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Office of the Minister of Health

Cabinet Expenditure Control Committee

# Drivers of Vote Health expenditure and options for controlling expenditure growth over the next five years

## Proposal

1. This paper sets out the key drivers in publicly funded Vote Health services and options for controlling expenditure over the next five years.

## Executive Summary

2. Vote Health's expenditure path of recent years, nominal 8% per annum, is unsustainable given the fiscal environment. We have commenced a reform programme for the public health system that goes a long way in contributing to lifting system performance but there are significant challenges still facing the health system.
3. A top-down estimate of price and volume pressures in the health system suggests that to maintain per capita service coverage and quality would require $618 million of new funding (nominal 4.9% increase) in Budget 2011, **[2]**
4. If Health received the same share of the operating allowance as it did in Budget 2010 (38%), or an annual increase of 3.3%, this would require ongoing performance improvement savings from MRG reforms and other expenditure control options averaging $195 million per annum between 2011/12 and 2015/16.
5. There is no single answer for managing the challenges the health system faces. We will need to use a combination of approaches and at times we may need to make some tough choices regarding the scope and range of services the public health system can provide to New Zealanders.
6. Of particular importance will be effectively managing controllable and uncontrollable demand, for example, the challenges of rising prevalence of chronic disease and population ageing. How we respond to these challenges through the investments we make and the system performance improvements we achieve will determine how well expenditure is managed and how the health of New Zealanders will improve.
7. We will need to maintain firm fiscal control in the face of rising expectations regarding what services the system provides and the labour costs of its workers. We will need to ensure that we incentivise ongoing performance improvement, robust prioritisation, weed out lower value spending, and make best use of our health workforce as demand places greater pressure on the health system.
8. I propose to address these challenges and build on the Government's reform programme through a programme of work that focuses on improving system performance and controlling expenditure growth through driving productivity and value for money improvements with service coverage and quality reductions as a last resort. This approach is shown in the table below.

**[2]**

**[2]**

## Background

9. I was invited by the Expenditure Control Committee (ECC) to report on a range of issues including the likely Vote Health expenditure growth path over the medium-term and options for controlling expenditure. To focus our ECC discussion on key Vote Health medium-term strategic issues, the Chairman of ECC and I have agreed that the following issues will be addressed separately:

    - financial risks to the sector and strategies for managing these over the next three years as informed by 2010 DAPs, NHB monitoring, and state of play in Industrial Relations addressed through existing processes such as Joint Ministers' sign off of the 2010 DAPs.
    - separate report to ECC with an overview of the Ministry's financial management capability, with a view to providing ECC with reassurance that the Ministry knows its business and underlying cost drivers.
    - separate paper to ECC with a detailed high-level assessment of MRG reform progress and expected results.

## Overview of Vote Health Operational Expenditure Growth

### Expenditure trends

10. Over the last ten years Vote Health operating expenditure increased by approximately $6.4 billion with almost half of this increase to fund new initiatives. This represents a nominal average increase in expenditure of approximately 8% per annum (pa), greater than Health's long-run nominal historical expenditure growth (5%) and nominal GDP growth pa over the same period (5%). In real per capita terms, Vote Health expenditure grew at 3.7% pa significantly exceeding GDP growth of 0.7% pa.

11. While Health's operating expenditure growth has slowed, nominal 3.4% in Budget 2010, resuming the average nominal Health growth rate of the last decade is not sustainable.

### Slower Vote Health Expenditure Growth Path Scenarios

12. Figure 1 below provides two scenarios for Vote Health's non-departmental expenditure growth path set against the Government's Fiscal Strategy ($1.1 billion Operating Allowance **[2]** ) over the next ten years.

**Figure 1. Vote Health Expenditure Scenarios 2011/12 to 2019/20**

**[2]**

13. The first scenario based on FFT/Demo[1] provides a top-down estimate of price and volume pressures in the health system and suggests that to maintain per capita service coverage and quality would require $618 million of new funding in Budget 2011 **[2]**

14. In the second scenario, Vote Health would receive the same share of operating allowance as it did in Budget 2010 (38%) which would require ongoing productivity and value for money improvements to live within available funding. Under either scenario, reprioritisation would be required to fund Government priorities.

15. The table below shows cumulative required performance improvement savings to live within the second scenario and assumes that each year productivity and deficit improvements are successful. It shows that significant performance savings are required before any reprioritisation to fund Government priorities.

**Table 2. Estimate of performance improvement savings to live within likely available funding between 2011/12 to 2015/16**

| $ millions | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | Total |
|---|---|---|---|---|---|---|
| Health annual operating allocation scenario based on Budget 2010 and 2% growth of Operating Allowance | 428 | 865 | 1,311 | 1,766 | 2,230 | 6,600 |
| *Less* | | | | | | |
| FFT (price pressure estimate of inflation, labour costs, and technology change at the margin) | 405 | 806 | 1,207 | 1,622 | 2,050 | 6,090 |
| Demo (annual adjustment to account for demographic pressures including population ageing) | 214 | 417 | 624 | 842 | 1,076 | 3,173 |
| Deficit improvement (required to reach sector break even) | 37 | 23 | 20 | 0 | 0 | 80 |
| *Total cost pressure (FFT, Demo, Deficit Improvement) estimate* | *656* | *1,246* | *1,851* | *2,464* | *3,126* | *9,343* |
| Cumulative performance improvement required to live within Health operating allocation scenario | -228 | -381 | -540 | -698 | -896 | -2,743 |
| Cumulative performance improvement savings as a % of respective year operating expenditure baseline | -1.80% | -2.91% | -3.99% | -4.99% | -6.21% | |

[1] This top-down estimate of price and volume pressures in the health system is based on Treasury and Reserve Bank estimates of GDP growth, inflation and labour costs alongside Statistics NZ estimates of demographic change adjusted for health care costs.

## Drivers of Vote Health Expenditure

16. There are multiple drivers of health and disability expenditure which interact in complex ways. They are shown in Table 3 with more detail on key drivers in following paragraphs.

**Table 3. Drivers of price, volume and scope/coverage pressures**

| Expenditure pressures | Key drivers | Scope of Government influence |
|---|---|---|
| **Price pressures (input) – Historically price pressures were managed within FFT funding but efficiency weighting in Budget 2010** | **[6],[2]** | |
| **Volume pressures (output) – Historically covered by Demo funding** | • **Population growth**<br>• **Population Ageing**<br>• **Incidence & prevalence of chronic conditions**<br>• **Clinical decision-making** | **Population growth is driven by birth and migration rates, the latter subject to Government immigration policies**<br>**Population ageing is a natural phenomenon resulting from the 'baby boom' generation. Chronic conditions are partly attributable to increasing life expectancy and also the result of an individual's health behaviours. However, Government has a range of policy choices available to manage the impact from population ageing and chronic conditions on public funding and service delivery**<br>**Clinical decision-making that leads to fiscal pressure results from a lack of incentives to make best use of resources. Government has a range of options to address this.** |
| **Scope and coverage pressures (range, mix, access to services) – Historically a mix of FFT & new initiatives funding provided to cover this pressure** | • **Public expectations – driven by income effects & technology**<br>• **Sector expectations – driven by technological & clinical innovation**<br>• **Government policy decisions** | **The Government and sector need to manage public expectations in line with the fiscal environment**<br>**Technology and innovation fiscal pressure can be mitigated by robust prioritisation of new investments and disinvestment from lower value or older technologies**<br>**Government can revise the scope of its investment decisions and/or fund new investments through reprioritisation of lower value spending** |

**[6]**

17. The primary driver of price pressure in the health and disability system is the cost of labour which accounts for around 63% of total Vote Health expenditure and around 65% of DHB provider-arm (public hospital) expenditure.

18. Workforce supply pressures for medical professionals exacerbate labour cost pressures and are forecast to increase across the OECD due to increasing service demand, ageing medical workforces, professional specialisation, and, until recently, constrained investment in training additional medical graduates.

19. It will be critical to make best use of our workforce to ensure clinical and financial sustainability in the context of increasing demand pressures. **[6]**

**Population ageing and chronic conditions volume pressures to be primarily managed through productivity improvement and shifting services from hospitals to community settings**

21. Over the next twenty to thirty years the proportion of people aged over 65 years will rise by nearly 70% with our projections suggesting demand will increase by up to 20% over the next ten years against population growth of about 10%.

22. The 'healthy ageing' effect is expected to offset up to half of population ageing fiscal pressure[2]. The 'healthy ageing' effect suggests that people will live longer, healthier lives. This will also mean that end of life care will occur at much older ages where care costs are relatively much lower.

23. Incidence[3] and prevalence[4] of chronic conditions is forecast to increase due to population ageing, people's lifestyles, social conditions and improving life expectancy. A central challenge is that with increasing life expectancy, the prevalence of non-communicable diseases will continue to increase as age is the strongest "risk factor".

24. As an example, the number of New Zealanders with type 2 diabetes is predicted to double by 2028 to almost 10 percent of the adult population (reflecting both demographic trends and rising obesity prevalence). In 2008/09, the average costs of a hospital discharge for a person diagnosed with diabetes was three times higher than the average ($1,862 compared to $561) per capita.

25. Complex interactions between changes in incidence, rate of condition progression, age, co-morbidities, and intervention effectiveness determine the significance of cost growth. Therefore increasing system costs will not necessarily be in proportion to changes in chronic condition prevalence.

26. Ensuring that people access services at the right time in the most cost-effective setting and make healthy lifestyle choices is critical for managing future demand pressure.

**Public and sector expectations leading to scope and coverage pressures to be primarily managed through improved prioritisation and value for money assessment**

27. As people become wealthier they tend to expect public services to increase in scope and quality by a relatively similar proportion (the "income effect") and, compare our health system to similar countries which are often wealthier and spend more on health than New Zealand, such as Australia, the United States, and the United Kingdom. This can drive system costs.

28. New technologies and procedures often provide better outcomes for people driving both public and sector expectations but can come at higher cost. This can be mitigated to some extent if they substitute for more expensive inputs and if lower value services are removed from the system. Alternatively, new technologies can decrease the cost of a service but increase overall expenditure as the demand for the service increases. Importantly, they can contribute to system performance and the health of New Zealanders where they are specifically targeted to the patient group where clinical and cost-effectiveness has been demonstrated.

## Contribution of Ministerial Review Group (MRG) reforms to Improving System Performance Within a Slower Expenditure Growth Path

29. Our Government has commenced a reform programme for the health and disability system. This reform programme will deliver real expenditure control benefits over the next 3 to 5 years but we need to maintain the momentum of system performance improvements and strong fiscal control.

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[2] See for example, OECD. 2009. *Economic Surveys: New Zealand*. Vol 2009/4.
[3] The rate at which new cases of a particular condition emerge in a given population.
[4] The rate at which a particular condition is present within a given population.

30. We have strengthened the prioritisation of new technologies and services expansion with a refocused National Health Committee (NHC) and expanding the role of Pharmac to include some medical devices. We have also begun to reduce waste and bureaucracy in the system through Health Benefits Limited and consolidation of PHOs. The establishment of the National Health Board and other boards focused on improving service and capacity planning will aid ensuring best use of resources in our current tight fiscal environment.

31. We have also communicated expectations to the sector that it will be required to live within a lower growth path for a number of years while delivering on Government priorities and providing high quality services to New Zealanders. We have also commenced reforms that will ensure greater DHB collaboration and hospital productivity initiatives to address looming clinical and financial sustainability issues. Our expectations and further reforms will deliver real DHB performance improvement in the medium-term.

32. The table below shows cumulative expected savings to be realised from specific MRG reforms as advised to support earlier Cabinet decisions. They have not yet been discussed with respective agencies. In some instances, specific MRG reforms and expected savings cannot be quantified but will likely contribute to performance improvement.

**Table 4. Contribution of quantified MRG reforms to performance improvements to live within likely available funding between 2011/12 to 2014/15**

| $ millions | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | Total |
|---|---|---|---|---|---|---|
| Performance improvement required to live within likely available funding (from table 2 above) | -228 | -381 | -540 | -698 | -896 | -2,743 |
| *Less* | | | | | | |
| Health Benefits Limited – reduce waste to reprioritise resources to frontline services | 40 | 80 | 130 | 180 | 250 | 680 |
| Quality & Safety Commission – improve frontline service productivity through better quality | 5 | 15 | 25 | 35 | 45 | 125 |
| Sector Services | 30 | 60 | 90 | 120 | 150 | 450 |
| Total expected performance improvement savings | 75 | 155 | 245 | 335 | 445 | 1255 |
| Further cumulative performance improvement savings required after expected MRG reform savings from specific initiatives (HBL, QSC, Sector Services) | -153 | -226 | -295 | -363 | -451 | -1488 |
| Further cumulative performance improvement savings as a % of respective year operating expenditure baseline | 1.21% | 0.84% | 0.68% | 0.59% | 0.57% | |

33. As shown in the table, cumulative expected savings from specific MRG reforms will contribute to controlling expenditure over the next five years but other savings and expenditure control initiatives are required to live within likely available funding.

## Future Work and Policy Options for Improving System Performance Within a Slower Expenditure Growth Path

34. There is no single answer to the challenge of controlling health expenditure growth while improving system performance. A combination of approaches will be needed to live within a slower growth path in both the short and medium term.

35. Decisions will be needed about the appropriate level of service coverage and quality, and agents in the system will need to focus on delivering these services at the highest quality for the least cost. I propose to address the challenges facing the system through a programme of work focused on driving performance improvement and better value for money as shown in the Table 6.

**Table 5. Key initiatives to support and build on the Government's reform programme for managing expenditure within a slower funding path**

**[2]**

**[2]**

**[2]**

**[6]**

**[2]**

**[2]**

[2]

## Consultation

62. The following Government agencies were consulted in the development of this Cabinet paper: The Treasury. The State Services Commission and the Department of Prime Minister and Cabinet were provided with a copy of the paper.

## Financial Implications

63. There are no financial implications arising from this paper.

## Legislative Implications

64. There are no financial implications arising from this paper.

## Human Rights and Gender Implications and Disability Perspective

65. There are no human rights, gender or disability implications arising from this paper.

## Recommendations

66. I recommend that the Cabinet Expenditure Control Committee (ECC):

    a. **note** that the health system will face considerable fiscal challenges over coming years which will require ongoing performance and value for money improvements to control expenditure growth

    b. **direct** the Ministry to provide further advice to ECC on likely impacts and recommended future actions of the options identified in this paper for lifting system performance by June 2011

[2]

e. **note** that as agreed with the Chair of ECC, I will address some of the questions asked by ECC though the following means:

- address financial risks to the sector and strategies for managing these over the next three years as informed by 2010 DAPs, NHB monitoring, **[2]**

- separate report to ECC with an overview of the Ministry's financial management capability, with a view to providing ECC with reassurance that the Ministry knows its business and underlying cost drivers.
- separate paper to ECC with a detailed high-level assessment of MRG reform progress and expected results.

Hon Tony Ryall

**Minister of Health**

**Date:**