/efficiency gains over the four year period that are far larger than those achieved to date. Much of DHBs' success in managing costs to date has been through labour cost constraint, more "passive" savings (eg: lower interest costs, Pharmac savings from patent expiry, exchange rate appreciation), and procurement initiatives (eg HBL) rather than through business model changes of the kind the 4YP [Four Year Plan] says will be required in future. Our view is that more ambitious savings options may need to be pursued to reduce risks (eg more targeted services and funding, accelerated implementation of HBL shared service initiatives, faster moves to regional-level service management).[10]

This was toned down a little in a letter from the State Services Commission and Treasury to the Chief Executive of the Ministry, but it is clear that future savings will be very hard to find[11].

Other Budget 2013 documents showed that the Minister of Health was under pressure not to continue to promise unfunded additional services: "We understand the Minister of Health has signalled that Budget 2013 is likely to see much less in the way of unfunded additional services expected of DHBs, allowing DHBs to focus on managing their current cost pressures within available resources."[12] In the event, such additional services still were part of Budget 2013, and as we have repeatedly noted, were forcing "savings" additional to those resulting from rising costs.

They warn that "new capital builds are more likely to result in large deficits for DHBs".

In total, the operational expenses portion of the Health vote will need to rise by 3.5 percent or $499 million from $14,135 million to $14,634 million to maintain the current levels of service. To provide for additional services and allow for productivity at the rates suggested by Treasury would require 4.7 percent or $670 million, taking the total to $14,805 million. Of that, $216 million allows for new treatments, rather than them being paid from spending cuts or increased user charges elsewhere. The productivity increases saves $44 million from that.

The $499 million is simply to keep up with population and cost increases (though it does not allow for significant recognition of improved performance, skills or experience of existing staff).

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[10] "Four Year Plan – Assessment and recommendation on final four-year plans submitted by Ministers to MoF and MoSS", p.4-5, available at http://www.treasury.govt.nz/downloads/pdfs/b13-info/b13-2564298.pdf.

[11] "Letter on final Four Year Plan to CE of MoH", 22 March 2013, available at http://www.treasury.govt.nz/downloads/pdfs/b13-info/b13-2595685.pdf.

[12] "Aide Memoire on four-year plans for Health, Education, Social Development to MoF, AssMoF, MoSS", Treasury, 11 December 2012, p.6, available at http://www.treasury.govt.nz/downloads/pdfs/b13-info/b13-2505130.pdf.

If the full amount is not funded, New Zealanders will face some combination of deterioration of services, inability to access new treatments and more or increased user charges. Further services may be "devolved" from public hospitals to private providers such as private hospitals, GPs and medical testing services. Past experience indicates that initially these may be fully subsidised but over time tend to incur part charges and may not be available in some areas. Community services including home help for the elderly, mental health services and support for primary health care in low income areas have been cut in recent times. These pressures could be relieved by any genuine productivity gains, but to the extent that significant savings in the last three years were genuine productivity gains and not just cuts in services, such gains are showing themselves to be increasingly hard to find.

Last year, Vote Health's operational funding increased $298 million on the previous year's Vote announced at Budget time. DHBs received $250 million of the new funding. If that occurred again this year, it would be $149 million short for DHBs and $201 million for the whole vote, or $372 million taking new services and productivity into account. The actual shortfall will depend on where the expenditure reductions to fund new and expanded services will come from, and comes on top of constraints in previous years.

Estimating capital needs is more difficult as the drivers for it are less direct. Capital goods prices are rising slowly[13] so cost pressures alone would raise the $520 million capital funded in the 2013 Budget to $531 million.

Sensitivity to changes in assumptions

The results above are sensitive to varying degrees to the assumptions made.

A change of 1 percentage point in the increase in senior medical staff salaries makes a $12.1 million difference in the $670 million increased requirements. A change in nursing salary increases by 1 percentage point changes the increased requirements by $15.2 million. For other non-medical DHB staff, a change of 1 percentage point makes a $12.3 million difference. Changing the increase for all other staff by 1 percentage point makes a $51.1 million difference.

If other cost increases are 1 percentage point different (that is, the CPI increase is as low as 1.1 percent or as high as 3.1 percent), the additional requirement changes by $55 million.

A 0.1 percentage point change in the population assumptions makes a $13.9 million difference.

Without the 0.3 percent productivity improvement, the additional funding requirement would be $45 million; if it rose to 0.6 percent the funding requirement would reduce by $45 million.

[13] The Capital Goods Price Index in the year to December 2013 rose 2.0 percent.