

PRODUCTIVITY IN THE HEALTH SECTOR:

Issues and Pressures

July 2019

INTRODUCTION

The biggest threat to the future fiscal health of New Zealand is the persistent expected growth in healthcare expenditure.

Strangely, those concerned about future structural deficits have largely ignored healthcare costs, choosing instead to focus on other issues.

For example, politicians and media regularly argue that New Zealand Superannuation requires reform in light of swelling pension liabilities, even though Treasury forecasts indicate public health expenditure growth will be much larger than growth in superannuation payments.

The debt effects from accelerating public health expenditure are projected to be catastrophic.

Treasury's Long Term Fiscal Statement projects net public debt to reach 205.8 percent of GDP in 2060 if no changes are made to health or superannuation obligations. This explosion in debt will drive accelerating debt financing costs, which will grow from 5.3 percent to 11 percent of GDP by 2060.

This will put significant pressure on the Government's budget. By 2060, the combined cost of healthcare, superannuation, welfare payments, and debt financing costs (33.3 percent of GDP) is expected to outstrip forecast government revenue (31.1 percent of GDP), leaving no room for education, law and

order, defence, or other key portfolios. Any improvements to initial structural deficits could significantly ease this burden, since debt financing costs increase as debt increases, even as the financing costs increase the total debt level. Alleviating this problem will require structural reform in order to promote health sector productivity growth.

Recent failure to achieve health sector productivity growth may be related to the dominant position of public sector healthcare service delivery. Bryce Wilkinson argues this case in the New Zealand Initiative's report, "Fit for Purpose?"¹:

"Why are we not doing better? This is a state-dominated industry. Existing practices and attitudes reflect the incentives and constraints embedded in current arrangements. The inadequate productivity focus is a telling symptom of dysfunction."

"Whether Treasury and/or the Ministry of Health are clear about what needs to be changed is not apparent from the limited number of documents reviewed in this section. There is no reason to think that exhorting the hard-pressed staff at the coal-face to do better will make much of a difference."

The implication: the Government should embark on systematic reform to increase competition and the role of privately-provided healthcare, in the style of the





attempted “big bang”² reforms of the early 1990s.

The OECD disagree.

Achieving productivity growth would make a difference to long-term costs: there is evidence to suggest a majority of the projected increase in public healthcare expenditure is attributable to non-age-distributional factors. In that sense, demography is not destiny.

While population ageing will put some fiscal pressure on the Government, cost increases and democratic pressure for ever-growing public healthcare coverage comprise most of the increase in expenditure.

Our series of health reports focuses on three examples of ways to improve DHB efficiency: reducing costs from adverse drug reactions, limiting missed specialist appointments, and cutting down on large DHB redundancy costs.

Tackling these issues won't fix the problem of spiralling health expenditure alone. Instead, there is a need to embed a culture of constant, incremental reform in DHBs and the Ministry of Health. While major reforms to the health sector might seem appealing, the political consequences of a heavy-handed agenda of reform could prevent change from taking place at all.

The same is true for the increased role of the private sector in health insurance and healthcare provision. Wilkinson (2018) correctly argues that continued dominance of the public sector on healthcare acts as a handbrake on reform and productivity growth but moving to a purely private model would be politically impossible and present its own distributional challenges.

In contrast, New Zealand should seek to replicate some components of other healthcare systems in other jurisdictions. Australia and Singapore, which provide affordable healthcare solutions for the genuinely vulnerable, while ensuring the well-off are encouraged to purchase private insurance and fund their own health requirements would be good models to look to for inspiration. Additionally, District Health Boards should look to our accompanying reports as examples of opportunities to trim waste (where possible) and improve the efficiency of existing service lines.

ROAD TO RUIN: HEALTHCARE EXPENDITURE AND PUBLIC DEBT PROJECTIONS



Treasury's Long Term Fiscal Statement 2016 projects public healthcare spending to rise from 6.2 to 9.7 percent (a 3.5 percentage point increase) of GDP by 2060, lower than the 2013 Statement's projection of 10.8 percent of GDP, but still larger than the expected growth in superannuation costs over the same time period (4.8 to 7.9 percent, a 3.1 percentage point increase)

The result of this fiscal pressure will be catastrophic for New Zealand's levels of public debt. Treasury's most recent Long Term Fiscal Statement³ projects net public debt to reach 205.8 percent of GDP by 2060 if no changes are made to health or superannuation obligations.

By 2060, the combined cost of healthcare, superannuation, welfare payments, and debt financing costs (33.3 percent of GDP) would outstrip government revenue (31.1 percent of GDP), leaving no room for education, law and order, defence, or other key portfolios.

Growth in healthcare expenditure is attributable to three factors:

- healthcare prices rising faster than the CPI;
- growth in healthcare coverage; and
- demographic changes.

A persistent and permanent increase in public healthcare expenditure would eventually require the Government to

increase taxes to meet the funding gap. While government debt could increase for a few years, large structural deficits could only be remedied in the long run by increasing revenue by levying additional taxes: a large state must eventually be accompanied by a burdensome tax regime.

Allowing the size of government (and tax levels) to grow too large will eventually dampen economic growth and living standards over the long run. If we can avoid that by improving healthcare productivity growth (delivering more, higher quality services for a similar number of input) we can limit the damage of growing healthcare demand on our living standards.

While there is a perception that rapid population aging is a fiscal time-bomb, demography is a surprisingly small part of the increase in healthcare expenditure.

The Office of the Auditor-General (OAG) examined the 2016 LTFS, finding that:

“non-demographic factors raise healthcare costs 35% faster than normal real output growth and 25% faster than normal consumer price growth. These two factors are behind most of the increase in healthcare costs during the 40-year projection period. If we removed them both, healthcare spending to GDP would increase only slightly during the projection period.”

“International evidence suggests that consumer spending on healthcare could rise faster than for other elements of GDP. This is through the higher price growth and proportionately greater demands for healthcare that come when incomes are higher. The Treasury’s healthcare spending projections are based on some historical evidence for this pattern in New Zealand.”

In short, the OAG claims that a majority of the increased burden in healthcare costs in the LTFM is attributable to healthcare cost pressures and higher demand for healthcare coverage associated with income growth, rather than an aging population.

Bryant et al. (2004)⁴ find similar results. The authors argue:

“Healthcare spending is also driven by non-demographic factors – things such as wage and cost increases, increases in the coverage of the public healthcare system and technological advances ... The modelling shows that overall health spending is more sensitive to assumptions about this factor than to assumptions about demographic influences.”

More directly, they claim:

“Regardless of the exact contributions of disability and distance to death, it seems likely that trends in age structure and health status will do less to raise the growth rate for government health

expenditure than is sometimes assumed.” This picture of future healthcare spending offers some hope for taxpayers: unavoidable demographic shifts are only partly responsible for the significant projected increase in public expenditure. Easing some of the pressure from other factors could put a limit on public healthcare expenditure growth, even while the country ages as a whole.

FAILURE TO LAUNCH: THE POOR PERFORMANCE OF HEALTH PRODUCTIVITY GROWTH

Limiting the long-term fiscal damage from rising healthcare costs without significantly reducing available care could be achieved by improving healthcare productivity. Healthcare productivity growth ensures greater (or improved quality) healthcare output can be produced for the same (or reduced level) of inputs. While improved healthcare productivity growth will not fix the problem of climbing long-term deficits alone, it would reduce the social burden of any reforms or higher taxes.

Available data indicates a persistent failure to achieve healthcare productivity growth. Productivity data from Stats NZ shows that in the last 20 years, health productivity growth has been weaker than productivity growth in the rest of the economy, demonstrated in Figure 1. More

specifically, in the period 2004 through 2015, health productivity growth was cumulatively close to zero, demonstrated in Figure 2. In short, New Zealand experienced a lost decade of health productivity growth, where higher health outputs were only possible due to more spending and resources being allocated to the health system.

The productivity measures provided by Stats NZ are not perfect. In an ideal world, productivity growth should be quality adjusted such that we can account for better surgeries and improved care. Patrick Nolan, Director of Economics and Research at the Productivity Commission, argues this in “Measuring Productivity in the Health Sector”⁵: we are only able to account for the relative quantities of

outputs and inputs, without consideration of output quality.

Efficiency failings are discussed in the OECD’s 2010 Working Paper “Healthcare Systems: Efficiency and Institutions”. The authors argue New Zealand has “very high administrative costs”, “rather low scores on the efficiency in the acute care sector” and note “the high share of out patient expenditure despite the low number of doctor consultations is striking” (p73).

While some of the data examined by the OECD goes back as far as 2007, the same problems likely persist today, given that there has been almost no healthcare productivity growth since 2007. Their proposed remedy (“Examine options to

Figure 1

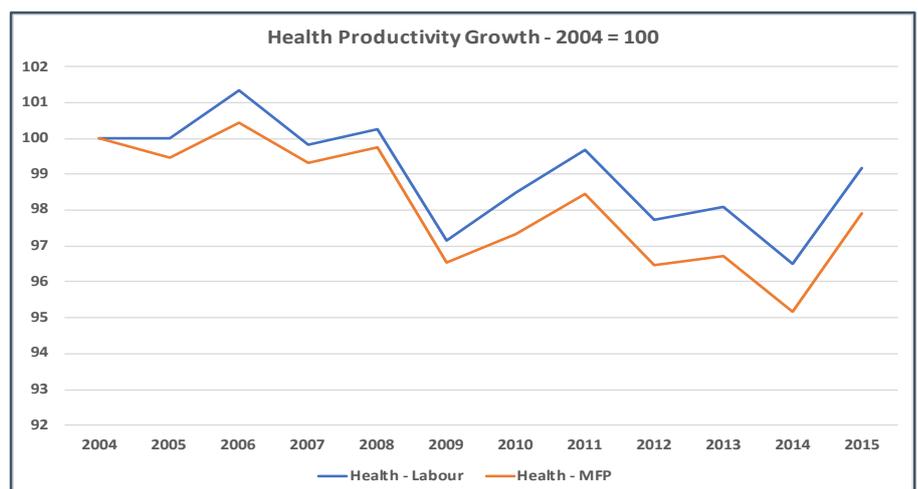
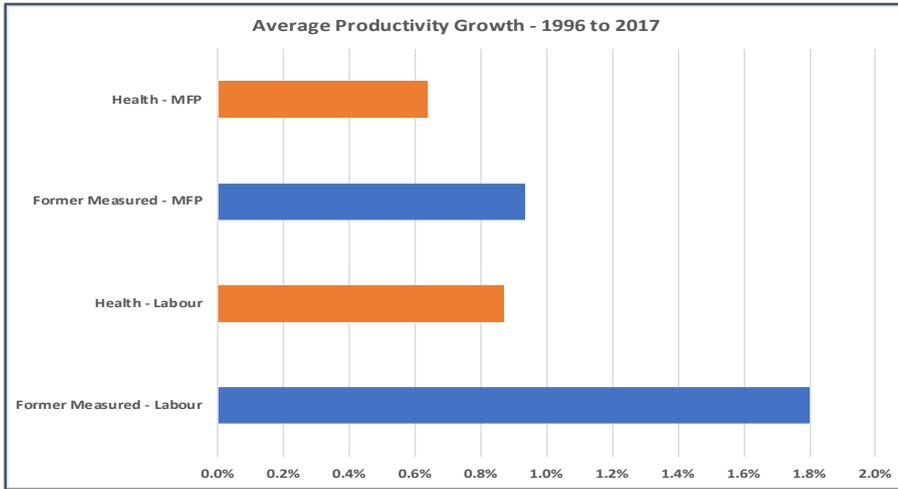


Figure 2



reduce administrative costs”) is probably still relevant today, eight years after the Working Paper was published.

So, why has healthcare productivity growth been so weak?

Nolan (2018) argues that “the two key drivers of productivity growth are diffusion and the reallocation of capital and labour”, but “[the] forces of reallocation tend to be weaker in the state sector ... which means diffusion of innovation needs to play a greater role in driving productivity growth.” In short, the public sector faces barriers to productivity growth not present in the private sector.

This point is echoed by Wilkinson (2018). The author argues poor productivity performance may be attributable to public sector dominance over service delivery.

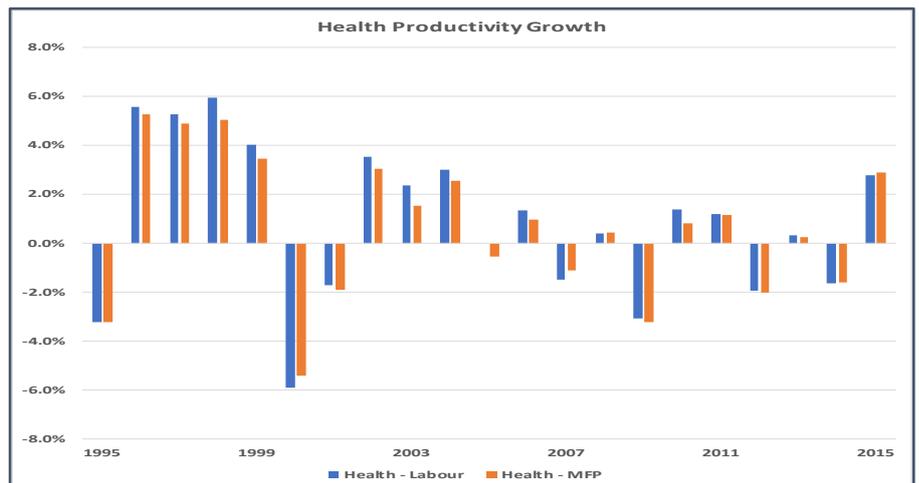
“Why are we not doing better? This is a state-dominated industry. Existing practices and attitudes reflect the incentives and constraints embedded in current arrangements. The inadequate productivity focus is a telling symptom of dysfunction.”

The argument for this is straight-forward. In absence of competitive commercial pressures, there are only limited incentives acting on DHBs to improve performance. Boards are not compensated according to performance or effective financial management. Boards

are only held accountable by voters in the first instance, although Ministers are able to sack boards and appoint commissioners (as happened at Southern DHB in 2015 and Waikato DHB earlier in 2019).

The lack of competitive incentives has clearly become a problem: every single DHB is now in deficit⁶ and Minister of Health David Clark is threatening broad changes to board membership.

Figure 3



MAKING CHANGES: POSSIBILITIES FOR REFORM

In seeking to improve the efficiency and productivity of the New Zealand health system, there are two available approaches to reform: upheaval or incrementalism. While some free-market ideologues might favour upheaval (vouchers, healthcare savings accounts, private sector service delivery, and abandoning ACC in favour of a greater role for individual insurance), there is very little evidence that broadly abandoning the public healthcare system would be effective.

While Singapore, which has a greater role for the private sector than New Zealand, spends very little on healthcare (only 4.25 percent of GDP)⁷, the United States has a notoriously expensive healthcare system (17.07 percent of GDP). It is difficult to analyse which way New Zealand would go in response to fundamental healthcare reform. Insufficient competition or informational asymmetries could cause significant price inflation in a healthcare system dominated by private provision.

Perhaps more importantly, the OECD argues against radical reform more generally⁸:

“The empirical analysis suggests that there is room in all countries surveyed to improve the effectiveness of health care spending; there is no health care system that performs systematically better in delivering cost-effective health care – big-bang reforms are therefore not warranted; increasing the coherence of policy settings, by adopting best policy practices within a similar system and borrowing the most appropriate elements from other systems will likely be more practical and effective to raise health care spending efficiency.”

The basic argument is that because no healthcare system is fundamentally better than the others, governments should focus on reforming existing service delivery in line with best practice; borrowing ideas from other systems should not be accompanied by dismantling the entire system.

There are a variety of opportunities for incremental policy reform.

Firstly, DHBs should consider the issues raised in the accompanying papers to this report: adverse drug reactions, missed specialist appointments, and redundancy

payments each inflate costs and dampen healthcare productivity.

Secondly, DHBs should consider tying the remuneration of Board members and executives to the financial performance of the DHB. DHB executives should face incentives to improve financial performance and service delivery efficiency. The simplest incentive mechanism would be to tie remuneration to measures of financial and efficiency performance.

Thirdly, the Government should consider amending the rules regarding ministerial appointments to DHBs. Currently, the Minister of Health may only appoint a maximum of four individuals to each DHB, each of which have a maximum of eleven members. While there might be some value to the community in electing representatives to their DHB, it is far more important that DHB members are qualified and perform highly. One possible reform would be to allow the Minister of Health to appoint a majority of board members at each DHB.

Fourthly, the Government should consider amalgamating some DHBs. Currently there are 20 DHBs, each of which



must manage their own administrative and support services. If DHBs were amalgamated, duplication of back-office functions could be limited – saving taxpayers money and freeing up resources for actual healthcare provision. Wellington region DHBs have already recognised these benefits: Capital and Coast and Hutt Valley DHBs are led by a single Chief Executive and a single Board Chair. A draft proposal for amalgamation is attached which would reduce the number of DHBs from 21 to 5.

Finally, the Government should allow individuals to purchase private health insurance using funds from their KiwiSaver accounts. Many individuals may value the benefits of access to a private health insurance scheme over the relative benefits of a higher level of future savings. Since KiwiSavers receive an annual lump-sum subsidy, this would apply an implicit subsidy to health insurance purchased through the scheme, without a significant increase in spending, since the vast majority of savers simply receive the KiwiSaver subsidy as a lump sum payment. In some ways, the annual KiwiSaver subsidy would function as a 'voucher' for health insurance, which can

be rolled over in the form of retirement savings.

This could improve the efficiency of the healthcare system in a number of ways. Firstly, reduced reliance on public healthcare provision would reduce the burden on capital resources and annual healthcare spending – with benefits to taxpayers and individuals who continue to use the public healthcare system. Secondly, a greater uptake of private health insurance – and any private healthcare funded through that insurance – may encourage a greater level of competition in the health system.

While some might argue that this would weaken the benefits to savings rates from KiwiSaver, there's strong evidence that KiwiSaver has had no impact on private savings levels. Law et al. (2011)⁹ and Law and Scobie (2014)¹⁰ employ different methods, but come to the same conclusion: KiwiSaver has had no meaningful impact on private wealth accumulation.

CONCLUSION

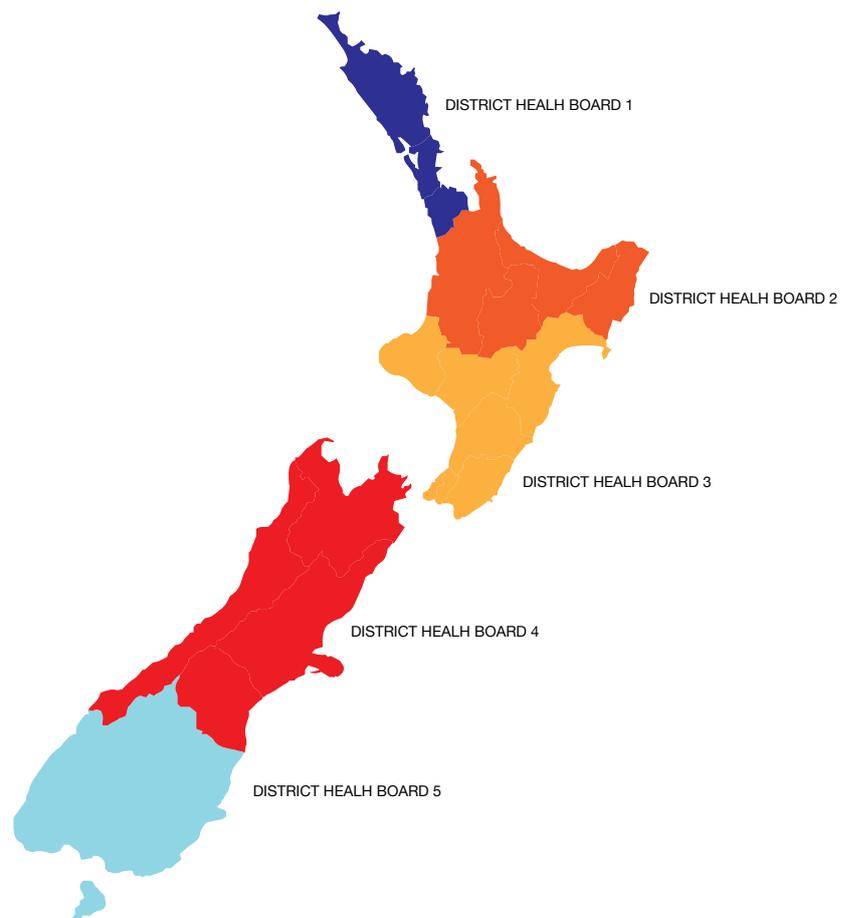
In the last 15 years, there has been a consistent failure to achieve reasonable healthcare productivity growth. If that failure continues, the results could be catastrophic. Debt is expected to grow to 205.8 percent by 2060, if no changes are made to our expected superannuation and healthcare expenditure commitments. Once debt climbs that high, servicing costs crowd out other forms of expenditure – expected revenue would not even be able to fund superannuation, healthcare, and debt servicing costs, let alone everything else we expect government to provide.

However, there is limited justification for tearing up the entire healthcare system and beginning again. The OECD is right to point out that there successful and unsuccessful healthcare systems across different models of delivery: the best approach to reform is to follow best practice within a country's existing delivery model. For New Zealand, that means focusing on incremental cost reform.

There are a variety of easy initial steps DHBs can take to limit waste, including limiting adverse drug reactions, limiting missed specialist appointments, and cutting down on large redundancy costs, as examined in the accompanying papers to this report.

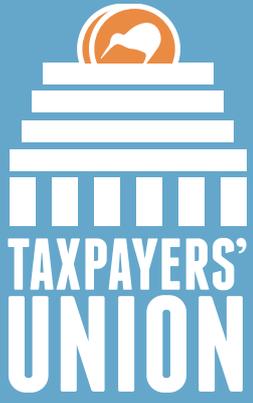
Next, the Government should consider appointing a greater share of DHB members and tying their remuneration to the financial performance of DHBs, along with amalgamating some DHBs to cut down on administrative costs. Finally, the Government should consider expanding uptake of private insurance by allowing individuals to purchase private health insurance through KiwiSaver accounts.

Figure 4 - Possible Amalgamation



Endnotes

- 1 Wilkinson (2018) "Fit for Purpose? Are Kiwis getting the government they pay for?", New Zealand Initiative
- 2 Ham, Chris (1997) "Reforming the New Zealand health reforms." British Medical Journal 314, no. 7098
- 3 New Zealand Treasury (2016) "He Tirohanga Mokopuna". Available at <https://treasury.govt.nz/sites/default/files/2016-11/tfs-16-htm.pdf>
- 4 Bryant, Teasdale, Tobias, Cheung, and McHugh (2004) "Population Ageing and Government Health Expenditures in New Zealand, 1951 – 2051" New Zealand Treasury Working Paper 04/14
- 5 Nolan (2018) "Measuring Productivity in the Health Sector". Available at https://www.victoria.ac.nz/__data/assets/pdf_file/0004/1686136/Nolan.pdf
- 6 <https://www.stuff.co.nz/national/politics/110758420/district-health-boards-careening-to-a-full-house-of-red-as-deficit-tops-200m>
- 7 Healthcare expenditure as percentage of GDP available at <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS>
- 8 ibid
- 9 Law et al. (2011) "KiwiSaver: An Initial Evaluation of the Impact on Retirement Saving" New Zealand Treasury Working Paper 11/04
- 10 Law and Scobie (2014) "KiwiSaver and the Accumulation of Net Wealth" New Zealand Treasury Working Paper 14/22



LOWER TAXES, LESS WASTE, MORE TRANSPARENCY
WWW.TAXPAYERS.ORG.NZ