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How much funding is needed in Budget 2011 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 19 May 2011 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.

Last year, we carried out a similar analysis for the 2010 Budget. 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 (we estimated that $512 million was required, compared to the Ministry's estimate of $507 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 methodology this year is similar, though we use better information on DHB expenditure patterns in some places.

[1] Note that the "Health package" in the 2010 Budget included items in budget areas outside the actual Health vote itself. 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 2.6 percent in the year to June 2012 (the Budget period), which is closely aligned to both Treasury and NZIER consensus forecasts, and an average increase in wages and salaries, apart from senior doctors, of 2.0 percent, reflecting last year's national DHB settlement and some more recent settlements with groups of employees not covered by it. Salary increases for medical staff are assumed to be 2 percent for junior doctors reflecting a recent settlement and 4 percent for senior staff. This compares to annual increases in the previous settlement for senior doctors of 4.25 percent, with negotiations for a new agreement still in train. These labour cost increases are not based on any polling of the intentions of any parties; they are simply what we believe are reasonable indicative values.

Wages and salaries are assumed to be 65 percent of expenditure. For hospitals (DHB "provider arm" operations), this includes 10.7 percentage points for medical staff, consistent with DHB accounts. These proportions are different from those we used last year, not because circumstances have changed but because of better information about DHB expenditure.

Population growth is a significant driver of health costs. We assume an increase of 1.7 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 between 0.6 and 0.7 percent[2] (for simplicity we refer to this as the "population increase" factor in the following). Other population increases are estimated by using the increases in the year to December 2010: 2.2 percent for births and 0.25 percent for children (1-14 year olds).

Offsetting these increases in costs we assume, with Treasury[3], a 0.3 percent productivity increase. This reduces costs in all areas except international health organisations.

The restructuring of the Health system whose planning began in 2009 and now is well under way has potential financial consequences. While the responsibility for some expenditure may change we assume that funds will be required for the same services and they will have the same cost drivers for this year, even if they appear on different lines of the 2011 Budget. We also assume that the restructuring will produce no net financial savings or costs in the 2011/12 financial year, but that any such savings will be available to be used in the health system. For example, we are told that any DHB savings in the costs of their administrative, support and procurement services which are achieved by sharing resources are available for them to use. The 2009 Cabinet papers on the changes implied that any savings would not appear until the implementation phase is complete[4]. We are not aware

[2] Advice from the Ministry of Health.

[3] "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.

[4] For example "The Government's response to the Ministerial Review Group's Report 'Meeting the Challenge'", 19 October 2009, states (p.5) "Estimated savings will be up to $700m over the first five years after shared services are fully implemented. Experience with quality implementation of shared services overseas suggests

of any significant savings to date and if there have been any, how much they have saved. For all these reasons we do not include any savings in this analysis, but if savings have been found they will reduce DHB costs.

It has been suggested that all employer superannuation contributions in the state services, currently paid for by the State Services Commission, will in future have to be paid by the agencies themselves. There is no information on whether that would be a new cost to the agencies or would be funded. A rough estimate is that it would cost the Health Sector $20-25 million a year for Kiwisaver contributions.

Findings

In the 2010 Budget, the Health vote amounted to $13,063 million for operational expenses, plus $511 million for capital expenditure, a total of $13,574 million.

Of that, $216 million was for the operation of the Ministry of Health, and a further $32 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 2.6 percent, and for all but the WHO membership, increased wage costs, taking them to $220 million and $33 million respectively.

The biggest portion of the Health vote is $10,042 million to fund District Health Boards (DHBs) and $2,773 million to fund other health programmes such as provision of clinical training, infection control and immunisation programmes, public health and other national health services.

Hospital funding is the responsibility of the DHBs, and a significant pressure on hospital costs is salaries of health professionals, especially medical staff (doctors), which are being driven up faster than the rest of the workforce by skill shortages in New Zealand and internationally. Wage and salary cost increases are based on 4.0 percent for senior medical staff and the standard 2.0 percent for other staff. Other costs are assumed, in line with standard health funding formulas, to rise by CPI (2.6 percent). Services provided directly by DHBs (mainly hospitals) make up only about half their funding however (we assume 55 percent). The remainder is used to fund a wide range of other services. We base our cost increases for these on labour costs increasing by 2.0 percent and other costs increasing at 2.6 percent.

On top of these cost increases we apply the 1.7 percent population increase noted above, a 0.8 percent allowance used by Treasury to indicate increase in demand due to the availability of new treatments[5], and the productivity improvement to give a total of a 4.6 percent or $461 million increase in costs for DHBs which needs to be met in the 2011 Budget to maintain the current level of

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that implementation takes around 3 years. This means that in the first year after full implementation, it is estimated there will be up to $100m in savings and in the fifth year after full implementation up to $180m." Available at http://www.beehive.govt.nz/sites/all/files/MRG%20Decision%20Q&As%2021%2010%2009.pdf.

[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.

services for each New Zealander. That would take their combined budget from $10,042 million to $10,503 million.

It should be recalled however that last year we estimated that DHBs needed $10,153 million to maintain the 2009/10 level of services into 2010/11. In fact the 2010 Budget was $111 million short of that, so the DHBs are starting the new financial year that far behind where they were a year ago. It would require $10,620 billion or an additional $578 million to return them to their buying power in 2009/10.

For health services other than the DHBs which are funded directly by the Ministry, we assume that in the main, labour costs will rise by 2.0 percent and other costs at the rate of CPI (2.6 percent) but that in most cases, the population increase (1.7 percent) will require a further increase in their funding. There are some exceptions but we estimate that the total vote for these services will still need to rise 3.6 percent or $97 million to maintain service levels, taking it from $2,773 million to $2,870 million.

In total, the operational expenses portion of the Health vote will need to rise by 4.3 percent or $564 million from $13,063 million to $13,626 million to maintain the current levels of service. Of that, $520 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). The remaining $44 million allows for $85 million in new treatments and $41 million saved in productivity improvements.

The $564 million total is 70 percent of the $0.8 billion of "new spending"[6] which the government has said it will allocate in the 2011 Budget, mainly to health and education, though paid for by cuts in expenditure elsewhere. It would leave little room for funding improvements in health, let alone maintaining the spending power of the education budget or other public services.

If it 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 which initially may be fully subsidised but tend to increasingly incur part charges and may not be available in some areas.

Last year the government highlighted a number of new or improved services costing $149 million and also funded $8 million for restructuring of the Health system. All of this was paid for by reductions in funding and hence services elsewhere in Health. It is inescapable that this pattern of reductions in services, increased charges, and improvements in one service at the cost of another service will be repeated.

Estimating capital needs is more difficult as the drivers for it are less direct. Capital goods prices are close to static at present[7] so cost pressures alone would leave the $511 million capital funded in the

[6] This has in the past been called the "operating allowance", but given that it no longer is new money, it has lost that meaning.

[7] The Capital Goods Price Index in the year to December 2010 fell 0.3 percent. However capital goods prices in 2010 would have been significantly affected by the rising exchange rate, and this is unlikely to continue.

2010 Budget at the same level. With that, the total Health vote would rise from $13,574 million in 2010/11 to $14,137 million to 2011/12.

Sensitivity to changes in assumptions

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

If no allowance is made for increase in demand due to the availability of new treatments the increase in operational expenses required drops from $564 million to $479 million, or 60 percent of the $0.8 billion "new spending" on health and education.

A change of 1 percentage point (down to 3 percent or up to 5 percent) in the increase in senior medical staff salaries makes a $7.4 million difference in the $564 million increased requirements to between 70 and 71 percent of the "new spending". A change in other salary increases by 1 percentage point (down to 1 percent or up to 3 percent) changes the increased requirements by $79 million to between 61 and 80 percent of the "new spending".

If other cost increases are 1 percentage point different (that is, the CPI increase is as low as 1.6 percent or as high as 3.6 percent), the $564 million additional requirement changes by $47 million to between 65 and 76 percent of "new spending".

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 increase from $564 million to $605 million – three quarters (76 percent) of the "new spending". If the productivity increase was 0.6 percent, the requirement would fall to $523 million or 65 percent of the "new spending".