NEW ZEALAND COUNCIL OF TRADE UNIONS
Te Kauae Kaimahi

Working Paper on Health

Number 14, 7 June 2015

Did the 2015 Budget provide enough for Health?

Bill Rosenberg, Policy Director/Economist, NZCTU Te Kauae Kaimahi
Lyndon Keene, Director of Policy and Research, Association of Salaried Medical Specialists

Contents

Summary 1
Did the Health Vote keep up with rising costs? 2
District Health Boards 3
National Services 3
Ministry of Health operational funding 4
Successive years of under-funding 5
The consequences of chronic underfunding 6
Reduced access to services 6
Negative impact on the health workforce 8

Summary

This analysis compares the 2015 Budget with the analysis the CTU carried out prior to the Budget, which found a conservatively estimated $629 million of additional funding was required to maintain current levels of services and pay for new initiatives announced by the Government prior to the Budget.

- The Health Vote in the 2015 Budget is an estimated $245 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, and new initiatives such as for hospice and palliative care services, and the move to enable children under 13 to have free access to primary health care, these will be paid for by cutting funding to other services.
- We estimate the accumulated funding shortfall in government health expenditure for 2015/16 compared to 2009/10 is more than $1 billion.
- Core government health expenditure is continuing to fall as a proportion of Gross Domestic Product (GDP).
- District Health Boards (DHBs) are underfunded by an estimated $133 million to cover increased costs and demographic changes, and to fund free after-hours access to primary care for children under 13.

- Centrally managed national services such as National Disability Support Services, National Elective Services, and Public Health services received $36 million below what they needed to cover cost increases and demographic changes, and $108 million short when the costs of additional services are included.
- The Ministry of Health itself was underfunded by $4.2 million.

This analysis and our pre-Budget analysis assumed that CPI would rise by 1.6 percent in the year to June 2016 (the same as Treasury's Budget forecast), wages would increase by 2.0 percent (the forecast Labour Cost Index rate), and allowed for an increase of 2.06 percent for the growing and ageing population. See the report on the pre-Budget analysis for further details.

Did the Health Vote keep up with rising costs?

The Health Vote's operational funding increased by only $377.8 million between Budget 2014 and Budget 2015 (from $14,442.5 million to a comparable $14,820.3 million[1]). This is $171.3 million short of the $549.1 million we estimated is needed just to keep up with costs without providing for new or improved health services. The Budget introduced some "new policy initiatives" costing a net $74.0 million in 2015/16, bringing the total needed to $623.1 million. The shortfall is therefore $245.3 million.

The Vote listed "new policy initiatives" totalling $406.3 million, but the bulk of that ($353.2 million) is simply partial recognition of cost and population increases and a continuation of the bowel cancer screening pilot, rather than new initiatives. This is offset by "savings" of $12.5 million, $9.8 million of which is identified as Pharmac savings and the remainder a shift of $2.7 million in funding for the 'Social Sector Trials' to the Social Development vote.

Risk reserves and provision for Ministerial initiatives totalling $35.8 million in last year's Budget have been withdrawn. These previously came from the Health Services Funding appropriation which provided "Funding to respond to emerging health sector risks, provision for DHB structural deficit support, and contingency funding for Government priority health policy initiatives." In other words, it allows the Minister to announce further initiatives during the year and is a contingency for emergencies and DHB deficits. The Budget estimates explain that the risk reserve "has been returned to the Crown as emerging risks in the health sector will now be assessed and funded from the centre on a case-by-case basis". Withdrawing this funding reduces the Ministry's ability to manage unexpected events during the year and reduces Ministerial spending discretion. This completes a trend for reductions in this reserve and reflects critical Treasury comments on its use by the previous Minister.

The Health Services Funding appropriation has been disestablished and the DHB deficit support component now has its own appropriation, but as capital. Deficit support has risen from $39.5 million in the 2014 Budget to $55 million in this year's Budget, an acknowledgement by the government of the increasing financial stress that DHBs are under.

[1] Operational funding provided in 2015/16 is $14,765.3 million but provisions for DHB deficits which in previous years came from operational expenses is now coming from capital. For comparability with 2014/15 we have included this amount of $55 million in National Services operational funding.

District Health Boards

Budget appropriations for DHBs are just $315.1 million more than in last year's Budget (increasing from $11,404.7 million to $11,719.8). This falls well short of the $445.8 million that we estimated they needed just to cover increased costs and demographic changes. However, $11.9 million of the $30 million allocated for the new policy of free primary care for under-13s is to come out of DHB budgets to pay for after-hours consultations and prescriptions. In addition there are savings from Pharmac of $9.8 million (which is earmarked specifically for disability support services in 2015/16). DHBs are therefore underfunded by a total $132.8 million.

We note also that the 2014 Budget estimates advised that while new policy initiatives have been shown against their original appropriation, or current equivalent, "subsequent changes may have been made to some of these initiatives by way of fiscally neutral transfers to other appropriations, devolution of funding to DHBs, or rephasing of the expenditure through expense transfers". Just what proportion of these additional services become the responsibility of the DHBs is not revealed, but it points to a practice of shifting, wholly or partly, the costs of new services to DHBs to absorb in future years.

National Services

The centrally managed national programmes such as National Mental Health Services, National Māori Health Services and National Electives Services gained just $63.3 million in operational funding (rising from $2,816.2 million to $2,879.5 million), which is $35.8 million below what is needed to maintain the status quo.

In addition the providers of these national services, which include non-government organisations and health agencies, as well as DHBs, have to provide new services costing $74.6 million. There is a small offset of $2.7 million in savings in National Mental Health Services due to the cost of the Social Sector Trials Extension being transferred to Vote Social Development. These national services are therefore underfunded by an estimated $107.7 million.

Following the Budget the Minister of Health announced that $28.8 million had been provided for four "social bond" privatisation programmes in Mental Health services, as pilots for further such programmes. Preparatory work for this was budgeted to cost $1.493 million in the year to June 2015 and a further $360,000 in each of the next two years, a total of $2.2 million. Social bond advocates, business lobby the New Zealand Initiative, say the programme's novelty is not that it is a form of privatisation as the Government is currently running a number of other privatisation programmes, but in that "investors help in choosing the non-governmental organisations" providing the services. The announcement met widespread opposition and concern from professionals and non-governmental organisations in the mental health sector.

The Budget saw just four genuinely new initiatives in 2015/16, all within the national service appropriations. Palliative Care Community Service Support gained $3.1 million and Hospice Community Palliative Care Services received $13.0 million (both are included in the National Contracted Services appropriation). "In-Between Travel" (National Disability Support Services) providing wages for travel time between clients for low paid home care workers, was allocated $14.0 million in addition to $24 million provided in last year's Budget. In addition, the free primary care for

under-13s policy received a nominal $30 million in 2015/16 though, as discussed above $11.9 million is to come from DHB appropriations.

The additional costs of these services, however, have been at the expense of other services. As in last year's Budget, those most hard-hit in 2015/16 include Public Health, Primary Health and Disability Support Services. The latter two have come off badly because their total budgets were not enough to maintain existing services, taking into account rising costs and population changes, let alone pay for the new initiatives discussed above.

Continuing successive years of budget increases, National Elective Services received a further $23 million in this year's Budget for more elective surgery. However, we estimate that to keep up with rising costs and demographic changes and provide the additional surgery, the National Electives Budget was short of $16.1 million. In order to keep up with the Government's elective surgery targets, DHBs will need to either take funds from other services or focus more on the less expensive procedures to make up the numbers, or both.

Cost of additional services and funding provided in the Budget ($000)

National Service	Required for rising costs and population	Appropria-tion	Shortfall on rising costs and population	"New Initiatives"	Shortfall after initiatives	Shortfall after "savings"
Health Services Funding*	78,281	55,000	23,281	0	23,281	23,281
Health Workforce Training and Development	176,930	174,250	2,680	0	2,680	2,680
Monitoring and Protecting Health and Disability Consumer Interests	27,598	27,096	502	0	502	502
National Advisory and Support Services	265	260	5	0	5	5
National Child Health Services	83,955	87,048	-3,093	0	-3,093	-3,093
National Contracted Services - Other	24,841	45,378	-20,537	16,100	-4,437	-4,437
National Disability Support Services	1,161,681	1,158,113	3,568	14,000	17,568	17,568
National Elective Services	309,589	316,512	-6,923	23,000	16,077	16,077
National Emergency Services	97,441	96,440	1,001	0	1,001	1,001
National Health Information Systems	12,639	14,887	-2,248	0	-2,248	-2,248
National Māori Health Services	7,597	7,308	289	0	289	289
National Maternity Services	146,892	146,767	125	0	125	125
National Mental Health Services	58,083	55,797	2,286	0	2,286	-440
National Personal Health Services	88,421	77,933	10,488	0	10,488	10,488
Primary Health Care Strategy	176,444	172,130	4,314	18,100	22,414	22,414
Problem Gambling Services	18,225	17,130	1,095	0	1,095	1,095
Public Health Service Purchasing	446,491	427,491	19,000	3,400	22,400	22,400
Totals	**2,915,372**	**2,879,540**	**35,832**	**74,600**	**110,432**	**107,706**

* This fund was disestablished in the 2015 Budget; the appropriation, which is now in Capital, is given for comparability.

Ministry of Health operational funding

The Ministry of Health received $192.4 million. We estimated it needed $196.6 million to cover increased costs. Its funding shortfall is therefore $4.2 million.

Like the rest of the health system, the Ministry of Health has seen funding cuts over successive years In the 2010 Budget it was allocated $216.3 million for 2010/11 (approximately $228 million in today's dollars). In this year's Budget it received $192 million – a real cut of $32 million (14 percent) since 2010/11.

The Ministry's role, as summarised on its website, is to lead and have overall responsibility for the management and development of New Zealand's health and disability system. More than ever, the changing and complex nature of the sector and the rapidly growing challenges it faces call for strong, innovative leadership, effective monitoring and evaluation of policies and health programmes, and high-quality intelligence gathering for evidence-based policy development, including strategies to reduce health demand, and improve population health and health equity. It is difficult to see how a ministry undergoing continuing budget cuts can fulfil its roles effectively and attract and retain the required expertise.

In contrast to the Ministry of Health's 14 percent cut in real funding, the Policy Advice and Support Services component of Vote Prime Minister and Cabinet increased by 50 percent from $17.1 million in 2015 dollars ($16.2 million actual) in 2010/11 to $25.5 million in 2015/16.

Successive years of under-funding

The funding shortfall in this year's Budget follows significant shortfalls in each Health Vote the CTU has analysed since the 2010 Budget. Data are not available to enable an accurate assessment of how much money has been saved over those years through genuine efficiencies and how much has been "saved" through service cuts and increases in user charges. With that qualification, taking into account the new services and claimed savings in each Budget, and actual expenses, CPI, population and average wage increases we estimate an accumulated funding shortfall in spending power of $0.8 billion between the 2009/10 and 2014/15 financial years. This year's funding shortfall would make that more than $1 billion.[2]

Another way of viewing the funding comparison over this period is to compare vote Health expenditure as a proportion of GDP. Figures provided in the Estimates show in 2009/10 vote Health operational expenses were 6.32 percent of GDP, which had dropped to 6.01 percent of GDP (forecast as $239.771 billion) by 2014/15 and is forecast to be 5.91 percent by 2015/16. For vote Health expenditure to match 6.32 percent of GDP in 2014/15, it would have needed a further $0.75 billion and on the Budget forecasts, a further $1.03 billion in 2015/16.

More widely, for core government health expenditure to match 6.72 percent of GDP in 2014/15, it would have needed a further $1.03 billion and $1.21 billion in 2015/16.[3]

It is often argued by Government that spending more on health would be at the expense of other government expenditure. However, Treasury's figures show that while core health expenditure has risen from 19.5 percent of core government expenditure in 2010/11 to 20.6 percent in 2014/15, the main reason has been that government expenditure as a whole has fallen as a proportion of GDP by more than 4 percent over that period – from 34.6 percent of GDP in 2010/11 to 30.5 percent in 2014/15.

[2] NZCTU Health Budget analyses are available at: http://union.org.nz/health-working-papers
[3] Treasury, *Budget Economic and Fiscal Update*, 21 May 2015.

The conclusion from this is that the Government's overall priority of reducing expenditure has led to a substantial funding shortfall for health services and an even great shortfall for combined other government services.

The consequences of chronic underfunding

The effects of year-on-year funding shortfalls of public health services are largely hidden from public view because they are not measured and reported. There are, however, clear signs of a health system that lacks the capacity to meet growing health needs; that is being forced to compromise on quality and effectiveness; and where the focus on cost-cutting is actually making services less cost-efficient.

Reduced access to services

Chronic under-funding of health services leads to reduced access to care, poorer outcomes and health inequities. It is well recognised in the sector that there is hidden unmet need across a range of health care services, such as primary health care, dental health, mental health, sexual health, disability support and primary services for disadvantaged communities, as well as medical and surgical specialties.

Even in areas like elective surgery, which the Government has targeted for additional funding, there are numerous reports of increasing barriers to accessing treatment. Patients have to be in more pain to access elective surgery now than ever before. They are ranked by their pain and assigned a number - they only make it on to the waiting list if their number is high enough to meet five different criteria thresholds. These thresholds are getting further out of reach every year. As the New Zealand Medical Association put it, the gap between the patients who meet the clinical threshold for surgery, but fall short of our hospitals' financial threshold is widening.[4]

Recent reports indicate Taranaki DHB has seen a 142 percent increase of people needing a first specialist appointment for orthopaedic surgery being referred back to their GP. In the Bay of Plenty there has been a 396 percent increase; while the West Coast DHB sent out 200 letters of decline for orthopaedic first specialist assessments in 2013/14, up from 11 in 2011/12. [5] [6]

A further recent report revealed more than a quarter of ear, nose and throat patients who need surgery are being turned away from the overloaded Dunedin Hospital department.[7]

A recently published study shows New Zealanders with cancer die from the disease sooner than Australian cancer patients. If New Zealand's relative survival rate matched Australia's, 705 fewer New Zealanders would die from cancer each year, according to University of Auckland and Ministry of Health researchers.

Differences in cancer care, including funding and access issues, are thought to underlie the trans-Tasman survival gap, rather than differences in primary prevention, because earlier research has indicated the two countries have comparable rates of people being diagnosed with cancer. [8] [9]

[4] O Carville. "Unmet need 'a national disgrace'", *The Press*, 31 May 2014.
[5] A King. Parliamentary Questions for Oral Answer. 5 May 2015, Vol 705, page 3125.
[6] A King. "Kiwis left in pain as DHBs refuse specialist appointments," media release, 30 April 2015.
[7] E Goodwin. "Surgeon fears for ENT service," *Otago Daily Times*, 15 May 2015

The bowel cancer survival gap puts New Zealand about six percent behind Australia one year after diagnosis, prompting new calls for a national bowel cancer screening programme. However, the Budget has merely extended a pilot programme operating in the Waitemata DHB for the last four years. Health Minister Dr Jonathan Coleman said, "The largest constraint is having the workforce to do the colonoscopies." Around 1,200 to 1,400 New Zealanders die each year from bowel cancer.[10]

In primary healthcare a measure of unmet need is well established through the New Zealand Health Surveys, which indicate nationally one in five children and 27 percent of adults have an unmet need for primary healthcare. In some regions more than a third of children and adults report an unmet need. The worst region is Hawkes Bay with 35 percent of children with an unmet need and 43 percent of adults.[11]

The new initiative which extends free GP visits and prescriptions for children under six to all children under 13 from 1 July 2015 will address a part of that unmet need. However, it is likely to come at a cost of access to other services.

Our post-Budget analysis in May last year estimated the policy was likely to cost around $40 million a year, based on current population trends and the available data on average fees and GP use, while the Budget allows for only $30 million. That estimate is conservative because it does not include covering fees for practice nurse visits. Further, the median population projections for 6-12-year-olds are now approximately 3 percent higher than in 2014 and it is reasonable to assume average fees, if anything, will also have gone up to cover costs. However, the funding shortfall has now been bridged to some extent by ACC signing up to the free under-13s policy for children with injuries and is contributing a further $9 million a year on average. That contribution is based on paying an additional $24 for a GP or nurse practitioner consultation and an additional $5 for a practice nurse consultation. However, a nationwide survey of 280 general practices in February 2013 found GP fees for 6-17-year-olds ranged from nil to $60 in normal hours and between nil and $89 for after-hours consultations. [12]

If ACC's $24 payment is indicative of DHB payments to be made to primary care practices to enable free services for the under-13s, many GPs will either have to take a cut in their incomes, continue to charge for children to make up the for the shortfall on their current fees, subsidise the costs of children's visits by increasing costs for other patients, or simply not sign up to the policy programme. The Ministry of Health is only willing to go as far as saying that "the majority of general practices will also opt in to 'zero fees' for under-13s" (i.e. in addition to the existing under-sixes scheme). This is despite its experience that the under-sixes scheme "has achieved almost universal coverage in under-sixes, with zero fee general practice care available to 99 per cent of under-sixes during the

---

[8] P S Aye, J M Elwood, V Stevanovic. "Comparison of cancer survival in New Zealand and Australia, 2006–2010," *NZ Medical Journal*, 19 December 2014, Vol 127 No 1407.
[9] M Johnston. "New Zealand lags behind Australia in cancer survival rates," *NZ Herald*, 19 December 2015.
[10] C Broughton. "Budget failure on national bowel screening 'saddening'," Stuff, 22 May 2015. Available at: http://www.stuff.co.nz/national/health/68748576/budget-failure-on-national-bowel-screening-saddening
[11] NZ Health Surveys 2011-2014.
[12] Haran C, Ruscoe C. (2013) Primary health care cost for children between 6 years and 17 years in New Zealand. Proceedings of Paediatric Society of New Zealand Annual Scientific Meeting. In *Our children, our choice: priorities for policy*, MC Dale, M O'Brien, S St John (eds), Child Poverty Action Group, May 2014.

day and 97.7 per cent after-hours"[13]. The Health Estimates (p.79) released with the Budget show that the government is targeting only an 80 percent uptake for free access to Under 13 services, implying that the expected uptake for the new 6 to 12 age group is only around 65 percent[14].

The new services this year are partly funded by cuts in other services. The primary health care strategy allocation, for example, has had funding for "very low cost access" nursing placements and "long-term conditions" discontinued in this year's Budget, as well as a reduction of "flexible funding" for rural general practice. On top of that, as indicated earlier, financial pressures on DHBs will continue, leading to cuts to services some of which may be visible (as with Southern DHB) but some may be difficult for the public to detect. Nationally, there has been a growing deficit in the DHBs' provider arms (mainly their hospitals) partly met by their funder arms underspending on other health services, which are mainly in primary and community care. The increase in provision for funding DHB deficits is recognition of the financial stress DHBs are under.

Negative impact on the health workforce

Funding shortfalls have seen wages in public health service jobs drop 2.8 percent below the inflation rate between March 2010 and June 2014 and 2.5 percent below the increase in the general private sector workforce over the same period measured by the Labour Cost Index (LCI) according to a comparison made by the State Services Commission.[15] By March 2015 (the latest LCI data available), wages in public health jobs were 2.4 percent behind the increase in CPI since March 2010, and 3.2 percent behind the increase in the private sector.

This trend is unsustainable and will inevitably lead to poorer recruitment, retention, and staff morale, across the spectrum of services. In such a labour-intensive service (personnel costs comprise more than 60 percent of health service budgets), the quality, stability and morale of the workforce are critical to an efficient and effective service. This is especially so considering a significant proportion of New Zealand's health workforce is approaching retirement age and the fact that New Zealand relies heavily on overseas recruitment in many health professions which are either facing or about to face growing international shortages.

Immigration New Zealand's Skills Shortage Lists include almost all medical specialties, which have the highest dependency on overseas recruitment (42 percent of the specialist workforce) in the OECD. Medical Council data show the retention rates for overseas-recruited specialists are poor and getting worse; additionally, about 19 percent of the specialist workforce will be lost within the next five years as they approach retirement age.[16]

Says Health Workforce New Zealand's report *Health of the Health Workforce*, published in November 2014: "The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors."

---

[13] See http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/zero-fees-under-13s, accessed 5 June 2015.

[14] At March 2015, the estimated resident population (Statistics New Zealand) showed 371,800 children aged 0 to 5 and 418,100 aged 6 to 12. The Estimates target 97 percent accessing free Under-Sixes services.

[15] State Services Commission. *Human Resources Capability in NZ State Services*, December 2014. Available at: http://www.ssc.govt.nz/hrc-survey-2014 and Reserve Bank....

[16] ASMS. Taking the Temperature of the Public Hospital Specialist Workforce, August 2014. Available at: http://www.asms.org.nz/wp-content/uploads/2014/07/The-Public-Hospital-Specialist-Workforce-web.pdf

While the Government regularly announces more doctors being employed in the public health system, the Association of Salaried Medical Specialists estimates the annual growth rates is around 100 specialists short of what is needed.

An indication of the true state of the medical workforce is well illustrated in a recently published survey of doctors at Capital and Coast DHB showing that over a 12-month period 82 percent of respondents (55 percent of whom were specialists) turned up to work when they were sick. The main reasons given for practising while ill were: "Not wanting to burden co-workers" and "Feeling of duty to patients". One of the researchers commented that the results would be reflected in other DHBs. [17]

Nursing is facing similar issues. The New Zealand Nursing Organisation's fourth biennial employment survey, conducted in December 2014, found the morale of New Zealand nurses continues to fall, affected by heavy workloads, restructuring and unresponsive leadership. The pressures are taking a toll on workplace-acquired injury and infection, which caused 20 percent of the surveyed nurses to need time off work, a 10 percent rise on the previous survey two years ago.[18]

Reports from Australia are predicting significant nursing shortages, with expectations Australia will be looking to recruit from New Zealand. At the same time, HWNZ reports New Zealand will need to start increasing its nursing workforce over the coming years because "the risk of staff shortages becomes greater as the proportion of experienced nurses approaching retirement increases". This is a particular issue in specialty areas with the highest average ages, such as in palliative care and mental health, and hard-to-staff areas such as aged care and primary care. However, unemployment among new graduate nurses, including Māori and Pacific nurses who are underrepresented in the nursing workforce, continues, and several nursing categories remain on Immigration New Zealand's essential skill shortages lists. The lack of long-term health workforce planning leaves New Zealand exposed to volatile swings in labour demand and supply to meet projected skills shortages, and is a barrier to sound health workforce development.

Many occupational groups in the allied health workforce are small, which means these professions can quickly become vulnerable if even a small number leave, and this in turn can have a major impact on the effectiveness of the health service team. A number of allied health professions are on Immigration New Zealand's long-term skill shortage list. Because there are too few home-grown professionals to fill vacancies in these professions at present, the percentage of overseas-trained practitioners tends to be high. HWNZ acknowledges sonographers, medical physicists and radiation therapists are experiencing "critical shortages".

A national survey of aged care workers in residential and home settings in 2014 found high workload is a concern for both groups of caregivers, but especially for residential caregivers. The survey report says this has importance for job satisfaction, retention, health and safety as well as the quality of care. But while the workloads are high, the wages are notoriously low. Poor wages, gender pay gaps and the lack of training and development in residential care, as exemplified by Kristine Bartlett's equal pay case (won in principle in the courts and now awaiting hearings as to implementation) and the "in-between" payments to home care workers for their travel between clients (agreed by the

[17] PC Tan, G Robinson et al. "Coming to work sick: a survey of hospital doctors in New Zealand," NZMJ, August 2014, Vol 127 No 1399.
[18] NZNO. "Morale of nurses falling – research," *Kia Tiaki Nursing New Zealand*, Vol 21, No 3, April 2015.

Government following court action), are just two established examples of chronic under-funding of the sector. The survey found wages average little more than the minimum wage, which in 2014 was set at $14.25 per hour. As a comparison point, the New Zealand Living Wage for 2014 was set at $18.80. The survey report says that unless retention of quality workers improves, projections indicate "a significant labour shortage in aged care in the short, medium and long term future". [19]

[19] K Ravenswood, J Douglas, S Teo. *The New Zealand Aged Care Workforce Survey 2014*. NZ Work Research Insitute, AUT University. Available at: http://www.hrc.co.nz/files/2614/3019/0144/NZ_Aged_Care_Workforce_Survey_report.pdf