EDITORIAL

Funding New Zealand’s public healthcare system: time for an honest appraisal and public debate
Lyndon Keene, Philip Bagshaw, M Gary Nicholls, Bill Rosenberg, Christopher M Frampton, Ian Powell

ABSTRACT
Successive New Zealand governments have claimed that the cost of funding the country’s public healthcare services is excessive and unsustainable. We contest that these claims are based on a misrepresentation of healthcare spending. Using data from the New Zealand Treasury and the Organisation for Economic Cooperation and Development (OECD), we show how government spending as a whole is low compared with most other OECD countries and is falling as a proportion of GDP. New Zealand has a modest level of health spending overall, but government health spending is also falling as a proportion of GDP. Together, the data indicate the New Zealand Government can afford to spend more on healthcare. We identify compelling reasons why it should do so, including forecast growing health need, signs of increasing unmet need, and the fact that if health needs are not met the costs still have to be borne by the economy. The evidence further suggests it is economically and socially beneficial to meet health needs through a public health system. An honest appraisal and public debate is needed to determine more appropriate levels of healthcare spending.

The New Zealand Social Security Act, passed in 1938, was intended to ensure that there should be universal access to comprehensive healthcare services funded through a taxation system. This was a laudable aim and a leader in the western world, but healthcare costs have risen with time as a result of many factors. They include increasing availability of new and often expensive treatments, an increasing total and aging population, and a widening income gap, which has since the 1980s left an increased and sizeable percentage of the population in poverty, whether measured in absolute or relative income terms. At the same time, there have been repeated claims by governments and their agencies that the cost of funding New Zealand’s public healthcare services has become unsustainable. Such claims do not bear scrutiny, however, and the situation calls for urgent public debate as to how much should be spent on the public health system, based on the full facts.

In this article we document the level and growth of healthcare expenditure in New Zealand whilst providing a perspective on the relationship between healthcare spending and the overall economy. We emphasise that successive governments and their agencies in New Zealand have tended to misrepresent vital aspects of spending on healthcare and have implemented expensive and unsuccessful changes in the organisation of healthcare.

Healthcare funding in New Zealand
Claims that funding of healthcare in New Zealand is excessive and increasing at an alarming rate are not new. Such claims underpinned the disastrous ‘health reforms’ of the early 1990s. Whereas Treasury maintained at the time that spending on public health was high and rising, economist Professor Michael Cooper noted that total health spending remained around 7%
of gross domestic product (GDP). He also found real health funding per capita had actually declined within the public sector between 1980 and 1992, despite medical advances and rising public expectations.\textsuperscript{11,12} Economist Brian Easton likewise disputed Treasury figures, stating:

“The mistake [figures claiming that real public spending on healthcare were rising] arose in a Treasury paper which deflated the nominal spending with the wrong price index, failing to compare apples with apples, and then using a period which maximised the size of the error.”\textsuperscript{13}

In fact a Treasury Working Paper found health expenditure as a proportion of GDP rose steadily from the 1950s to about 1980, but then showed no consistent trend—upwards or downwards.\textsuperscript{14}

Subsequent to the ‘health reforms’ of the 1990s, claims of unsustainable healthcare spending have continued. For example, a Ministerial Review Group reported in 2009:

“As a country we do not have the resources to continue spending increasing amounts on the public health and disability system at the rate at which we have”.

In 2014, The Press in Christchurch opined: “New Zealand is on the brink of a healthcare funding crisis that is threatening to bankrupt the Government”.\textsuperscript{15} This perspective has been promoted by various organisations, including the New Zealand Institute of Economic Research (NZIER), and the Health Funds Association, which have advocated changes to the public healthcare system and greater use of the private sector. As was the case before the ‘reforms’ of the 1990s, this oft-repeated perspective is not supported by the evidence.

Figure 1 is a version of a Treasury graph suggesting health expenditure is excessive and growing alarmingly as a proportion of both government spending and the economy. Superficially, the graph might be taken to support these claims. However, the graph is misleading as it presents two variables (health spending and GDP) of highly disparate size on the same percentage scale, which has the effect of significantly exaggerating the apparent importance of health spending compared to GDP.

This graph has been widely used without qualification or explanation by government agencies, including the Ministry of Health as well as the media. It has also been used by the private health sector to support their case for privatisation.

To put GDP and health expenditure into perspective, GDP is forecast to be approximately $240 billion in 2015, while Vote Health’s operating budget is approximately $14.8 billion, so in absolute terms a 1% increase in GDP is many times greater than a 1% increase in government

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure1.png}
\caption{Treasury's graph tracking real percentage growth per capita of government core health spending and GDP.}
\end{figure}

Reproduced from the Ministry of Health’s Annual Report 2013\textsuperscript{16}
EDITORIAL

health expenditure. To put it another way, it would take a one-sixth (16%) increase in the Vote Health operating budget to consume another 1% of GDP. The situation in New Zealand has parallels in Australia where economist Professor Jeff Richardson stated: “The unsustainability myth is created by focusing on percentages and not on the absolute level of resources available” and fear that the rising share of GDP spent on health will harm the economy or our standard of living “is probably a result of bad arithmetic.”17

In New Zealand between 2009/10 and 2014/15, Vote Health’s nominal operational expenditure increased by $2 billion, and core government spending as a whole increased by $8.8 billion, whereas nominal GDP increased by $45.2 billion (from $195.4 billion to $240.6 billion).18

A more accurate way of illustrating health (and other government) spending trends is to map core government expenditure relative to GDP, as shown in Figure 2, using Treasury figures. This shows a modest increase in health expenditure as a proportion of GDP from 2000 (along with a similar rise in total government spending) until recent years where the trends have reversed, as discussed further below. The trends shown in Figure 2 are in contrast to the impression of an unsustainable rise in government health spending given in Figure 1.

Government health funding is falling as a proportion of GDP

Vote Health’s operational budgets have been falling as a proportion of GDP over recent years—an intentional policy move flagged by Treasury in a document dated June 2012.19 Treasury data, including recent GDP adjustments, show Vote Health’s total operational expenditure has decreased as a proportion of GDP from 6.32% in 2009/10 to 5.95% in 2014/15 (Table 1).

If GDP rises at a faster rate than health spending, then health spending as a proportion of GDP will fall, even if there is no change in health spending. In this case, the drop in health funding as a proportion

Figure 2: Trends in the proportion of core government spending/GDP.

Compiled by the Association of Salaried Medical Specialists (ASMS) 2015
Sources: Treasury Budget Economic and Fiscal Updates 2005-2015; Time Series of Fiscal & Economic Indicators (BEFU 2015); Statistics New Zealand: M5 GDP
EDITORIAL

of GDP reflects significant funding shortfalls in Vote Health's operational funding since 2009/10. Data are not available to enable an accurate assessment of how much money has 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, analyses of Budget data from 2009/10 show Vote Health allocations have fallen short of what is needed each year to cover the stated costs of announced new services (taking into account stated savings), increasing costs (Consumer Price Index and average wage increases), and the Ministry of Health’s cost-weighted index for population growth and ageing. The assessed annual shortfalls between 2009/10 and 2014/15 have accumulated to an estimated $0.8 billion. The estimated funding shortfall for 2015/16 would make that more than $1 billion.

Similarly, core government expenditure has been falling in recent years, having peaked in 2011 (Figure 2). The intention, according to Finance Minister Bill English, is to see it drop to 25% within the next 6 to 7 years. In line with those policy priorities, the Government’s trajectory is one of continuing cuts in health spending. Total real government health spending is forecast to drop by approximately 4% each year, taking into account forecast inflation and the Ministry of Health’s cost-weighted index for population growth and the effects of ageing. The extent to which that forecast funding is adjusted upwards depends on how much is allocated to Vote Health from the Government’s general budget operating allowance. However, in the past, the additions to Vote Health from the operating allowance have not been enough to keep up with rising costs, population growth and new programmes. In preparing the 2013 Budget, Treasury warned that such large cuts will require major changes to the health sector. The continued under-re-sourcing of our health services, then, is not owing to unaffordability; it is a policy decision to reduce government expenditure overall and introduce tax cuts.

New Zealand government spending is low internationally

A common defence for constraining health spending is that government finances are finite and more money on health means less money is available for other government services. However, like core government expenditure, general government expenditure (including all central and local government spending) has been falling as a proportion of GDP in recent years. It was 40.1% of GDP in 2013, down from 47.4% in 2010, ranking New Zealand 26th out of 32 OECD countries. The OECD average for general government expenditure in 2013 was 45.2% of GDP. In other words, New Zealand’s general government spending as a proportion of GDP fell short of the OECD average by 5.1 percentage points, or $11 billion, based on New Zealand’s GDP for

<table>
<thead>
<tr>
<th>Year</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vote Health operational expenditure ($m)*</td>
<td>12,348</td>
<td>12,797</td>
<td>13,267</td>
<td>13,561</td>
<td>14,001</td>
<td>14,313</td>
</tr>
<tr>
<td>Nominal GDP for the year to June ($m)**</td>
<td>195,399</td>
<td>203,791</td>
<td>212,307</td>
<td>216,585</td>
<td>234,027</td>
<td>240,571</td>
</tr>
<tr>
<td>% of GDP</td>
<td>6.32%</td>
<td>6.28%</td>
<td>6.25%</td>
<td>6.26%</td>
<td>5.98%</td>
<td>5.95%</td>
</tr>
</tbody>
</table>

Sources:
* Actual operational expenditure (estimated actual expenditure for 2014/15), including multi-category expenses and “other” non-departmental expenses—ie, contributions to international health organisations, legal expenses and provider development. $49 million has been subtracted from the funding allocations for 2012/13 onwards to account for estimated health provider superannuation contributions such as to Kiwisaver, previously paid for by the State Services Commission.
2013. The figures indicate that, with different fiscal policies, the New Zealand Government could afford not only to spend more on health but also on other areas of government while remaining at or below average government spending in the OECD.

**Economies are flexible and constantly changing**

It is important to also recognise that health is not the only sector that has grown relative to the rest of the economy. National economies are highly flexible and the composition of spending can vary significantly over time and between countries. In the early 1970s, New Zealand's economy was heavily reliant on manufacturing, as was the rest of the industrialised world. Manufacturing made up 26% of GDP; it is now 12% of GDP. New Zealand has instead become a more service-oriented economy, mirroring trends in the rest of the OECD. The increase in the proportion of the economy dedicated to private and public health services over the past few decades (with similar increases in areas such as finance and insurance, and rental, hiring and real estate) reflects that structural shift. It also reflects the high value that New Zealanders place on good health, which is one of the fundamental determinants of a good life. As good health is also a major contributor to productivity and economic growth it is not clear why investment in good health is singled out as problematic for the economy.

**Rationale for increasing health spending**

There are a number of reasons why New Zealand should and could be spending more on health, including:

- New Zealand’s health needs are increasing with population growth and ageing
- If these needs are not met by public health services, the costs do not disappear; they still have to be borne by the economy
- There is mounting evidence of increasing unmet need
- Investment in health can mitigate health costs and improve the quality of life.

While the population is projected to increase by approximately 0.9% per year over the 10 years to 2026, the Ministry of Health estimated the cost of demographic changes, including the impact of an ageing population, will require an increase in health service budgets of approximately 1.8% per year on average over the same period.

While the contribution of population ageing to past health spending growth has been modest, the projected growth in the proportion of older people in the coming decades will lead to a greater impact on health spending. Chronic diseases disproportionately affect older adults and contribute to ongoing disability and increased need for long-term health care. These impairments might be physical (e.g., rheumatological, cardiological, respiratory, or a decline in hearing or eyesight), psychological, or related to cognitive functioning and loss of memory, including the dementias. Thus, ageing is associated with a growing need for acute health care services and ongoing chronic illness that sometimes requires long-term care.

However, when older people are in good health, they will need relatively fewer health care resources. Policies that allow a healthy ageing of the population include a better coordination of health and long-term care services and enhanced prevention services to tackle obesity, smoking and mental illnesses. These policies need long-term planning and investment but they will allow more people to age healthily and will help to ensure future health services are properly equipped to accommodate population ageing.

The importance of ensuring people age well, including having timely access to treatment when it is needed, is underscored by Treasury modelling indicating that by 2060 a ‘no healthy ageing’ scenario (increased longevity with an increase in the number of years lived in poor health) could cost the equivalent of 2.9% of GDP more than a ‘healthy ageing’ scenario (increased longevity with an increase in the number of years lived in good health).

Pressures on the health system also arise from the introduction of new technologies.
EDITORIAL

The impact of new technologies on health expenditure is complex. On the one hand, they can reduce costs through efficiency gains or health improvements that reduce the need for further, and perhaps more costly, care. On the other hand, they can also contribute to higher costs, such as by extending the scope and range of possible treatments available. Either way, new technologies, when put to use after proper evaluation, are highly desirable for the well-being of the population.

The alternative to public health care

If people do not have reasonable access to the public health system when they need it, either they must go untreated or face longer delays in being treated, or they must pay for treatment privately—individually or through private insurance. The first option is likely to reduce quality of life and there is a wealth of evidence showing poor access to treatment is more costly for health services in the long run, and more costly for the economy through lost productivity.36,37,38,39

The option of people paying privately means the economy still has to stand the cost of the increase in health expenditure—it is just that the government does not pay for it. The important question then becomes whether it is more efficient and equitable to pay for health needs privately or publicly. There are good reasons to conclude that it is more efficiently and equitably provided publicly. As Treasury itself has noted:

“We do not currently see a clear case for moving away from a predominantly single-payer, tax-financed health system. Systems like ours are typically better at containing health spending and there is no one system that presents a clearly more efficient alternative.”40

If we add considerations of equity to cost-containment, private provision is not likely to be better for people, the country and the economy, and that is well illustrated by the costly and inequitable situation in the US.41,42

Of course it is important that New Zealand gets the best value out of each health dollar. Treasury's assessment is that, “New Zealand’s health system as a whole is not obviously underperforming those of other developed economies.”43 Reports comparing health systems internationally rate New Zealand’s health service favourably. For example, the Commonwealth Fund's comparison of health systems in 11 comparable countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the UK, and the US) show New Zealand's performance on efficiency and quality of care is ranked 3rd and 4th respectively. This has been achieved despite being ranked bottom on health expenditure per capita.44,45

Unmet need

Indications of unmet need in New Zealand are reflected in the Commonwealth Fund's performance indicators for access to services (7th out of 11), and equity (10th), and on a measure of ‘healthy lives’ (infant mortality, healthy life expectancy and mortality amenable to health care—that is, deaths that could have been prevented with timely and effective care) New Zealand was placed 9th. New Zealand’s poor rankings for access-related performance measures include: access to diagnostic tests (11th out of 11); long waits for treatment after diagnosis (10th); long waits to see a specialist (9th); and long waits for elective surgery (8th). Currently, there are no detailed or accurate measures of unmet need in New Zealand, but anecdotally it appears to be unacceptably high and growing. Of the New Zealand doctors surveyed by the Commonwealth Fund, 59% reported difficulty for patients gaining access to diagnostic tests, and 34% said patients “often experience long waits to receive treatment after diagnosis”. Twenty-one percent of New Zealanders surveyed reported cost-related barriers to accessing health care, compared with 4% reported for the best-ranked UK. In fact, the New Zealand Health Survey for 2014/15 reports 27% of adults have one or more types of unmet need for primary care. Even in the Government’s high priority services, such as elective surgery, the Commonwealth Fund reports 15% of New Zealand patients waited 4 months or more for their operation compared to an average of 9% across the 11 comparable countries surveyed. Reports of increasing barriers to accessing elective surgery have also been appearing in the media. They reinforce a 2013 survey by the Health Funds Association
(HFA) and Private Surgical Hospitals Association (NZPSHA), which indicated 170,000 people needing elective surgery did not make it onto the waiting list that year, although the accuracy of that survey has been questioned owing to possible conflicts of interest.\textsuperscript{46,47} The New Zealand Medical Association has noted that, anecdotally, the gap between the patients who meet the clinical threshold for surgery, but fall short of our hospitals’ financial threshold, is widening.\textsuperscript{48}

**Overview**

As health systems in most countries face the challenges of increasing needs and growing public expectations, policy makers search for new ways to deliver services in innovative and cost-effective ways. In New Zealand, there is continuing talk of restructuring and new system models, despite their lack of obvious success in the past—especially in the 1990s. Looking back at the 1990s ‘reforms’, economist Brian Easton, notes that:

“The New Zealand experience provides strong evidence that comprehensive commercialisation—business practices within, market relations between institutions—will not make a significant contribution to the design of effective health systems.”\textsuperscript{49}

While it is clear that the ideologically-based reforms of the 1990s were an expensive failure, it is not clear whether appropriate lessons have been learned. For example, in 2009, the OECD suggested that New Zealand should radically reform its health sector proposing: “...more competition among public hospitals and with private providers...so as to spur competition and burden-sharing.”\textsuperscript{50} Of particular concern Bill English, Minister of Health at the time of the Stent inquiry into unnecessary deaths from the ‘reforms’ of the early 1990s and now Minister of Finance, has stated: “We’re already implementing some of the (OECD) ideas and will consider others.”\textsuperscript{51}

Indeed the competitive market-based approach of the 1990s underlies proposals emanating from the recent Director-General of Health’s Review of Health Funding Arrangements,\textsuperscript{52} led by banker and former Treasury Secretary Murray Horn. The proposals include opening up DHB services to competitive tendering and fragmenting DHB funding into four ‘pools’, with a suggestion this may be managed by some unidentified body in the future.\textsuperscript{53} At the time of writing, the Government had yet to officially announce its response to the proposals, but they are an example of the kind of thinking currently going on in some government circles.

The Government also seems to be reverting to the 1990s’ contractualism approach with its experimental ‘social impact bonds’ policy programmes, encompassing specific health and social initiatives, including in mental health services, which will be funded through private investment. The bond-holding investors’ profits would be derived by achieving certain goals—or ‘targets’ by another name—but there is no evidence to show the policy works, and there are significant risks that it may do a lot of harm.\textsuperscript{54}

Given that OECD data indicate government spending in this country is low internationally, fiscal policies that moved New Zealand’s general government expenditure back towards the average OECD level would allow substantial increases in those areas of government that have endured funding shortfalls over recent years, including health.

The oft-repeated, but unsubstantiated, assertion that health funding levels are unsustainable echoes the tactics used to introduce the radical, ideological health changes in the 1990s. Notwithstanding, the issues with access and the unacceptable—but poorly documented—level of unmet need,\textsuperscript{55} the country’s healthcare system, as already mentioned, has delivered relatively well in recent times on basic indices such as quality of care and efficiency. The system does not need ‘reforming’, it simply needs to be funded to a level that enables New Zealanders’ healthcare needs to be met. Indeed, there is a moral imperative to do so.

There are also alternative and more productive avenues for achieving better cost efficiency, such as the promotion of clinical leadership.\textsuperscript{56,57} The potential for this to be realised has been hindered by entrenched shortages of medical specialists—\textsuperscript{58}—an issue that has been recognised by the Government’s health workforce agency, Health Workforce New Zealand: “The most important issue
EDITORIAL

currently is the impact of a prolonged period of medical labour shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors."\textsuperscript{59}

As already noted, New Zealand is not alone when it comes to wrestling with what level of funding should be directed to its public healthcare system. Nor is it alone when it comes to obscuring or confusing what is the true, versus the claimed, cost of funding healthcare.\textsuperscript{60} The National Health System (NHS) in England is reported to be under severe financial stress with calls for an emergency injection of £1 billion.\textsuperscript{61} Substantial underfunding of hospitals is probably key to these current problems in England, as highlighted by the recent down-grading of the renowned Addenbrooke's Hospital (part of Cambridge University Hospital NHS Foundation Trust) because it is running at a weekly deficit of £1.2 million. The King's Fund has suggested to Treasury in England that public spending on health and social care should be increased to 11\%-12\% of GDP.\textsuperscript{62}

But just as the underfunding of the NHS has occurred amid reports of official obfuscation,\textsuperscript{63,64} it is clear that an honest appraisal of health funding in New Zealand has been similarly hampered by official misinformation. The likely reasons for this subterfuge include a desire by both the Labour Government in the 1980s and the National Government in the 1990s (and signs of this in the current Government) to support the private healthcare industry under an umbrella of pro-market ideology, to set the scene for yet more reduction and restructuring of the public healthcare system and to employ funding policies designed for short-term political gain rather than longer-term health gains. It is time for an honest appraisal and public debate about what the appropriate level should be to fulfil the original aims of universal access to comprehensive healthcare services.

Author information:
Lyndon Keene, Director of Policy and Research, Association of Salaried Medical Specialists; Philip Bagshaw, Chair, Canterbury Charity Hospital Trust and Clinical Associate Professor, University of Otago–Christchurch; M Gary Nicholls, Emeritus Professor, Department of Medicine, University of Otago–Christchurch, Christchurch Hospital, Christchurch; Bill Rosenberg, Economist and Director of Policy, New Zealand Council of Trade Unions; Christopher M Frampton, Professor, University of Otago–Christchurch, Christchurch; Ian Powell, Executive Director, Association of Salaried Medical Specialists.

Corresponding author:
Lyndon Keene, Director of Policy and Research, Association of Salaried medical Specialists, PO Box 10763, Wellington 6143, New Zealand.
lk@asms.org.nz

URL:
REFERENCES:


32. Data supplied by the Ministry of Health, June 2015.


37. Doran CM: The evidence on the costs and impacts on the economy and productivity due to mental ill health: a rapid review, Mental Health Commission, NSW, April 2013.


43. NZ Treasury. Briefing to the Incoming Minister, October 2014.


46. Health Funds Association of New Zealand. Lengthy time off work for sick and caregivers costly to country. Media release. 29 December 2013.


53. Horn M. From Cost to Sustainable Value: An independent review of health funding In New Zealand,

54. Chambers C. Review of social impact bonds. ASMS Research brief; No 1: 10 August 2015.


58. ASMS. Taking the temperature of the public hospital specialist workforce, August 2014.


60. Walsh E, Smith J. Comprehensive spending review and the NHS.


63. Webster R. It's time to be honest about NHS funding for the next five years. BMJ. 2015;350:h1978.

64. Oliver D. Is the NHS at war? BMJ. 2015; 351:h4127