Information paper for incoming Minister of Health

Hon Tony Ryall

December 2011

Context

This paper is for information purposes and is provided to you in your capacity as Minister of Health. Like most countries, NZ is mixed health system, including public and private/not for profit sectors. While there is no Ministerial responsibility for the budgets and finances of the non-government health sector, a responsibility exists for the on-going functioning of the health system as a whole, as the two are intertwined and impact on each other.

In recognising this, many OECD governments involve themselves beyond the finances of public hospitals and actively promote a more balanced health care system for a whole range of reasons. This paper explores some of the cross-over issues which will have an impact over the next four years and beyond. It also provides a brief overview from the non-public health sector perspective on some of the present issues and trends, together with their implications for the health system as a whole, and specifically to the public sector, both from a health perspective and financial perspective.

Executive Summary

- Budget environment is one of constrained spending – both operating and capital – for the foreseeable future, with a focus on debt containment;
- Health spending pressures will continue with demographic movement and demand shift from private sector
- keeping health spending within overall parameters will be challenging or impossible over a prolonged period, without cuts to service levels, or some other rebalancing of public-private shares
- New Zealand has a dangerously high reliance on the public system when compared to OCED average. This means a high fiscal exposure to overall increases in health system costs.
- NZ's Public-private share has become increasingly unbalanced over the last decade. Early attention to policy options for re-balancing is recommended.
- There are potentially significant savings in proposed public capital expenditure on theatre capacity for elective surgery, when options for utilising surplus private capacity are considered.
- Small changes in insurance coverage levels can have a big impact over time on the resulting demand for public elective surgery.
- Present insurance coverage levels are trending down, with a forecast drop in coverage in coming years, particularly for older age groups.

- The level of demand transfer from private to public is increasing and will be exacerbated by proposed reductions to public waiting times.
- Engagement on policy options to date has been limited. There is a need to conclude policy engagement and reporting on both rebate and FBT options relating to health insurance.

Recommendations

- Close scrutiny of assumptions underpinning the future health spending projections, especially those relating to historic trends, when the Treasury's long term fiscal outlook is updated in 2012.
- Consider broad policy options for rebalancing of the public-private contributions to the healthcare system
- Review the medium term capital investment plans of DHBs as part of any broader Government initiatives to assist with capital expenditure restraint and debt reduction.
- Note the projected decline in the level of insurance coverage, particularly for older age groups, and the implications this will have for public sector demand for elective surgery.
- Instruct officials to finalise their reporting on the rebate for 65+ and options for implementation.
- Instruct officials to continue engagement on the FBT issue with a view to preparing an options paper for consideration.

Constraints on operational spending growth

It is noted that the current environment is one of low increases to operating spending. These are set to continue, with the PREFU setting out new spending allocations over the next four years which average just $1 billion, or around 1.4% of Government spending.

It is also noted that, although Vote Health has accounted for the lion's share of recent new spending allocations, there are still many in the public health sector who view the level of increase as too low.

HFANZ supports efforts to rein in the rate of growth in public health spending, as this has in the past had an unwelcome inflationary impact on the non-public health sector. Over the last decade, the average annual increase in Vote Health was $800 million.

On present settings, it is apparent that the public health budget will need to consume half of the new spending allowance in every one of the next four years, plus make the $700 million savings planned for reallocation. Even then, there could be a need for service reductions in some areas.

It is also noted that the Government intends to keep the increase in overall spending within the rate of cpi inflation plus population growth. However, on the face of it, this seems less challenging than keeping to the limits contained in the PREFU.

Beyond four years

The combination of factors requiring modest budget increases is likely to persist for some time according to most economic commentators. These constraints on spending, combined with the need to keep debt to responsible levels, will tightly constrain government spending – both operational and capital – over the next decade and beyond.

While these are exceptional circumstances, largely driven by external factors beyond New Zealand's control, it raises the question of how realistic is it to expect to be able to tightly constrain Government spending over a longer term period.

The problem is exacerbated due to the huge demographic shift underway with the first baby boomers turning 65 this year. The aging of this cohort is expected to significantly increase both pension and health costs over the next decade and beyond – just when Government spending must be tightly constrained.

Long term health projections

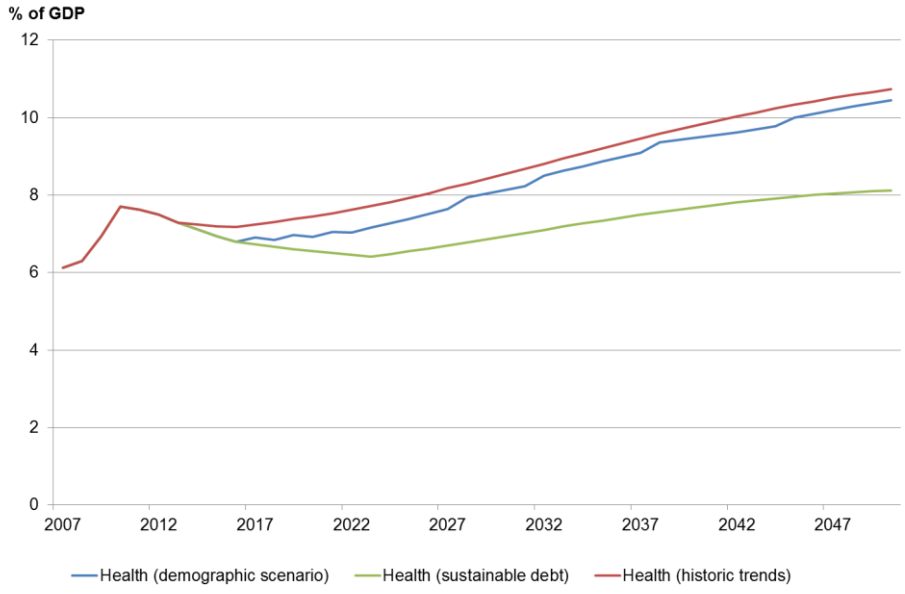
The Treasury highlighted these issues in its 2009 long term fiscal outlook, which painted a bleak picture of the future based on present policy settings (mainly regarding health and NZ super policies).

The Treasury's model charted several projections for future health spending. Under both the historic trends and demographic projection scenarios, health costs rise from today's 7% of gdp to 11% of gdp in 2050.

Only the sustainable debt scenario shows a more modest rise – to just over 8%. This scenario assumes very low increases in health spending over the next 40 years – below or at the rate of inflation.

Note: The most recent updates to the long term projections for health spending appear questionable as they incorporate the next four years' unusually flat forecasts as part of the base data for the 'historic trends' scenario. While a constrained period of health spending growth is supported and needed, it remains to be realised and is a poor proxy to represent either historic trends or the underlying drivers of health spending.

Health Spending to 2050 as Percent of GDP



Source: Treasury Long Term Fiscal Outlook, 2009

The Treasury's long term fiscal outlook is due to be comprehensively updated in 2012. It is recommended that close attention is paid to the assumptions underpinning the future health spending projections, especially those relating to historic trends.

A more reasonable basis would be to include only actual spending, and to go back sufficient years, eg to 1990, in order to increase the robustness of the base data.

Health sector rebalancing required over medium term

The sustainable debt scenario assumes a way has been found of keeping the increases in health spending under the rate of inflation every year for 40 years. While this may be achievable in a given year, or for a short period, it is likely to be impossible on a longer term basis under present policy settings. A rebalancing of the health sector will be required at some point.

The gap in 2050 between the level of government spending under the above scenarios is around 3% of GDP. In present terms, that equates to around $6 billion, or around $1,400 p.a. for every person in NZ.

Given that total health costs are likely to keep increasing over the next 40 years, if the amount of public spending is reduced, then the private share must inevitably increase. This means the 'gap' of $6 billion represents the amount that people will have to fund privately – either out of pocket or through health insurance – on top of what they already pay.

New Zealand private spending on health is currently 20% of total health expenditures. The OECD average is closer to 30%. The $6 billion shift from public to private outlined above would take New Zealand to around 35% private – not too dissimilar from where Australia is currently. Regardless of the scenario, it is clear that a massive rebalancing of our health system will take place in coming decades.

Luckily, New Zealand has room to move and time to make policy choices, although that time is running out. As Treasury rightly points out in their outlook, it is better to debate the policy choices sooner rather than later.

It is recommended that consideration be given to broad policy options for rebalancing of the public and private contributions to New Zealand's healthcare system.

Containment of capital spending and debt

Just as the Government's operational spending faces constraints in the foreseeable future, there are severe constraints on the level of capital spending, driven mainly by the need to keep public debt levels at prudent levels.

A good starting point is the forecast capital projections contained in the Budget 2011, which forecast a capital spending requirement of $25 billion over the next four years; ie: $7.6 billion, 6.0 billion, $5.7 billion and $5.4 billion.

Projected income from partial sell-downs of shareholdings in state-owned enterprises will help part fund a small portion of this capital spending forecast – around one-fifth.

There may be risks on the downside to the medium term debt outlook, such as through capital spending requirements increasing, or the SOE sell-downs proceeding at a more measured pace, or realising less than expected.

In the medium term, the pressure on both debt containment and containment of capital expenditure is likely to continue.

Contribution of health to overall capital expenditure

Capital expenditure in the health budget makes up a small but important component of the Government's overall capital spending programme. More importantly, it offers scope for making a contribution to reductions in capital spending, primarily in the form of construction of new theatre space for elective surgery.

In the current year, $454 million in capital spending was in health. This may actually understate the level of capital spending, as DHBs may fund some capital spending through accumulated reserves or debt.

The next three years' forecast capital spending looks very light, being $133m, $39m and $85m, or an average of $85 million per annum. This is compared with an average over last six years of $316 million, or nearly four times the forecast levels.

Keeping within the forecast track for capital spending, including equity injection to DHBs, will likely be challenging against the backdrop of recent actual spending levels. There will likely be calls from DHBs which greatly exceed the provisions available.

Potential capital spending efficiencies

It is against this backdrop that a suggestion is made for pursuing capital savings. In particular, much of the planned expansion of public theatre space for elective surgery is not required when the spare capacity in the private health sector is taken into account.

The planned public capital expenditure represents an overinvestment in theatre space by the public sector. There are better ways of accommodating rising demographic demand, which look to make use of the resources available in the whole health system, rather than taking a narrow public-only focus.

Not only does capacity exist in the private hospital setting, but private hospitals would look to add to that capacity over time in response to demand and the right policy settings and signals. Key to this is not just the contracting arrangements for the public sector and ACC, but the state of the health insurance industry, the level of insurance funded demand and future projections of this.

It is recommended that medium term capital investment plans of DHBs are reviewed as part of any broader Government initiatives to assist with capital expenditure restraint and debt reduction.

Government goals for elective surgery

The Government's targets for improving access to elective surgery are noted, particularly the wish to reduce waiting times from six months to four months.

HFANZ provides no comment on this goal, other than pointing out that there will likely be implications in terms of increased demand transfer from private to public in the event the goal is realised.

The last year or two has already seen anecdotal evidence of demand shift from private to public, as access to public elective surgery has been improved. Such demand shift occurs for a range of reasons, bearing in mind that all those with health insurance cover have a choice of getting surgery done publicly or privately.

Sometimes the public system has been the first choice, but for access difficulties such as waiting times. Other factors might be the impact of having excesses or co-payments required on insurance policies, where these are traded off in relation to the perceived waiting time and inconvenience of this.

As evidence of the tangible impact, the annual increase in total claim dollar value paid, (recently running at an average of 9% per annum for the last five years), fell to 0.7% for the year ending 30 September 2012. Even adjusting for the drop in the number of policyholders, this is an annual increase of less than 2%. Were total claims costs for 2011 to have increased by the recent average, then insurers would have funded an additional $60 million in claims over the past year – mainly for elective surgery.

While a reduction in underlying health inflationary pressures will be a contributing factor, HFANZ believes that a significant proportion of this $60 million difference is explained by demand shift, from private to public, in the elective surgery area.

To the extent that the Government is successful in achieving its target of four months waiting times, then it could be expected that further demand shift will occur in the medium term. We assume that such demand shift will have been quantified and modelled by Ministry of Health officials, although in the event that it hasn't, HFANZ would be pleased to assist with this exercise.

As a final comment, it is noted there is potential for the perception of access to be a driver for increased demand transfer, thereby hampering the ability of the public sector to actually deliver on the four month target. Some care will be required in managing public expectations.

Taken together with the overall spending constraints and demographic movements, HFANZ considers the targeted improvements in elective surgery access and wait times will be difficult to achieve.

Longer term implications

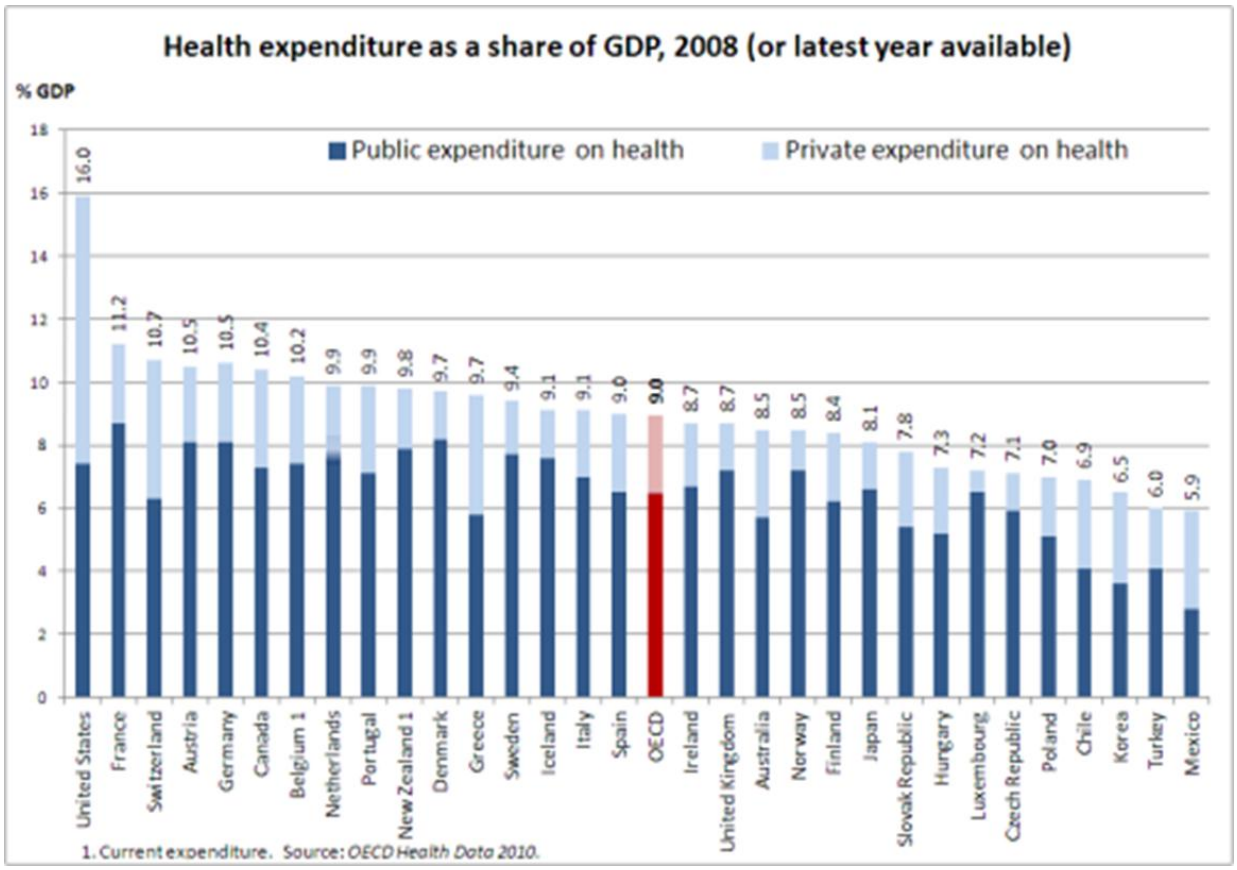
New Zealand has been moving towards an increasingly unbalanced healthcare system for over a decade now. There has been a crowding-out of the private health sector as the Government's health budget was increased dramatically in the late 2000s.

New Zealand now has the fifth highest public health spending as a percentage of GDP in the OECD. (This is probably at odds with what you hear from those agitating for an increase in the public health budget).

Only four countries – Germany, France, Austria, Denmark – spend more of their GDP on public health than New Zealand. Even the UK manages the NHS while spending publicly 7% of GDP, compared with NZ's 8% of GDP.

It is noted that all of these are European countries. Given the size of public spending and deficits, together with the likely focus on restraint in Europe, NZ could be moving up the rankings in coming years.

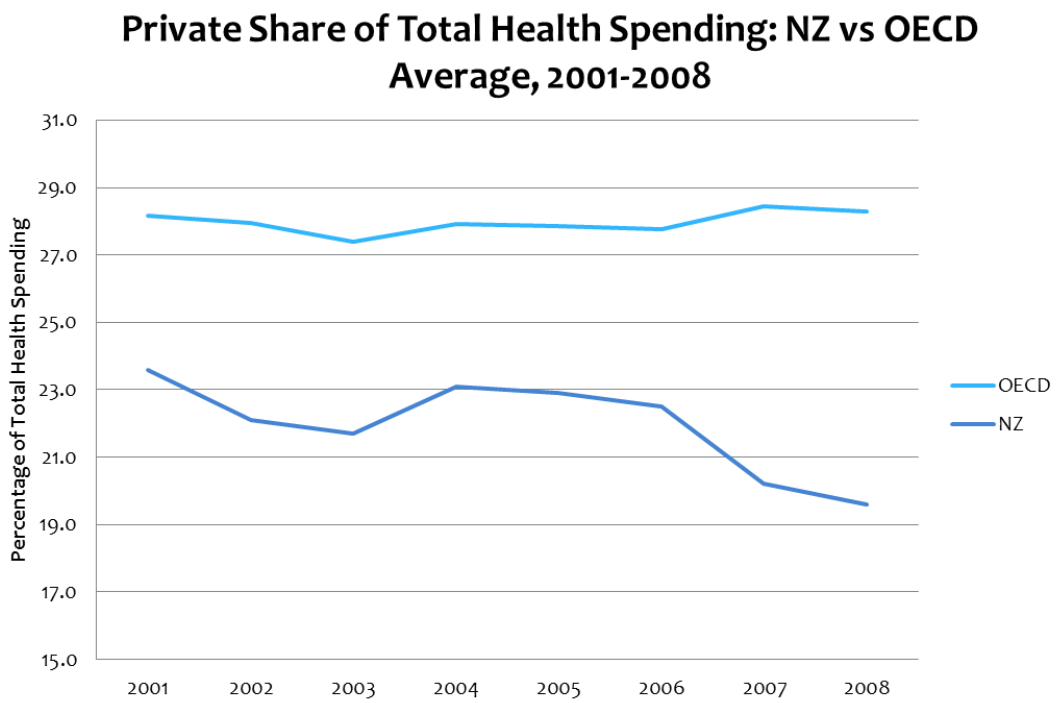
Most Governments internationally are now actively looking to curtail their public spending on healthcare and make better use of the private healthcare systems in their countries as a key means of doing this.



NZ private share declining

There is no evidence as yet that New Zealand is looking to move in a similar direction – other than in terms of containment of public expenditure growth. In terms of public-private shares, the actual evidence points to the reverse – ie a widening gap between public and private spending. This is effectively a *crowding out* effect on the private health sector.

The private healthcare share of total health spending in New Zealand is now just 19.5% and moving in the opposite direction as the OECD average. A decade ago it was around 24% of total health expenditures. Even simply maintaining that ratio, while keeping total health expenditure constant, would have saved $1b annually from public budgets.



New Zealand's Health Insurance industry

This part deals with the present shape of NZ's health insurance industry, together with recent trends and the likely outlook over the next five years or so. Where possible it provides commentary on the implications of any trends or changes for the public health sector.

Health insurance current situation

Key statistics for New Zealand's health insurance industry as at September 2011 are:

- Currently 31% of New Zealanders covered, or 1.4 million people
- Predominantly elective surgical & specialist cover (67%) rather than comprehensive
- Variation in coverage across age groups:
- Peaks at 45% for age 55-59
- Drops to 25% by age 70-74
- Premiums of $1.02 billion in the year ended 30 September 2011;
- Claims paid of $823 million in the year ended 30 September 2011.

Note: Premiums reflect claims risk for the age of policyholders, with the exception of some community rated group schemes.

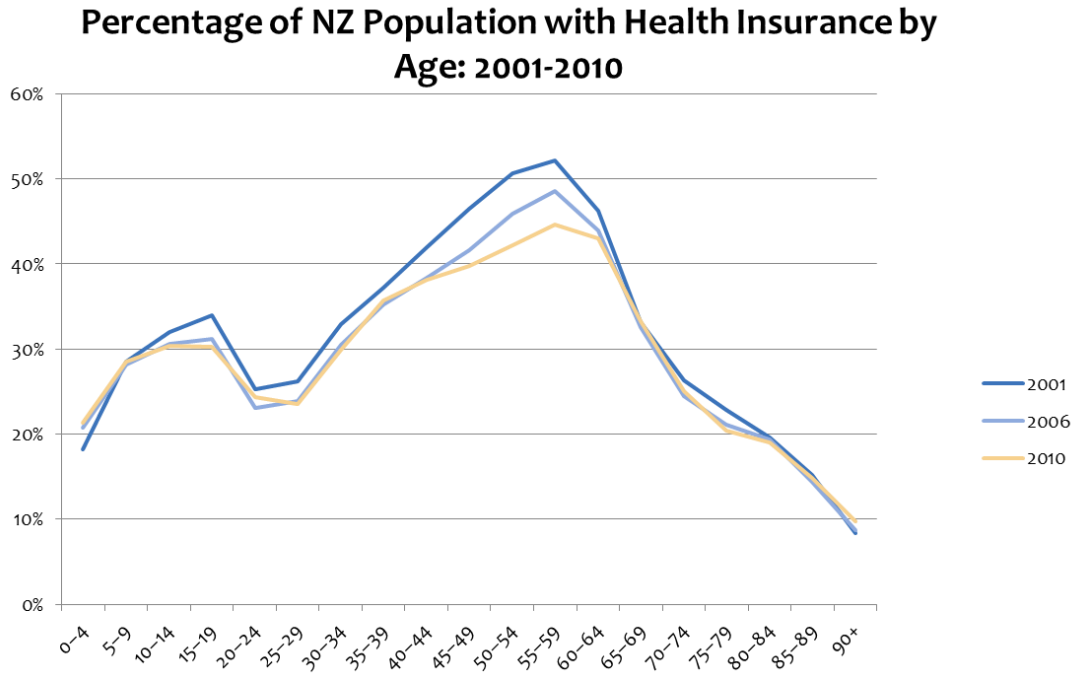
Recent trends

Recent trends in the health insurance industry have seen a dramatic rise in claims costs, fuelled by high levels of health sector inflation, together with increased demand for specialist services, some new treatments offered, and cost-shifting from public sector, particularly ACC.

Premium increases have occurred in response to claims cost rises, with the effect that the health insurance industry has grown to a $1billion a year industry, effectively doubling in size over the last decade (measured on a dollar basis), with virtually no change in the number of lives covered.

The Government's recent overhaul of the regulatory environment, particularly the new prudential regulation and supervision for insurers, has added significantly to the level of compliance costs in the health insurance sector. These additional costs have had to be passed on to policyholders in the form of higher premiums.

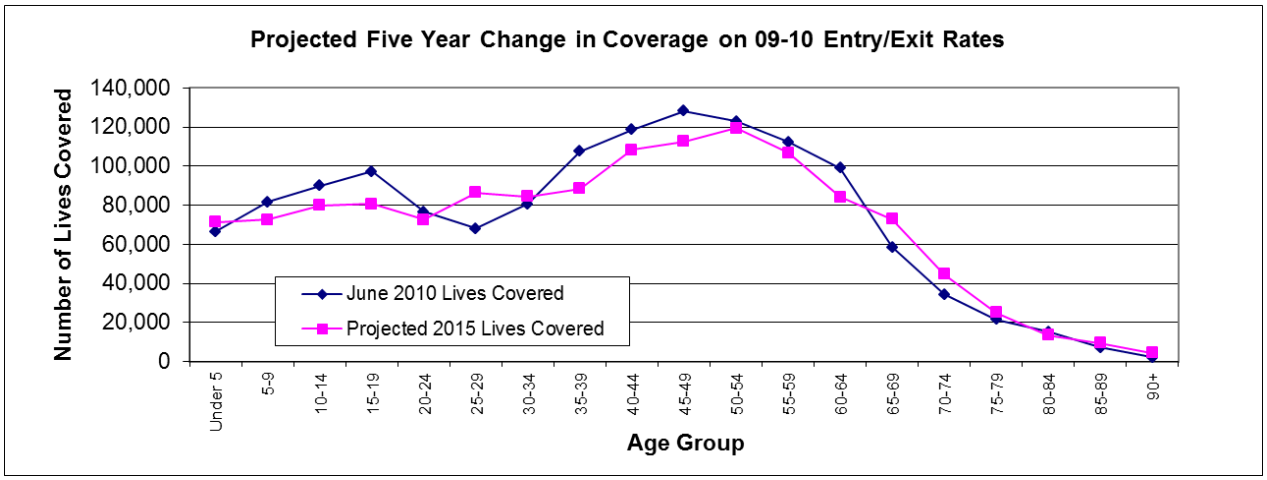
In terms of the percentage of New Zealanders with health cover, this has dipped slightly over the decade, from 33% to 31%. The drop is most noticeable at the peak coverage point – age 55-59, where in 2001, over 50% of that age group held health insurance. This has steadily reduced to just 45% today.



Future projections for health cover

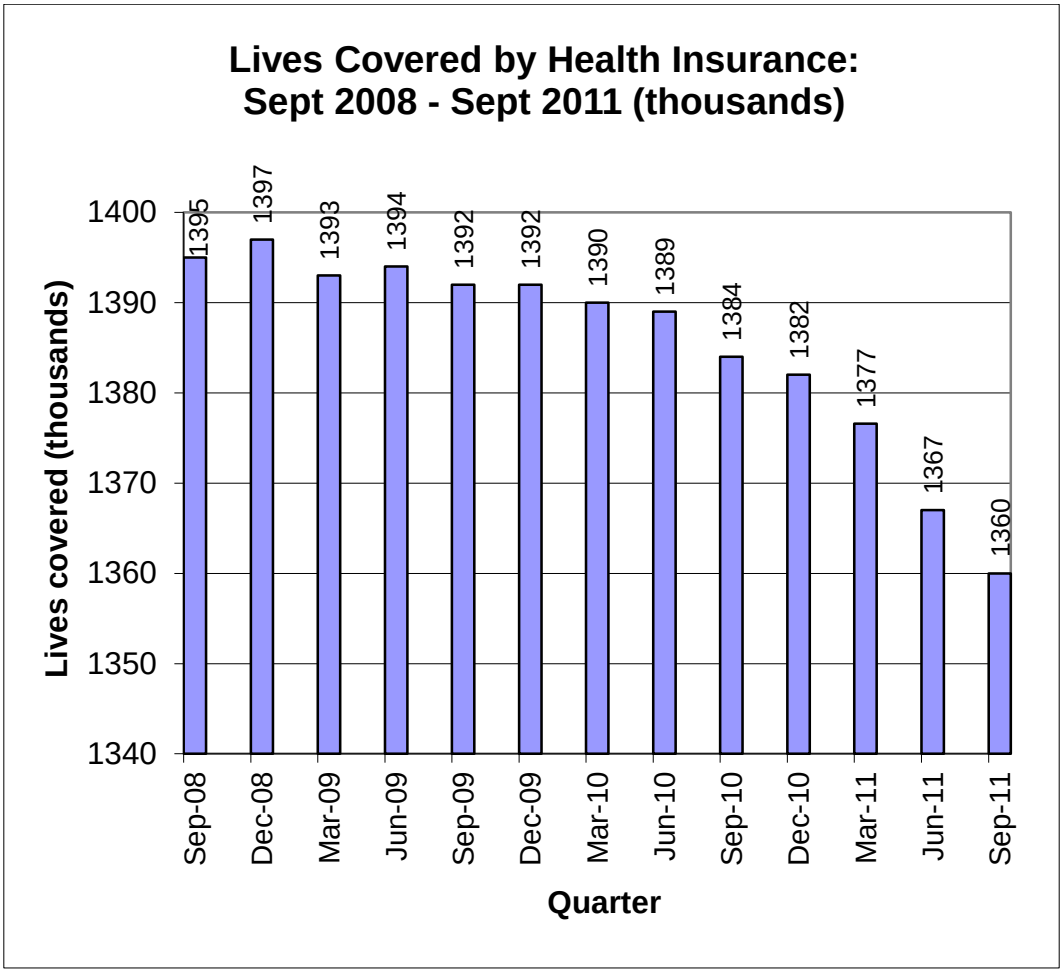
There is a demographic 'bulge' moving through each year with higher than average coverage. The size of the peak has been reducing over the last decade, and this is expected to continue, with an eventual flattening of the 'peak' at around 40%. Currently the peak is at age 55-59. In five years the peak could be for the 60-65 age group. However, it is very unlikely that a significant percentage of that cohort will retain cover post 65. As the above chart shows, despite the aging of the cohort, the percentage retention rates for the age groups over 65 have remained stubbornly low.

Last year, as part of ongoing engagement with Ministry of Health officials, a model of projected change in coverage over the next five years was developed. This rolled forward entry and exit rates to project a likely scenario for coverage in 2015.



In total, this showed a drop of 50,000 lives covered, from 1.38 million to 1.33 million.

Part of this reduction has already occurred, with a 37,000 reduction in lives covered between December 2008 and September 2011, taking the total to 1.36 million.



The total reduction in coverage could be even greater due to a number of factors:

- The length of downturn is expected to be longer: Health insurance coverage varies with the economic cycles, picking up when employment and economic growth increase and falling

back in periods of downturn. A longer period of subdued or low growth points to lower coverage.

- Increasing employer contributions to kiwisaver: These have potential to squeeze the level of discretionary employer contributions to other areas, including around $150m employers commit annually to employee health insurance. If employers cease funding, or reduce the level of subsidy, then employee participation in such schemes will reduce significantly.
- Increasing public system performance, including reduced waiting times: To the extent that this is achieved, there will be a number of policyholders, particularly in older age groups, who opt to discontinue insurance and rely on the public system for elective surgery in the event they require it.
- Claims pressure on premiums: Potential further increases in premium, based on higher claims costs, could accelerate the drop in coverage post age 65. Currently at 25% of the 65+ population, this will potentially fall to 20% or even lower over the next decade.

Implications for public system

A recent study[1] on elective surgery demand, co-funded by HFANZ, showed the close relationship between public and private sectors.

Even a small incremental change each year in health insurance retention rates can add up to a big impact over a longer period.

The coming drop in coverage, particularly among older policyholders, will likely lead to a significant jump in the level of public elective surgery demand. This will depend upon the progress made in waiting times and hence the relative attractiveness of the public sector, but nevertheless will be greater than a simple adjustment for demographics.

The following table compares the study's main estimate for additional public and private surgery demand over 20 years (first column) with what this would be if the propensity to use private hospitals was to increase or decrease by one percentage point per year, from increased health insurance funding.

	Main estimate	One percentage point increase p.a.	One percentage point decrease p.a.
Public elective demand increase over next two decades	44% 75,000 events	22% 38,000 events	65% 111,000 events
Private elective demand increase over the next two decades	32% 47,000 events	58% 83,000 events	7% 10,000 events

The present trajectory appears to most closely resemble the last column, with an almost flat level of private elective demand over the next two decades, but an increase in public elective demand of over 100,000 events.

[1] Kim von Lanthen, 2009: Growth in Elective Surgery Demand to 2030.

It is recommended that you note the projected decline in the level of insurance coverage, particularly for older age groups, and the implications this will likely have for public sector demand for elective surgery.

Revisiting policy engagement

Despite a clear direction from the Associate Minister of Health for policy engagement with the industry on this, progress has been very disappointing. The process has dragged on over a year and a half, with no final report on the proposals for the rebate for over 65s.

During the engagement with industry, there have been many stumbling blocks with officials taking an overly pessimistic view in relation to assumptions and scenarios used in the analysis. They have been overly concerned with the level of deadweight cost and the apparent need to precisely quantify and map the level of demand transfer from private to public under different scenarios.

This process has been time consuming and resource intensive from an industry perspective. The reality is that an accurate answer to many issues will only be possible post-implementation, and even then there will likely be debate (as evidenced overseas) as to the relative causes and effects and differing views as to what might otherwise have occurred in the absence of a rebate. This is the nature of public policy.

What is apparent is that both fiscal cost and deadweight cost of a rebate are tiny in comparison with other significant public policies – such as kiwisaver – where the fiscal and deadweight costs run into the billions.

There is a need to conclude the piece of work which has been underway for some time, and bring the report and any recommendations to a conclusion. To the extent that differences in view (between industry and Ministry officials) remain, these need to be quantified and the implications spelt out in the form of alternative scenarios or sensitivity analysis. Options for progressing the proposal can then be assessed in the light of this body of work.

It is recommended that officials be instructed to finalise their reporting on the rebate for 65+ and options for implementation.

Health premiums and FBT

While progress investigating the rebate policy has been disappointing, progress in terms of engagement on the issue of FBT on employer contributions to health insurance group plans appears to have been non-existent.

There has been no significant engagement on the FBT issue yet, although feedback suggests a lack of interest on the basis of precedent setting and slippery slope arguments.

While a reluctance to consider on the grounds of revenue base protection is understandable as a first reaction, there are a number of arguments set out in the preliminary papers HFANZ produced which indicated this particular issue was worthy of more serious consideration.

It is recommended that officials be instructed to continue engagement on the FBT issue with a view to preparing an options paper for consideration.

Further information

I have attached to this information paper, the summary papers on both the 65+ rebate and the FBT issue for your information.

Please let me know if there is any further information or clarification you would like on any of the matters in this paper, or any other aspects of the health insurance industry.

Roger Styles

Chief Executive

Attachment 1

HEALTH FUNDS ASSOCIATION OF NEW ZEALAND

Summary paper

Fringe Benefit Tax and Health Insurance

March 2010

Key issues

- Fringe benefit tax is a significant disincentive to employer-subsidised health insurance.
- Since its imposition in the 1980s, health insurance coverage in New Zealand has declined from 50% to 33%
- Provision of workplace-based health insurance benefits a range of parties, including employer, employee, and the Government
- In New Zealand, around $320 million is spent annually on group health schemes, providing coverage for around 630,000 New Zealanders
- Around 50,000 procedures are funded each year under group schemes.
- Removal of FBT on employer contributions to health insurance would have a range of benefits, which would over time outweigh the fiscal cost associated with its removal.

Broader benefits from employer-subsidised health insurance

- Recent studies show key employer benefits, including reduced days off work, reduced incidence of workplace stress, and reduced loss of productivity in the event of illness.
- The combined productivity benefit from group health insurance amounts to $133 million per annum.
- Employees benefit from having piece of mind and from obtaining timely medical treatment under their policies in the event they need it.
- The Government benefits in two key ways. First, through the additional tax collected as a result of increased productivity across the economy. Secondly, through reduction in pressure on the public health system. The combined benefit is $191 million p.a.

Rationale for removal of FBT on health insurance

- The significant employer benefits means health cover is a legitimate business expense.
- There is an inconsistency in the treatment of health insurance compared to accident insurance under ACC.
- The fiscal cost of removal is outweighed by the broader benefits.

Impact of removal of FBT on health insurance

- The removal of FBT can be expected to lead to a medium term increase in workplace based health insurance of up to 250,000 people;
- Annual boost to productivity of $31-46 million.
- An additional 20,000 medical procedures funded annually under group schemes.
- Immediate fiscal cost to the Government of $57 million p.a.
- Medium term benefits to Government of $50-$75 million p.a. in health savings and additional tax.

Attachment 2

HEALTH FUNDS ASSOCIATION OF NEW ZEALAND

Summary paper

Health Insurance Rebate for those aged 65+

March 2010

Key issues

- 137,500 people aged 65 or over have health insurance or 24.7% of that age group. This compares with nearly 50% of those aged 55-59.
- Annual health claims costs total $222 million for those aged 65 or over – almost a third of claims.
- Affordability is a major concern for this age group, as premiums rise in line with higher expected claims costs. Claims have risen dramatically over the last decade.
- Many countries target specific assistance to help boost coverage and take pressure off the public health system.
- Improving retention rates post age 65 would have a significant impact on reducing pressure on the public health system.
- A rebate on health premiums of up to $500 a year would lift the level of coverage by around 30% over the medium term.

Impact of a rebate for those aged 65+

- The initial fiscal cost of a 30% rebate capped at $500 p.a. is estimated at $44 million p.a.
- Over the medium term, higher retention rates will mean a further 44,000 people aged 65+ will have health cover.
- Lesser increases in other age groups are also expected, depending on how the rebate policy is designed.
- An additional $110 million p.a. in claims paid are expected over the medium term, mainly for elective surgery, with an extra 15,000 to 16,000 discharges annually.
- A reduction in pressure on the public system is anticipated. This may be a direct cost saving in the public sector, or it could allow for a lowering of thresholds for elective surgery, allowing more procedures to be carried out within the same overall budget.

Key benefits to the Government

- Encouraging higher levels of health insurance cover for older New Zealanders will take pressure off an increasingly stretched public health sector.
- Cost per additional elective discharge of between $2,600 and $3,600 compares favourably with other recent elective surgical initiatives with a greater cost.
- Reducing pressure allows a reduction in the public elective surgical thresholds, meaning a lower average complexity and patients being seen earlier in the public sector.
- A significant improvement in overall health outcomes for the 65+ age group, with reductions in levels of morbidity and improvements in quality of life.
- Helps preserve a balanced health system in New Zealand, with a better balance between public and private contributions to future healthcare costs.
- Helps to stimulate private investment in theatre capacity going forward, and mitigate the requirement for additional fiscal costs of new public theatre development.