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How much funding is needed in Budget 2012 to avoid the condition of the Health System worsening?

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The health system needs more money each year just to maintain its current standards and services. The population increases, the population ages, new treatments become available and general costs rise, as do new technology, pharmaceutical and salary costs. If we want improvements in the health system 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 24 May 2012 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 two years, we carried out a similar analysis for the Budgets. 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 addition we allowed for 0.8 percent to provide for new treatments, and offset that with a 0.3 percent increase in productivity, both based on Treasury long term assumptions, which the Ministry did not allow for. Our estimates are therefore conservative: they tend to underestimate the needs of Vote Health. Our methodology this year is similar, though we use improved information on DHB expenditure patterns in some places and incorporate announcements to date from the Ministers of Health rather than rely on the 0.8 percent estimate for new treatments.

[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.

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 2.0 percent in the year to June 2013 (the Budget period), which is closely aligned to both Treasury Budget Policy Statement and NZIER consensus forecasts, though it is higher than the Reserve Bank's forecast of 1.5 percent in its March Monetary Policy Statement. 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 2.6 percent for medical salaries, 1.8 percent for nursing salaries, and 0.5 percent for others due to a number of settlements which were one-off payments. 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 June 2013 of 1.85 percent. Salary increases for medical staff are assumed to be LCI (1.85 percent) for junior doctors and 3 percent for senior staff reflecting their settlement.

Wages and salaries are assumed to be 63 percent of expenditure, based on DHB provider arm data. For DHBs, this includes 10.2 percentage points for medical staff and 13.4 percentage points for nursing staff consistent with DHB accounts. These proportions reflect expenditure (unaudited) for the year ended June 2011.

Population growth is a significant driver of health costs. We assume an increase of 1.56 percent during the year, which includes both an increase in the population and the increased expenditure requirements due to the ageing of the population of approximately 0.7 percent[2] (for simplicity we refer to this as the "population increase" factor in the following). Other population changes are estimated by using Statistics New Zealand's national population projections (an average of the projection for 2011-2016): a fall of 0.4 percent for births and a fall of 0.2 percent for children (0-14 year olds). This compares with a fall in live births of 3.7 percent in the year to March 2012 and a fall in the number of 0-14 year olds of 0.2 percent in the year to December 2011.

The restructuring of the Health system, the planning for which began in 2009 with the Horn Report and is now well under way, has potential financial consequences. While the responsibility for some expenditure may change, we assume in the absence of other information that funds will be required for the same services and that they will have the same cost drivers for this year, even if they appear on different lines of the 2012 Budget.

There is little publicly available documentation of actual savings. In answer to a Parliamentary Question in February 2012, the Minister of Health said that Health Benefits Ltd (HBL) had found savings of $55 million in the year to June 2011. Its Statement of Intent, updated in February 2012, projected $40 million savings in 2010/11, $20 million further savings in 2011/12 and a further $60 million in 2012/13. Assuming the 2011/12 savings were factored into last year's Budget, a $60 million saving might be expected for the period of the 2012 Budget. However we consider that is

[2] Advice from the Ministry of Health.

optimistic given that projects it has in development are likely to have significant costs in the first year, even if they get underway on schedule. There is also concern among DHBs that any savings in one year will lead to funding cuts in future years so that savings will in effect go to the overall Health vote for reallocation rather than directly to the DHB. 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. Rather than factor the savings into our estimates, we simply state the potential savings.

On the restructuring of Health agencies that has been announced, it is assumed that all the estimated savings will be found and that the transition costs were met from 2011/12 expenditure. These are: the new Health Promotion Agency which incorporates the Health Sponsorship Council, the Alcohol and Liquor Advisory Council and some functions of the Ministry of Health (estimated cost is $400,000 transition costs with savings of $1.875 million per year); the disestablishment of the Mental Health Commission from 30 June 2012 and transfer of some of its functions to the Health and Disability Commissioner (estimated cost is $350,000 transition costs with savings of $1.11 million over three years); and the disestablishment of the Crown Health Financing Agency (CHFA) and transfer of its functions to the Debt Management Office and the Ministry of Health (estimated cost is $290,000 transition costs with savings of $1.7 million per year)[3]. This brings $4.685 million savings in 2012/13. This saving is simply an assumption, not a judgement as to the likelihood of its success. The savings are attributed to the Crown Health Financing Agency itself ($1.7 million) and the balance of $2.985 million to non-DHB non-departmental output expenses. The remaining $200,000 that the CHFA cost in 2011/12 is assumed to become a cost to the Ministry which is taking over some of its functions.

In the 2011 Budget it was announced that all state services employer superannuation contributions such as to Kiwisaver, currently paid for by the State Services Commission, would have to be paid by the agencies themselves from 1 July 2012. The overall cost of that for DHBs was estimated to be $45.9 million and $2.4 million for the Ministry of Health in the year to June 2013[4]. Other health agencies receiving funding from the Health vote would also be affected: for example the Health and Disability Commissioner ($100,000), and the New Zealand Blood Service ($500,000). We have included these costs as specific additions to the requirements for the DHBs as a group, the Ministry, and non-DHB expenditures as a group (allowing $700,000).

Another cost increase the Health system will have to cover is the settlement of the "sleepover case" which ensured carers in mental health and disabilities 24 hour care were paid at least the minimum wage.

[3] Cabinet Minute: "Public Services to Meet the Needs of 21st Century New Zealand: Due Diligence Report on Proposals for Structural Change", CAB Min(11) 28/5, 1 August 2011, p. 6. Available at http://www.ssc.govt.nz/mog.

[4] "Crown as an Employer: KiwiSaver and State Sector Retirement Savings Schemes", Treasury/SSC, 18 March 2011, report number T2011/472.

Findings

In the 2011 Budget, the Health vote amounted to $13,499 million for operational expenses, plus $454 million for capital expenditure, a total of $13,953 million.

Of that, $205 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 2.0 percent, and, for all but the International Health Organisations membership, increased wage costs, taking them to $211 million and $28 million respectively.

The biggest portion of the Health vote was $10,497 million to fund District Health Boards (DHBs) and $2,768 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, especially medical staff (doctors), which have been driven up faster than the rest of the workforce by skill shortages in New Zealand and internationally. However wage and salary increases look to be a less pressing factor in the coming year. We estimate that they will rise only 1.6 percent overall, which is significantly less than our estimated CPI increase. Other costs are assumed, in line with standard health funding formulas, to rise by CPI (2.0 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 1.85 percent and other costs increasing at 2.0 percent. Labour costs in the whole Health sector are estimated to rise 1.7 percent on average. On top of these cost increases we apply the 1.56 percent population increase noted above.

This would take the DHBs' combined budget from $10,497 million to $10,908 million, requiring an increase of $411 million or 3.9 percent which needs to be met in the 2012 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 0.8 percent allowance for this[5]. 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 $10,962 million, an increase of 4.4 percent or $465 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 1.85 percent and other costs at the rate of CPI (2.0 percent) and that in most cases, the population increase (1.56 percent) will require a further increase in their funding. We estimate that the total vote for these services will need to rise 3.2 percent or $88 million to maintain service levels, taking it from $2,768 million to $2,856 million. With

[5] Called "non-demographically-driven growth". See "Challenges and Choices: Modelling New Zealand's Long-term Fiscal Position", Matthew Bell, Gary Blick, Oscar Parkyn, Paul Rodway and Polly Vowles, Treasury Working Paper 10/01, January 2010, p.52.

the above allowance for additional services and productivity increases, an additional 3.7% or $102 million would be required, a total of $2,870 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. This means that the DHBs and national health services are starting the new financial year considerably behind where they were both one and two years ago.

In total, the operational expenses portion of the Health vote will need to rise by 3.7 percent or $506 million from $13,499 million to $14,005 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 4.2 percent or $573 million, taking the total to $14,073 million. Of that, $109 million allows for new treatments, rather than them being paid from spending cuts or increased user charges elsewhere. The productivity increases saves $42 million from that.

The $506 million is simply to keep up with population and cost increases (though note that it does not allow the majority of health sector staff pay rates to keep up with inflation, nor for significant recognition of improved performance, skills or experience of existing staff).

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 hospitals to private providers such as GPs and medical testing services. Past experience indicates that these initially these may be fully subsidised over time tend to incur part charges and may not be available in some areas. This could be relieved by any genuine productivity gains, but to the extent that significant savings in the last two years were genuine productivity gains and not just cuts in services, such gains must be increasingly hard to find.

So far, the government has announced spending on a number of areas that it describes as new or expanded services. In Disability Support Services, new or expanded services costing $143.7 million over four years was announced on 15 May, and $11.0 million in unidentified savings. We assume they are evenly spread over the years which would incur $35.9 million in costs and $2.75 million in savings in the 2012/13 year. Notably, Disability Support Services requires the same amount – $35.9 million – just to cover increasing costs and population growth. Therefore, unless further increases are allowed for in the Budget, the $35.9 million "new investment" will have to be paid for in savings from the Disability Support budget over and above the $2.75 million the Minister announced.

In surgery and cancer services, $101 million has been announced over four years, or $25.3 million a year. Expenditure reductions have been announced as a result of the increase in prescription charges from $3 to $5 from 1 January 2013, saving $20 million in 2012/13. A programme to significantly reduce rheumatic fever will receive an additional $12 million over five years, or $2.4 million a year.

In total these amount to $63.6 million in new expenditure and $22.75 million in expenditure reductions over the 2012/13 financial year. These are relatively modest increases in services compared to the 0.8 percent ($109 million) allowed for by Treasury in its long term projections. But unless funding increases to pay for them, they will need to be found from reductions in services or

increased user charges elsewhere. The government has signalled some of those reductions and increased charges, though it is not clear which services will be reduced. The remaining $40.8 million of cuts will only become apparent as the year progresses. In total, $570 million is needed to fund rising costs and population growth plus the new expenditure without loss in services or higher user charges.

However, the pattern of the last two years has been an actual increase in the Health vote from Budget to Budget of around $430 million: $436 million in 2011/12, $431 million in 2010/11. The Minister stated in Parliament that the actual increase ("new money") following the 2011 Budget was $420 million. The discrepancy lies in a variety of factors including underspending brought forward from the previous year. In any case, Budget 2011 documents released on the Treasury web site indicate that $420 million is projected for this year as well. An actual funding increase of between $420 million and $440 million in this year's Budget seems likely. That would leave Health $130-$150 million short of what is needed to cover increasing costs, population growth and the increased spending already announced. The $22.75 million of expenditure reductions already announced account for only a small part of the shortfall. If there are further announcements of new spending, they will imply the need for further savings.

DHB's usually receive $350 million of the new funding. That would be $61 million short, but 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.

Perhaps this year more productivity savings are coming through from group procurement schemes and restructuring, but actual evidence of further savings is yet to show, and claimed savings so far are very small. Even if the full $60 million of new savings from HBL projects for the year does come to fruition, its benefits have already been offset by $49 million of added costs through the loading of superannuation costs onto the sector, and there will be additional pressures to cut expenditure to meet the government's deficit reduction target.

Estimating capital needs is more difficult as the drivers for it are less direct. Capital goods prices are rising very slowly at present[6] so cost pressures alone would raise the $454 million capital funded in the 2011 Budget to $458 million.

Sensitivity to changes in assumptions

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

A change of 1 percentage point (down to 2 percent or up to 4 percent) in the increase in senior medical staff salaries makes a $7 million difference in the $552 million increased requirements. A change in nursing salary increases by 1 percentage point (down to 0.8 percent or up to 2.8 percent) changes the increased requirements by $15 million. For other non-medical DHB staff, a change of 1 percentage point makes a $12 million difference. Changing the increase for all other staff by 1 percentage point (down to 0.85 percent or up to 2.85 percent) makes a $53 million difference.

If other cost increases are 1 percentage point different (that is, the CPI increase is as low as 1.0 percent or as high as 3.0 percent), the additional requirement changes by $51 million.

[6] The Capital Goods Price Index in the year to December 2011 rose 1.0 percent.

A 0.1 percentage point change in the population assumptions makes a $13 million difference.

Without the 0.3 percent productivity improvement, the additional funding requirement would be $42 million; if it rose to 0.6 percent the funding requirement would reduce by $42 million.