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How much funding is needed in Budget 2013 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 3.2 percent or $445 million from $13,836 million to $14,281 million to maintain the current levels of service. The $445 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 3.7 percent or $514 million, taking the total to $14,350 million.

- The DHBs' combined budget will need to rise from $10,819 million to $11,170 million, requiring an increase of $351 million or 3.2 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 $11,226 million, an increase of 3.8 percent or $406 million.

- Last year, Vote Health's operational funding increased $358 million on the previous year's Budget. DHBs received $320 million of the new funding. If that occurred again this year, it would be $31 million short for DHBs and $87 million for the whole vote, or $156 million taking new services and productivity into account. If the increase is as low as $250 million, the shortfall will be almost $200 million, or $264 million taking new services and productivity into account.

- The Ministry of Health estimated that there was a $376 million shortfall in last year's Budget which had to be met by cuts and efficiencies. Our estimates in previous years have been very similar to the Ministry's, totalling $220 million in shortfall in the two years to June 2012 – but their estimate of the shortfall last year was considerably 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 3.2 percent or $90 million to maintain service levels, taking it from $2,799 million to $2,888 million. With the above allowance for additional services, new treatments and productivity increases, an additional 3.7% or $104 million would be required, a total of $2,903 million.

- Funding for the Ministry of Health will need to rise from $191 million to $194 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, 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 16 May 2013 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 three 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 estimate was that the total shortfall for the four years to 2015/16 would be $1.5 billion, consisting of $2.9 billion in "pressures" offset by a planned $1.4 billion in additional funding. We reproduce the following table from that paper which gives some idea of the size of the expenditure cuts or genuine savings that are being required of the sector:

[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.

Pressures facing the health sector with $350 million on-going Operating Allowance

	$(million)			
	2012/13	**2013/14**	**2014/15**	**2015/16**
Cost Pressures & New Initiatives				
Demographic	168.000	333.567	512.493	706.524
FFT	317.000	627.433	964.507	1,332.476
Kiwi Saver	45.000	67.000	67.000	67.000
Deficit Reduction	30.000	30.000	30.000	30.000
Total DHB Pressures	**560.000**	**1,058.000**	**1,574.000**	**2,136.000**
Ministry Demographic & FFT Pressures	121.000	235.000	358.000	492.000
Departmental efficiency & superannuation funding reduction	11.200	11.184	11.184	11.184
Total Pressures	**692.200**	**1,304.184**	**1,943.184**	**2,639.184**
New Initiatives	33.957	114.779	194.204	274.519
Total Pressures & New Initiatives	**726.157**	**1,418.963**	**2,137.388**	**2,913.703**
Less $350 million Operating Allowance	(350.000)	(700.000)	(1,050.000)	(1,400.000)
Required Efficiency &/or Re-prioritisation	**376.157**	**718.963**	**1,087.388**	**1,513.703**

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 1.8 percent in the year to June 2014 (the Budget period), which is the NZIER consensus mean forecast for the year to March 2014. The Reserve Bank forecasted 1.4 percent in the year to March 2014 and 1.4 percent to June 2014 in its March 2013 Monetary Policy Statement, which is at the bottom end of the NZIER Consensus range, while Treasury forecasted 1.9 percent for the year to March 2014 and 2.1 percent in the year to June 2014 in the December 2012 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 1.6 percent for medical salaries (including both senior and junior doctors), 1.3 percent for nursing salaries, and 1.8 percent for others. 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 2014 of 2.1 percent. In the year to June 2012, labour costs increased 4.9 percent in the DHBs according to their consolidated accounts, when we were

accounting for around 3.9 percent (assuming pressures from population growth led to proportionate increases in staff numbers and hence wages). The year before that, our wage cost estimate would have been approximately 1.5 percentage points too high on this basis of comparison.

Wages and salaries are assumed to be 62 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 ended June 2012. Medical staff costs represent 10 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 the year to June 2012 this accounted for 6.2 percent of DHB expenditure – equivalent to 10 percent of the personnel costs. This amounted to a blow-out in these costs: it rose 15.9 percent from 2011. In the year to June 2010 it fell 6.8 percent and in the following year rose 1.8 percent, so the 2012 increase was notable. It suggests stress in staffing levels in the DHBs.

Population growth is a significant driver of health costs. We assume an increase of 1.42 percent during the year, which includes both an increase in the population and the increased expenditure requirements due to the ageing of the population[3] (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): zero increases for both births and children (0-14 year olds). This compares with falls in live births of 0.4 percent and in the number of 0-14 year olds of 0.1 percent in the year to December 2012.

Savings are being sought through Health Benefits Ltd (HBL). Its Statement of Intent 2012/13 – 2014/15, updated in June 2012, showed actual savings of only $55 million in 2010/11. It forecasts further gross savings of $59 million in 2011/12, $97 million in 2012/13 and $212 million in 2013/14, some of which are occurring independently of HBL. These however do not take account of costs required to make the savings which it estimates at $67 million of one-off costs and $18 million of on-going costs in 2012/13, and $71 million of one-off costs and $57 million of on-going costs in 2013/14. 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 occurred last year 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. Further, the Auditor General has observed[4] 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

[3] Advice from the Ministry of Health.

[4] "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/2013/health-audits.

"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.

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

Last year there were a number of health agency restructurings. We assume that the savings were accounted for in the 2012/13 Health Vote (see our analyses for the 2012 Budget) and that the on-going savings will not be significantly different from that year, and so do not need additional provision. On the other hand there are on-going additional costs arising from the 2011 Budget announcement that all state services employer superannuation contributions such as to Kiwisaver, previously paid for by the State Services Commission, would have to be paid by the agencies themselves from 1 July 2012. Again, we assume that the additional costs will be similar to last year.

Findings

In the 2012 Budget, the Health vote amounted to $13,836 million for operational expenses, plus $289 million for capital expenditure, a total of $14,125 million.

Of that, $191 million was for the operation of the Ministry of Health, and a further $27 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 1.8 percent, and, for all but the International Health Organisations membership, increased wage costs, taking them to $194 million and $28 million respectively.

The biggest portion of the Health vote was $10,819 million to fund District Health Boards (DHBs) and $2,799 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 in the past been driven up faster than the rest of the workforce by skill shortages in New Zealand and internationally. However wage and salary increases were a less pressing factor in the previous year and look to be even less so in the coming year. We estimate that they will rise only 1.6 percent overall, which is less than our estimated CPI increase and a little less than last year. Other costs are assumed, in line with standard health funding formulas, to rise by CPI (1.8 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 (though note 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 McGregor[5]) and other costs increasing at 1.8

[5] "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.

percent. Labour costs in the whole Health sector are estimated to rise 1.8 percent on average. On top of these cost increases we apply the 1.42 percent population increase noted above.

This would take the DHBs' combined budget from $10,819 million to $11,170 million, requiring an increase of $351 million or 3.2 percent which needs to be met in the 2013 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[6]. 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 $11,226 million, an increase of 3.8 percent or $406 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 (1.8 percent) and that in most cases, the population increase (1.42 percent) will require a further increase in their funding. We estimate that the total appropriation for these services will need to rise 3.2 percent or $90 million to maintain service levels, taking it from $2,799 million to $2,888 million. With the above allowance for additional services and productivity increases, an additional 3.7% or $104 million would be required, a total of $2,903 million. Ministers have announced "new" spending for aged care and dementia at approximately $9 million a year, and for rheumatic fever at approximately $5 million per year. Given the small size of these announcements in dollar terms and uncertainty as to whether they will be offset by expenditure cuts elsewhere, we simply note these announcements.

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 above Ministry of Health 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 three years ago.

In total, the operational expenses portion of the Health vote will need to rise by 3.2 percent or $445 million from $13,836 million to $14,281 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 3.7 percent or $514 million, taking the total to $14,350 million. Of that, $112 million allows for new treatments, rather than them being paid from spending cuts or increased user charges elsewhere. The productivity increases saves $43 million from that.

The $445 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).

[6] 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.

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 these 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 $358 million on the previous year's Vote announced at Budget time. DHBs received $320 million of the new funding. If that occurred again this year, it would be $31 million short for DHBs and $87 million for the whole vote, or $156 million taking new services and productivity into account. If the increase is as low as $250 million, the shortfall will be almost $200 million, or $264 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 very slowly[7] so cost pressures alone would raise the $289 million capital funded in the 2012 Budget to $291 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 $7.5 million difference in the $514 million increased requirements. A change in nursing salary increases by 1 percentage point changes the increased requirements by $22 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 makes a $53 million difference.

If other cost increases are 1 percentage point different (that is, the CPI increase is as low as 0.8 percent or as high as 2.8 percent), the additional requirement changes by $53 million.

A 0.1 percentage point change in the population assumptions makes a $13.5 million difference.

Without the 0.3 percent productivity improvement, the additional funding requirement would be $43 million; if it rose to 0.6 percent the funding requirement would reduce by $43 million.

[7] The Capital Goods Price Index in the year to December 2012 rose 0.9 percent.