Working Paper on Health

Number 20, 21 June 2018

Did the 2018 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

Introduction 1

Key points 2

Assumptions 3

Did the Health vote keep up with rising costs? 4

District Health Boards 5

National Services 5

Ministry of Health operational funding 7

Successive years of under-funding 7

The consequences of chronic underfunding: Pressures on public health services 8

Pressures driving DHBs over budget 9

Why are acute hospital admissions rising so much despite increased use of primary health care? ... 10

Introduction

This analysis compares the Health vote in the 2018 Budget with the analysis of operational funding needs which the CTU and ASMS carried out prior to the Budget[1].

This is the first Budget in nearly a decade that has put more money back in to health than the coming year's estimated spending requirements. The previous Government's year-on-year funding

[1] "How much Health funding is needed in Budget 2018 to maintain current service levels?", available at http://www.union.org.nz/budget-2018-media-resources/how-much-funding-does-health-need-in-budget-2018/

shortfalls have accumulated into a gap of around $2 billion per year compared to the level of funding in 2009/2010.

The health vote however is very tight, with only $57 million estimated to spare in total operational spending of almost $17 billion, and this doesn't include the additional wage settlements and increased staffing for nurses, allied health staff and others which are coming, and which the Government says will be funded out of a separate contingency. Two national services under severe stress, maternity services and disability support services, receive significant new funding, but a third, national mental health services, is largely left waiting on the results of the Government Inquiry into Mental Health and Addiction for adequate funding.

Our analysis of unmet need shows that acute public hospital admissions increased by 20 percent over the seven years to 2017, much faster than population growth and outgrowing the capacity of many of our hospital emergency departments. There is still significant unmet need in primary health care services, despite increased use and expanded free care for children. That could result from a variety of factors, including poverty, poor housing, poor diets, obesity, our ageing population and unavailability or unaffordability of GP services.

It is often argued by Government that spending more on health would be at the expense of other government expenditure. However, while Vote Health expenses have risen slightly as a proportion of government operational spending since 2009/10, the main reason has been that government operational spending as a whole has fallen as a proportion of GDP. This falling trend is forecast to continue under the Government's Budget Responsibility Rules. It is a political choice rather than one of necessity.

In summary, the data outlined here indicate the rate of New Zealand's growing health need has overtaken the rate of growth in the capacity of our health services. As a result, over the years examined here, health services throughout the system have lacked the resources to adequately respond. Addressing the shortfall in health sector resources will require a system-wide approach, recognising the complex inter-relationships between the various parts of the system, as well as substantial new funding.

Key points

- Total operational funding announced was $16,972 million, $863 million more than the $16,109 million announced in the 2017 Budget. Capital funding announced was $1,253 million, almost double the $664 million announced in last year's Budget.
- The Health vote in the 2018 Budget is an estimated $57 million ahead of what is needed to cover announced new services, the next instalment of the pay equity settlement for care and support workers, increasing costs, population growth and the effects of an ageing population, compared to the 2017 Budget.
- This is the first year since 2010 in which our estimates show that the Budget was ahead of anticipated costs for the year.
- However this does not take into account any settlement with nurses and allied health staff on their pay rates and staffing levels. This is expected to come out of a separate contingency fund.

- We estimate an accumulated funding shortfall in annual spending power of $1.6 billion between the 2009/10 and 2018/19 financial years. It means that in the next Budget the Government will need to find around $2.5 billion for 2019/20 if it wishes to restore the value of funding to the 2009/10 levels.
- The Health vote is forecast to rise slightly as a proportion of Gross Domestic Product (GDP), from 5.56 percent to 5.57 percent of GDP. If it had maintained the proportion of GDP it had in 2009/10, it would be $2.1 billion higher in 2018/19.
- District Health Boards (DHBs) received an estimated $37 million more than they need to cover anticipated increased costs and demographic changes during the year.
- Centrally managed national services such as National Disability Support Services, National Elective Services, and Public Health services received $22 million more than what they needed to cover cost increases and demographic changes forecast for the year and to fund $96 million in new services, offset by $10 million being shifted to DHBs.
- The pay equity settlement for care and support workers was funded $348 million, exactly as budgeted in the settlement. In the 2017/18 year, $299 million was funded compared to $303 million in the settlement.
- The Ministry of Health itself was underfunded by $1.3 million and has had significant reductions in staff numbers since 2010.

Assumptions

Our pre-Budget analysis assumed that CPI would rise by 1.9 percent in the year to June 2019 (the Budget period), which was the Treasury forecast in its December 2017 Half Year Economic and Fiscal Update (HYEFU). However, Treasury changed that forecast to 1.5 percent in the year to June 2019 in the Budget Economic and Fiscal Update (BEFU), a significant reduction on its December forecast (similar to what happened last year). We assumed wages would rise in line with Treasury's HYEFU forecast of a 3.2 percent rise in the all-industries average hourly wage; Treasury has revised this down to 2.7 percent. In this post-Budget analysis we use these new forecasts for costs and wages except for the increase due to the pay equity settlement for care and support workers, and for wage increases for workers directly employed by DHBs. For employees of DHBs we conservatively allow for an increase of 2.0 percent, the increase in one collective agreement, but it is public knowledge that for nurses, allied health staff and others the final value is still to be decided at time of writing and will be considerably higher. We allowed for an increase of 2.34 percent for the growing and ageing population which we continue to do[2]. See the report on the pre-Budget analysis for further details.

The pay equity settlement for care and support workers is funded through a national appropriation ("Supporting Equitable Pay for Care and Support Workers"). While the cost to the Health vote detailed when the settlement was announced was estimated at $303 million[3], only $279 million was

[2] These are calculated from data provided by the Ministry of Health. These were calculated using the latest (2017) Ministry of Health demographic projections and 2015 age, sex and ethnicity cost weights. We believe the Ministry has updated its cost weights but has still not provided them to us.
[3] Previously linked from https://www.beehive.govt.nz/release/2-billion-pay-equity-settlement-55000-health-care-workers, but the link is broken. It can be supplied by the authors.

provided at Budget 2017. A further $20.3 million was added following that Budget, providing a total of $299.3 million (a further $2.5 million was provided to 'manage' the funds). No official estimate is yet available of the cost of the similar mental health and addiction care and support workers' claim which the Ministry omitted from the original settlement and the new Minister has agreed to negotiate[4], which we estimated conservatively at $25 million in the 2018/19 year. There are other pay equity claims whose cost is unknown.

Did the Health vote keep up with rising costs?

The Health vote's operational funding increased by $863 million between Budget 2017 and Budget 2018, from $16,109 million to a comparable $16,972 million. This is $130 million more than the $16,842 million we estimate is needed just to keep up with costs, population growth and ageing without providing for new or improved health services. In addition the Health vote has a net $72 million in additional requirements which means that Health is $57 million[5] better off compared to the previous year.

Table 1: New policy initiatives in 2018/19

Initiative	Amount
Very Low Cost General Practitioner Visits for Community Services Card Holders	$59,008,000
National Bowel Screening Programme Implementation Year Two	$17,391,000
Improving Mental Health Services for Children in Canterbury and Kaikōura	$7,300,000
Extending Zero Fees Doctors' Visits to Under 14s	$2,858,000
Expansion of School Based Health Services	$4,253,000
National Bowel Screening Business Case drawdown from Contingency Fund	$3,713,000
Integrated Therapies Pilot for 18- 25 Year Olds	$2,020,000
Radio Assurance	$3,740,000
Community Organisation Refugee Sponsorship Category	$249,000
Developing a Free Annual Health Check for SuperGold Card Holders	$1,000,000
Total	**$101,532,000**

The additional $72 million is made up of $102 million as in Table 1, less $29 million in Pharmac savings (after rounding; see below). The vote listed "new policy initiatives" totalling $812 million in operational funding, but the bulk of that ($710 million, principally $549 million to DHBs) is recognition of cost, population and demographic increases rather than new initiatives. The remaining $102 million constitutes the cost of announced genuinely new initiatives.

That cost is reduced by $29 million in "savings" which are cost savings made by Pharmac in purchasing pharmaceuticals. Counting these as savings to the Health vote, rather than allowing the Health sector to use it to relieve cost pressures, is a continuation of the practice of the previous Government. That leaves a net $72 million in additional requirements.

In addition, the previous Government's $25 million per year "Mental Health Social Investment Fund Contingency" has been dissolved, $7.3 million of which goes to "Improving Mental Health Services for Children in Canterbury and Kaikōura". This contingency fund ($100 million over four years) was

[4] See "Pay equity for mental health and addiction workers", David Clark, Minister of Health, 14 February 2018, available at https://www.beehive.govt.nz/release/pay-equity-mental-health-and-addiction-workers

[5] After rounding. This is less than the $80 million we estimated on Budget day. The difference is due to a number of details found in our post-Budget analysis.

the main basis for claims by the previous Government that it had put $200 million more into the mental health system. As was apparent at the time,[6] there were no "trials" developed on which to spend the $100 million and it has remained unspent.

This is the first Health vote we have reported on since 2010 in which the costs of initiatives, rising costs, population growth and ageing have been fully funded. In many years, the underfunding has been such that the "initiatives" and some of the rising costs have been unfunded.

District Health Boards

Together, DHBs received $13,236 million, a $553 million increase on the $12,683 million in Budget 2017. This is $18 million more than the $13,217 million we estimate is needed just to keep up with costs, population growth and ageing without providing for new or improved health services. In addition the DHBs are attributed the $29 million in cost savings made by Pharmac in purchasing pharmaceuticals but also had $10 million added to their costs due to the "devolution" of services from the nationally funded services during the current year. The Supplementary Estimates showed devolution to DHBs of a $3.1 million responsibility for Diabetes Care Improvement Packages, $3.8 million for "In-between Travel (Part B) agreement", $2.9 million for the "Drivers of Crime" programme in six DHBs, and $0.5 million in two other programmes. The net saving of $19 million meant that the DHBs were $37 million better off in real terms compared to the previous year.

None of the funding for the pay equity settlement for care and support workers in the national "Supporting Equitable Pay" appropriation was transferred to DHBs during the year.

For 2018/19, $139 million is set aside under capital for DHB "Deficit Support", an acknowledgement of the ongoing financial stress in the DHBs. Whether it will be sufficient depends on whether the Government continues the previous Government's policy of only partially funding deficits, and whether deficits will reduce compared to this year because of somewhat more adequate funding. In the 2017 Budget, only $50 million was provided for, but in the event $87 million is estimated will be paid out by 30 June 2018 using funding carried forward from 2016/17. The most recent publically available financial data available shows DHBs recording combined deficits of $142 million for the ten months to April 2018, $53 million larger than their plans and $23 million more than in the full year to June 2017[7].

National Services

The centrally managed national programmes such as Primary Health Care Strategy, National Disability Support Services, National Maternity Services, National Mental Health Services, National Māori Health Services and National Elective Services gained $301 million in operational funding (rising from $3,200 million to $3,501 million), which is $107 million more than what is needed to keep up with costs, population growth and ageing without providing for new or improved health services. However there were $96 million in new services (the bulk of the costs listed in the above table of "New policy initiatives" – the remainder is used by the Ministry to manage these initiatives),

---

[6] See our analysis at https://www.asms.org.nz/news/asms-news/2017/06/07/called-budget-mental-health-funding-boost-cut-real-terms/.

[7] See http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/summary-financial-reports

offset by $10 million devolved to the DHBs, leaving the national programmes $22 million better off in real terms compared to the previous year.

Table 2: National Services funding provided and cost of additional services ($000)

Red indicates shortfall

National Service	Required for rising costs and pop'n	Appro-priation	Shortfall on rising costs and pop'n	Initiatives	Shortfall after initiatives	Devolved to DHBs/ transfers	Shortfall after transfers & savings
Auckland Health Projects Integrated Investment Plan	665	1,000	-335	0	-335	0	-335
Health Sector Projects Operating Expenses	0	3,500	-3,500	0	-3,500	0	-3,500
Health Workforce Training and Development	190,951	186,745	4,206	0	4,206	0	4,206
Monitoring and Protecting Health and Disability Consumer Interests	29,393	29,546	-153	0	-153	0	-153
National Child Health Services	86,932	89,254	-2,322	4,253	1,931	0	1,931
National Contracted Services - Other	30,054	28,720	1,334	0	1,334	0	1,334
National Disability Support Services	1,264,495	1,268,594	-4,099	0	-4,099	-3,809	-7,908
National Elective Services	361,121	363,517	-2,396	0	-2,396	0	-2,396
National Emergency Services	115,065	129,597	-14,532	3,740	-10,792	0	-10,792
National Health Information Systems	8,422	8,042	380	0	380	0	380
National Māori Health Services	7,173	6,828	345	0	345	0	345
National Maternity Services	152,667	181,067	-28,400	0	-28,400	0	-28,400
National Mental Health Services	66,476	68,094	-1,618	8,700	7,082	-3,407	3,675
National Personal Health Services	87,583	78,151	9,432	0	9,432	-3,100	6,332
Primary Health Care Strategy	204,480	266,396	-61,916	61,466	-450	0	-450
Problem Gambling Services	18,335	20,941	-2,606	0	-2,606	0	-2,606
Public Health Service Purchasing	422,481	423,424	-943	17,353	16,410	0	16,410
Supporting Equitable Pay for Care and Support Workers	348,000	348,000	0	0	0	0	0
Totals	**3,394,294**	**3,501,416**	**-107,122**	**95,512**	**-11,610**	**-10,316**	**-21,926**

Particularly notable are National Disability Support Services and National Maternity Services, which both appear to be more than fully funded (although it is difficult to forecast needs in these areas). During the current financial year, the underfunding in Budget 2017 was highlighted by the need, as in the previous year, to find funds from other appropriations to provide relief for those services.

A total of $33 million was transferred to National Disability Support Services in the 2017/18 year from six other national services (including Child Health, Public Health, Māori Health and Primary Health) and from $9 million in additional funding.

A total of $20 million was found for National Maternity Services in the 2017/18 year, including a $2.5 million transfer from National Contracted Services - Other, $9 million in the 2018 Budget, and $8 million from a contingency fund.

A further $4 million was also transferred into National Elective Services.

Mental health however appears to be under continued stress, presumably waiting on the results of the current inquiry. National Mental Health Services are underfunded, but it is difficult to judge the overall position because the bulk of mental health funding is inside DHB budgets.

Ministry of Health operational funding

The Ministry of Health received $207 million, including multi-category expenses, which is $5 million more than what we estimated it needed to cover increased costs on current services. This makes no allowance for an increasing population. However, Budget 2018 includes additional management to be provided by the Ministry relating to four of the new initiatives above, totalling $6 million, leaving a funding shortfall of $1.3 million.

As noted last year, the Ministry of Health has seen severe funding cuts, repeated restructuring and staff loss over successive years. This year's Budget is still well below the $216 million the Ministry was allocated in the 2010 Budget for 2010/11, which is $244 million in June 2019 dollars using Treasury's CPI forecast. This year's Budget of $207 million is therefore a real cut of $37 million over that period.

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 in reality 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, we estimate an accumulated funding shortfall in annual spending power of $1.6 billion between the 2009/10 and 2018/19 financial years. It means that in the next Budget the Government will need to find around $2.5 billion for 2019/20 if it wishes to restore the value of funding.

This takes account of the costs of new services and claimed savings in each Budget, the actual expenses each year (estimated for 2017/18, forecast for 2018/19), CPI, demographic growth including ageing (supplied by the Ministry of Health)[8], actual increases in wages for DHB employees (from consolidated DHB accounts) and increases in the average hourly wage in Health Care and Social Assistance for most other employees in services funded by the Health vote. Treasury forecasts of CPI and the average wage are used for 2018 and 2019.

Another way to consider the adequacy of the funding trend is as a proportion of the measured economy – Gross Domestic Product (GDP). The Estimates show that in 2009/10 Vote Health operational expenses were 6.28 percent of GDP, which had dropped to 5.56 percent of GDP (forecast by Treasury as $291,020 million) by 2017/18 and are forecast to be 5.57 percent (of

[8] This is applied to the DHBs and to some of the national services, similarly to the calculation for this Budget.

forecast GDP at $304,591 million) by 2018/19. For Vote Health operational expenditure to match 6.28 percent of GDP in 2018/19, it would have needed a further $2.1 billion.

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 Vote Health expenses have risen from 19.4 percent of government operational spending (Core Crown expenses) in 2009/10 to a forecast 19.6 percent in 2018/19, the main reason has been that government operational spending as a whole has fallen as a proportion of GDP by 3.8 percentage points over that period – from 32.3 percent of GDP in 2009/10 to a forecast 28.5 percent in 2018/19. This falling trend is forecast to continue under the Government's Budget Responsibility Rules.

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

The consequences of chronic underfunding: Pressures on public health services

While health funding has been cut in real terms since at least 2019/10, health needs have been increasing, as demonstrated in Ministry of Health data showing the growing use of public health services is far outstripping the rate of population growth.

The number of public hospital inpatients (excluding mental health and addiction services) rose by 14.1 percent from 2010/11 to 2016/17 (13.2 percent when adjusted for 'case weights'[9]), while the population grew by 9.3 percent. This growth is due largely to a 20.0 percent increase in acute inpatients over that period – more than twice the population growth. When adjusted by case weight, acute inpatients increased by 14.2 percent. See Table 3.

Table 3: Acute and non-acute DHB inpatient discharges 2010/11 to 2016/17

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	percent increase
Acute	509,737	532,613	545,806	564,244	576,504	596,503	611,452	20.0%
Non-acute	336,864	328,612	332,291	335,550	343,080	351,617	354,677	5.3%
Population	4,384,000	4,408,100	4,442,100	4,509,700	4,595,700	4,693,200	4,793,900	9.3%

Source: Ministry of Health Caseload Monitoring Reports (data extracted from Excel spreadsheets)

The surge in acute cases appears to have squeezed out non-acute patients, whose numbers grew by just 5.3 percent. However that becomes a 12.0 percent increase when adjusted by case weight, indicating the non-acute cases are becoming more complex. This is possibly an effect of the ageing population. In addition it could also be an indicator of poor health status, as we have highlighted in previous analyses, due in part to poor investment in health promotion and illness prevention strategies.

Hospital day cases (non-overnight stays) are not included in this data but other Ministry of Health reports indicate a 16.9 percent rise from 2010/11 to 2014/15 (the latest data published) – again,

[9] Case weights measure the resources needed for the treatment given to each patient during a hospital stay. For example, a cataract operation will receive a case weight of approximately 0.5 whereas a hip replacement would receive 4 case weights. Case weight measurements are occasionally adjusted to reflect changing practices. These will make a small marginal effect on overall trends.

well above the population increase of 4.8 percent for that period. Likewise with Emergency Department presentations. Emergency Department presentations at Waikato District Health Board, for example, are reported to have seen an increase of nearly 70 percent in seven years.

As we reported in our previous post-Budget analysis of Vote Health, use of Mental Health and Addiction Services (MHA) is also far exceeding the growth in population. The number of unique 'clients seen' by MHA services teams grew by 50 percent in the years 2008/09 to 2015/16. Many of those clients are seen more than once in any given year, as indicated in other data showing 'new referrals' to MHA triage teams increased by 62 percent over the five years from 2010/11 to 2015/16 (earlier data is less robust).

The significant growth in the use of hospital and MHA services has occurred despite primary care use growing by 24.3 percent between 2008/09 and 2016/17, while the population grew by just 11.4 percent (Table 4). Much of that increase has occurred through a significant increase in nurse consultation (115.1 percent), while general practitioner consultations increased by 12.6 percent.

Table 4: Primary health care consultations 2008/09 to 2016/17

Consultation Type	2008/09 (000)	2009/10 (000)	2010/11 (000)	2011/12 (000)	2012/13 (000)	2013/14 (000)	2014/15 (000)	2015/16 (000)	2016/17 (000)	percent Increase
GP Consultation	11,909	12,036	11,969	12,269	12,239	12,532	12,731	13,190	13,410	12.6%
Nurse Consultation	1,538	1,958	2,221	2,337	2,492	2,648	2,927	3,251	3,307	115.1%
Total Consultation	**13,446**	**13,995**	**14,191**	**14,606**	**14,731**	**15,180**	**15,657**	**16,441**	**16,718**	**24.3%**

Source: Ministry of Health (unpublished data). Totals may not add up due to rounding.

More data is needed to gain a better understanding of the trends in the use of primary health care. Medical Council data show GP numbers increased by about 15 percent between 2008 and 2016 but at the same time the average number of hours worked are decreasing, suggesting increasing numbers of part-time GPs. The 12.6 percent increase in GP consultations may therefore simply reflect the increased capacity of the GP workforce. The number of registered nurses working in primary care and community increased by 28 percent between 2010 and 2015. The nurse consultation figures indicate an increasing role for practice nurses in primary health care and increasing use of nurse practitioners.

Pressures driving DHBs over budget

Ministry of Health data show the DHBs' planned (i.e. budgeted) inpatient case-weighted discharges were exceeded by 2.5 percent in 2016/17, compared to 1.3 percent in 2010/11.

In addition, while the Government has recognised the need for substantial investment in hospital facilities following years of deferred maintenance in many cases, the Government's 6 percent capital charge imposed on DHBs for that investment is expected to come from DHB operational budgets. In 2016/17 the capital charge to DHBs totalled $174.2 million. In the 2018 Budget a total of $1.25b is budgeted for capital (though not all for DHBs), almost double that budgeted for 2017/18 ($664m) and over three times what the Budget estimates will actually be spent ($378m). The impact of the capital charge is therefore going to become an increasing drain on DHB operational budgets. We have called for the capital charge to be abolished and replaced with loan funding from the Crown.

Why are acute hospital admissions rising so much despite increased use of primary health care?

Despite the increased use of primary health care, many people continue to face barriers to those services. The 2015/16 New Zealand Health Survey shows 29 percent of adults reported one or more types of unmet need for primary health care in the previous 12 months, up from 27 percent in 2011/12. The most common reasons for this unmet need were: being unable to get an appointment at their usual medical centre within 24 hours (18 percent), the cost of GP services (14 percent) and the cost of after-hours medical centres (7 percent).

Similarly in 2015/16, despite the policy of free access to primary care for children under 13, a quarter of children (24 percent) experienced one or more types of unmet need for primary health care at some point in the previous 12 months, up from 20 percent in 2011/12. As with adults, a major barrier was difficulty in getting a timely appointment.

Further, there will be many factors contributing to the big rise in acute hospital admissions, including location and capacity of primary health services (and 24-hour access); barriers and delays in accessing non-acute hospital care leading to deteriorating health; the increase in chronic illnesses due to the growing and ageing population; the substantial increase in unmet need for mental health care (mental health and physical health are inextricably linked and the literature shows many people with an unmet mental health need also have an unmet physical health need); and unplanned hospital readmissions (for which we have sought data but it was not provided by the time of writing). Not least, the well-reported determinants of ill-health will be having an effect, including poverty, poor housing, increasing obesity, poor diets, and alcohol use.

In summary, the data outlined here indicate the rate of New Zealand's growing health need has overtaken the rate of growth in the capacity of our health services. As a result, over the years examined here, health services throughout the system have lacked the resources to adequately respond. Addressing the shortfall in health sector resources will require a system-wide approach, recognising the complex inter-relationships between the various parts of the system, as well as substantial new funding.