

CONFIDENTIAL



The elephant in the room: ethical rationalisation

July 2010

Summary Presentation Document

This material was used by Temple: Capital Investment Specialists during an oral presentation; it is not a complete record of the discussion.

Problem statement

What are the underlying causes of health cost growth,

are they likely to prevail and ...

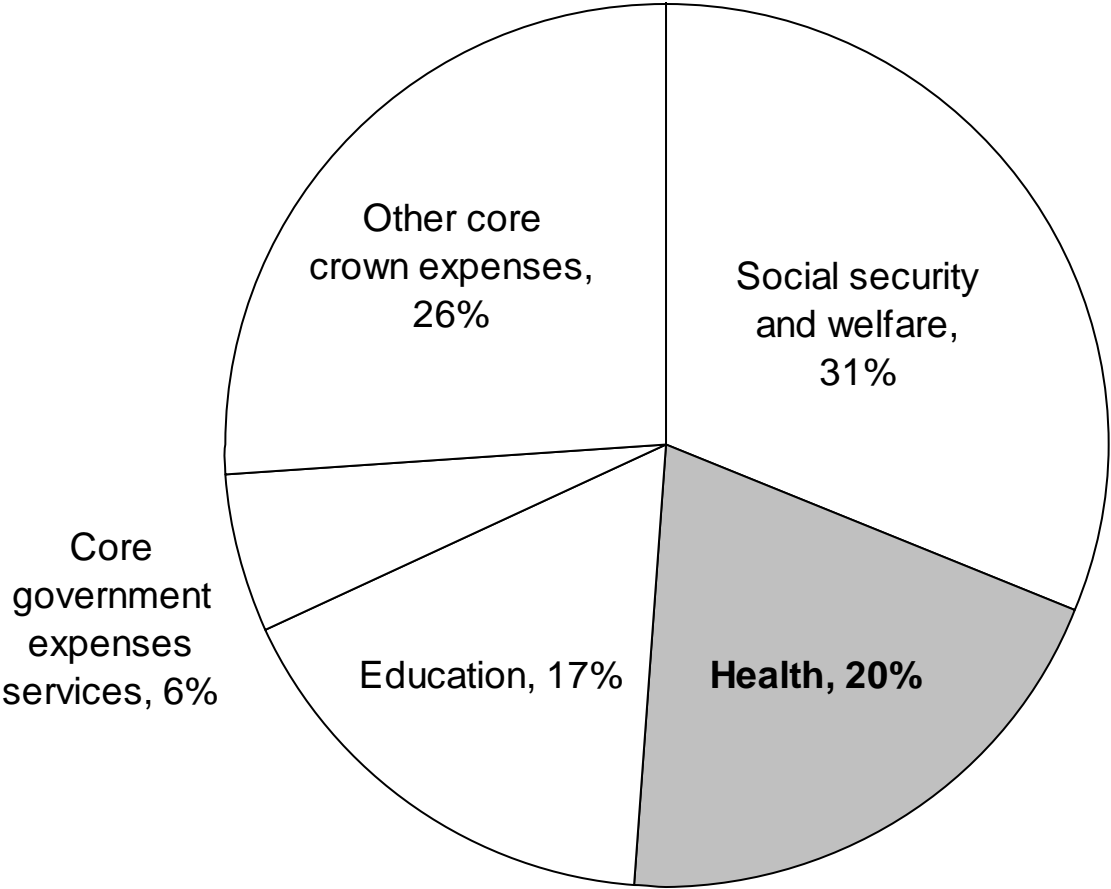
what if anything can be done to arrest this growth?

WHAT YOU SHOULD WALK AWAY FROM THIS PRESENTATION THINKING

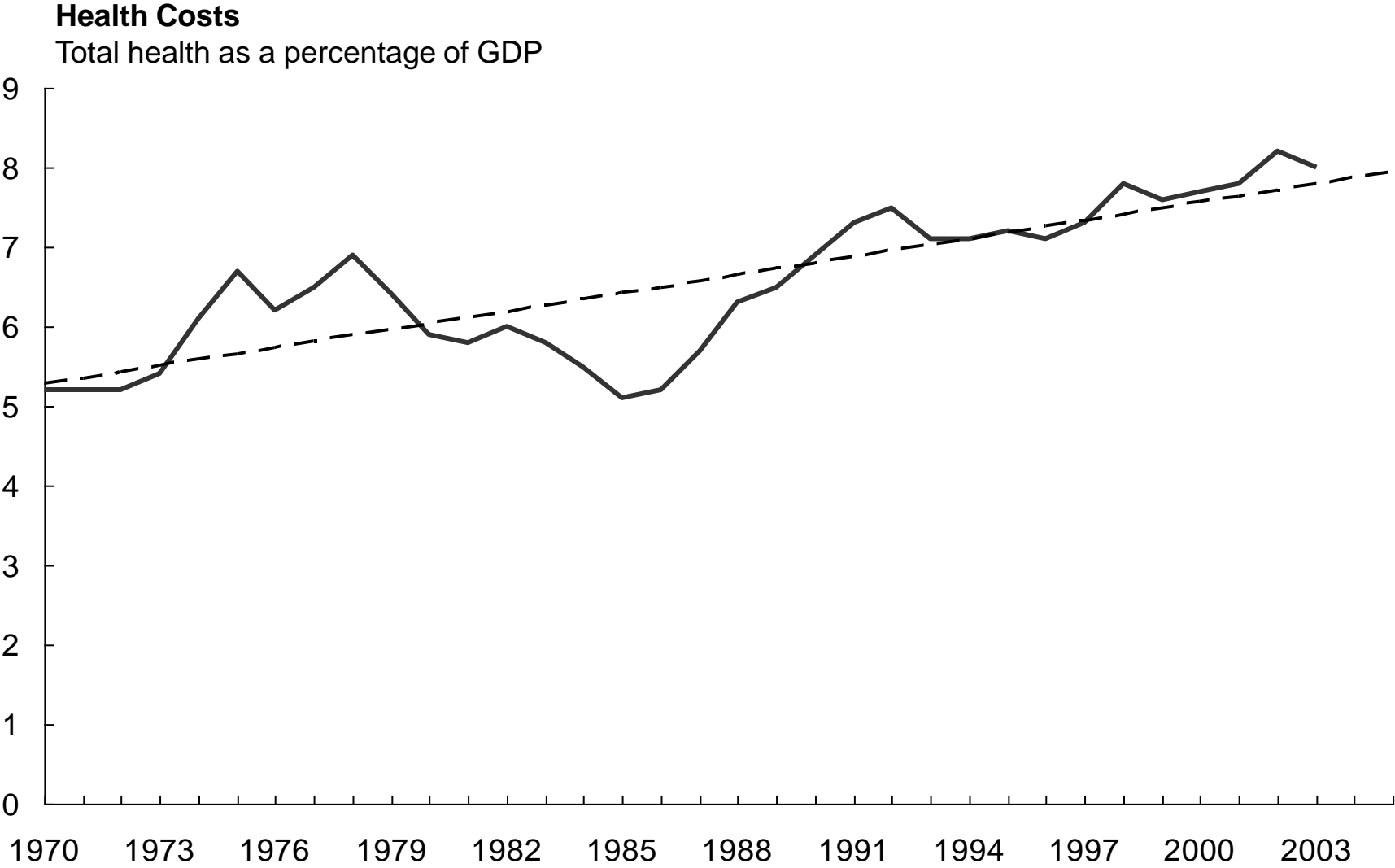
- **Takeaway One:** The health funding crisis hasn't even started – this is going to get a lot worse
- **Takeaway Two:** The initiatives on the table are inadequate. The elephant in the room is the discussion on the specifics of who gets what
- **Takeaway Three:** The government cannot and will not be the white knight. Leadership in discussing the elephant will likely come from those in this room.

HEALTH ACCOUNTS FOR ~20% GOVERNMENT EXPENSES

Breakdown of core government expenses (2008)
\$m (2008)

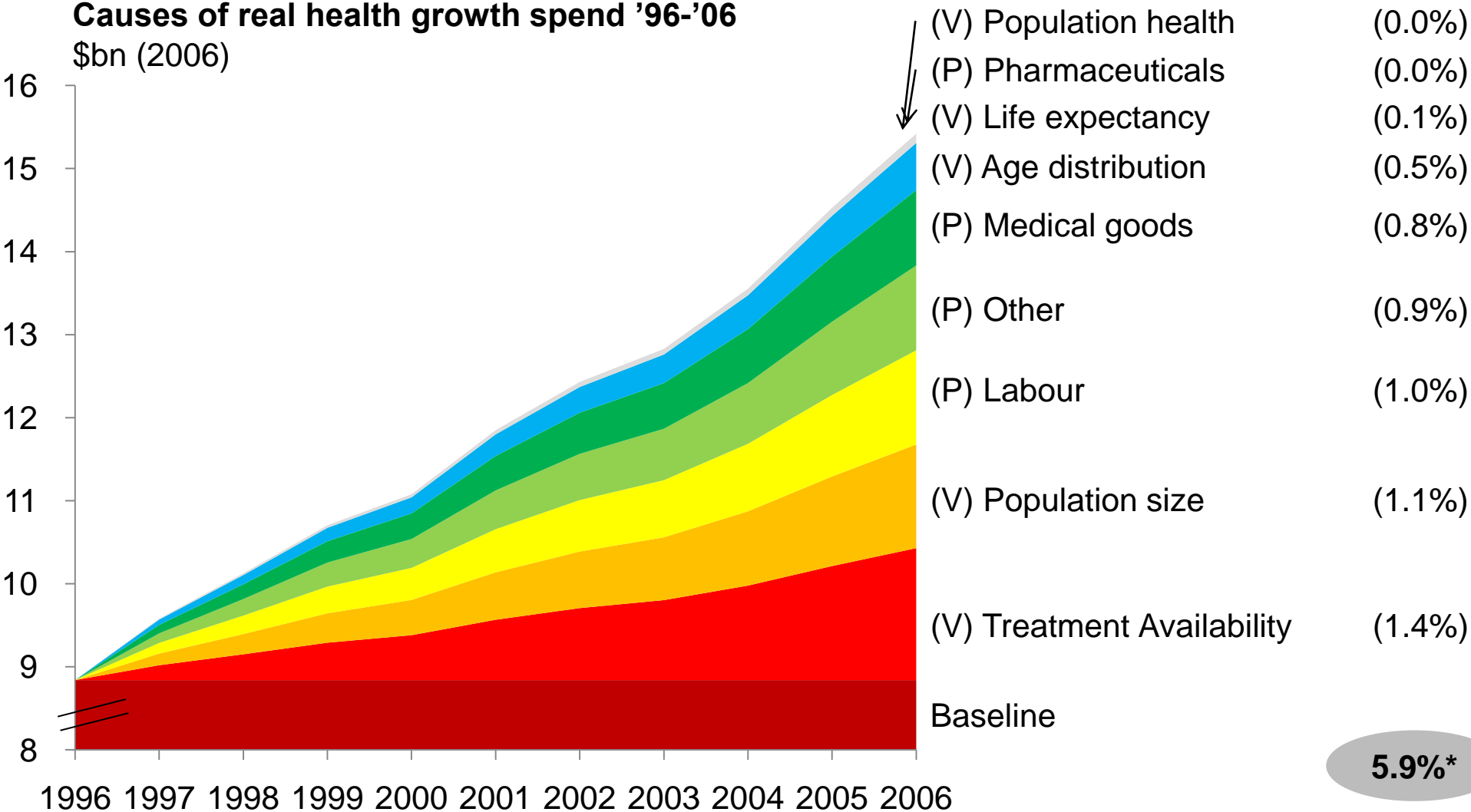


HEALTH COSTS HAVE GROWN FASTER THAN GDP FOR THE LAST QUARTER CENTURY







Source: OECD

POPULATION GROWTH, INCREASED TREATMENT AVAILABILITY AND LABOUR COSTS ACCOUNTED FOR ~60% OF GROWTH



A DECLINE IN POPULATION HEALTH HASN'T DRIVEN VOLUME OF CARE PROVIDED

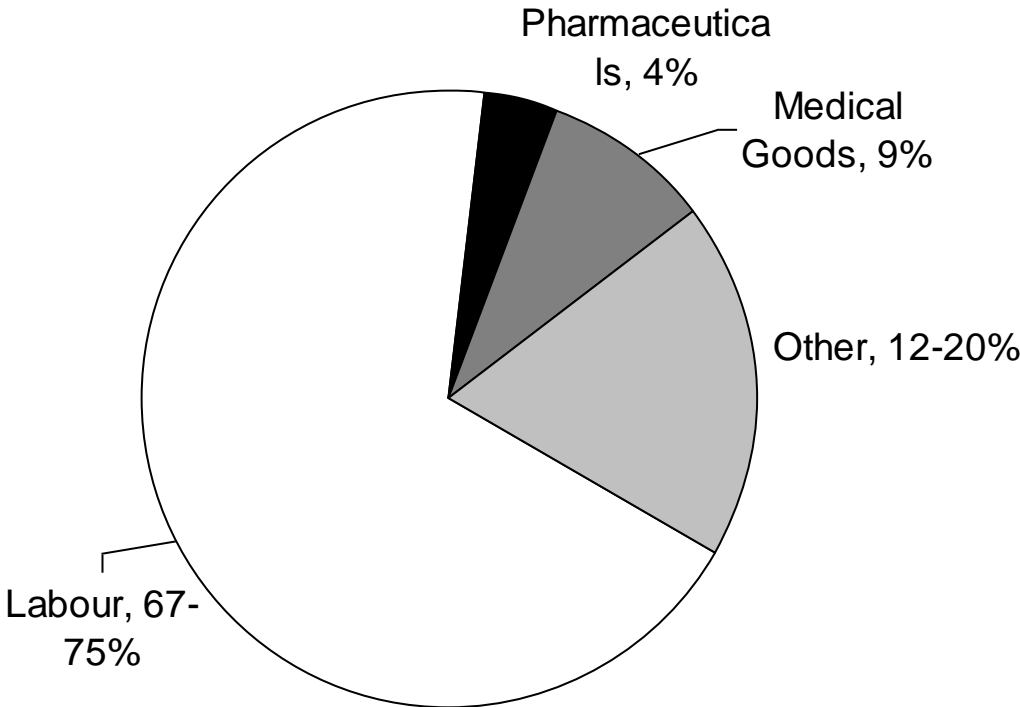
Proxies for Population Health Status (1996 – 2006 or nearest available)	
Measure	Status
Life expectancy (Years)	
Infant mortality rate (per 1,000)	
Maternal mortality rate (per 100,000)	No measureable trend
Disability adjusted life years lost (age standardized per 100,000)	
Self rated health % rating health as good, very good or excellent	

Source: NZHIS, NZ MoH, OECD, WHO, Statistics New Zealand

LABOUR IS A LARGE COMPONENTS OF HEALTH CARE COSTS AND LABOUR PRICE GREW FASTER THAN NATIONAL AVERAGE EVERY YEAR

Cost components of healthcare in New Zealand

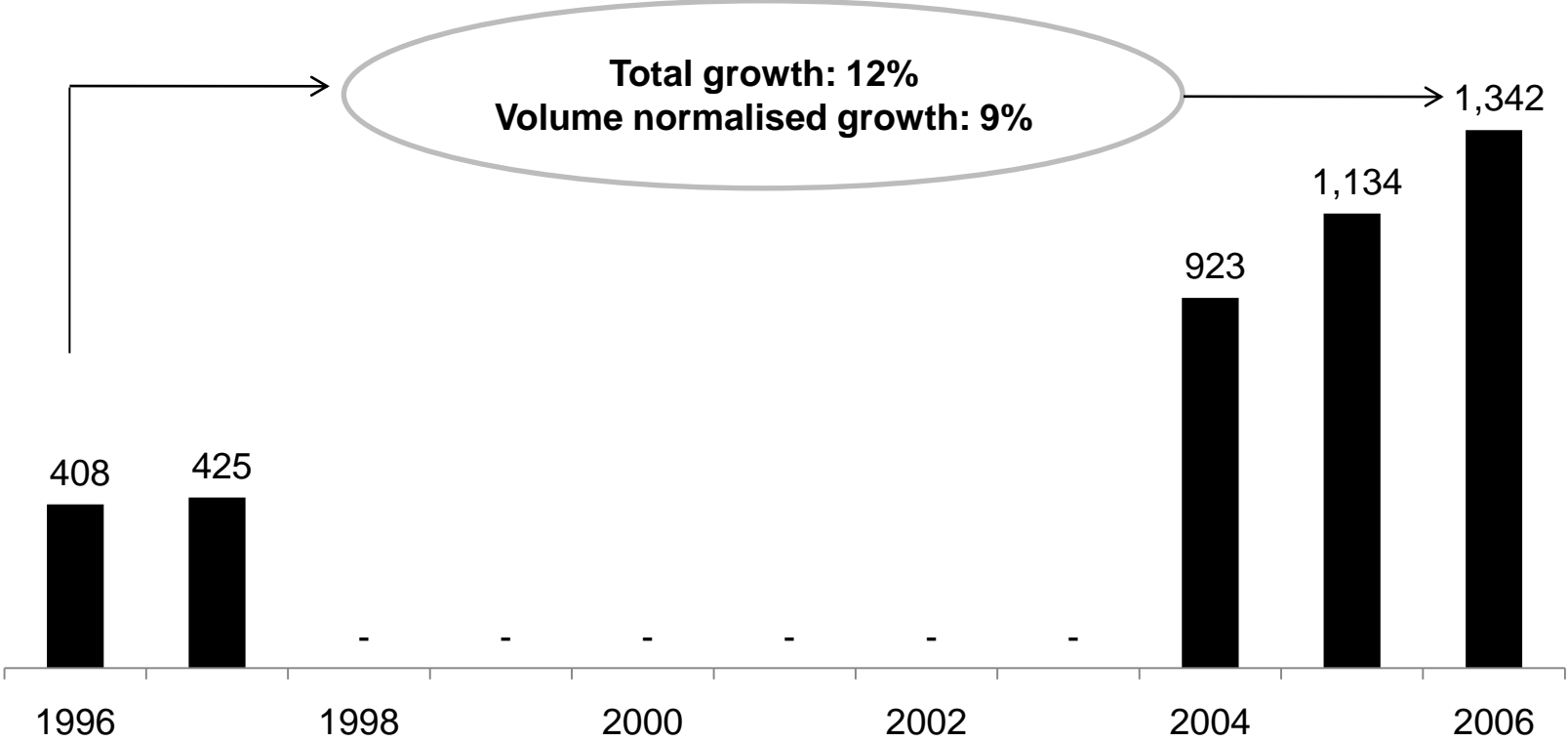
100% = \$15,433m (Public and Private, \$2006)



- Real health labour cost growth of ~1.4% CAGR
- Total real wage cost growth of ~1.2% CAGR
- **Contribution to cost growth: ~1.0%**

GROWTH IN MEDICAL GOODS ADDED 0.8% CAGR BY INCREASING THE PRICE OF CARE

Spend on Therapeutic appliances and medical durables and non-durables*
\$m (2006)



Health Outlook 2007 (OECD) commented that,

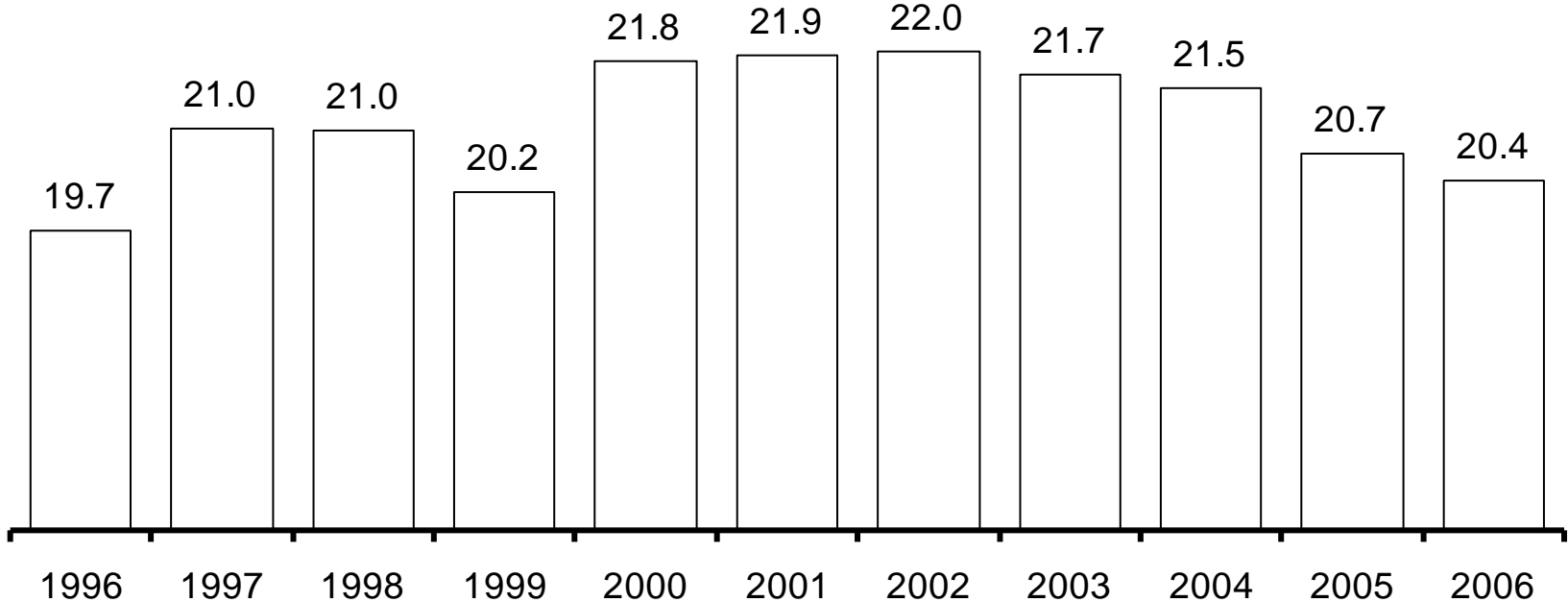
“The diffusion of modern medical technologies is one main driver of rising health expenditure across OECD countries.”

Weighted contribution to total price growth: 0.8% CAGR

Source: OECD Health Data, PHARMAC

PHARMAC CONTROLLED REAL PRICE GROWTH AT NEAR ZERO

Average price per prescription
\$ (2006)



- Real cost per prescription cost growth of 0.3% CAGR
- Weighted contribution to total price growth: 0.01% CAGR

PRODUCTIVITY CHANGE OVER THIS PERIOD WAS NEGLIGIBLE



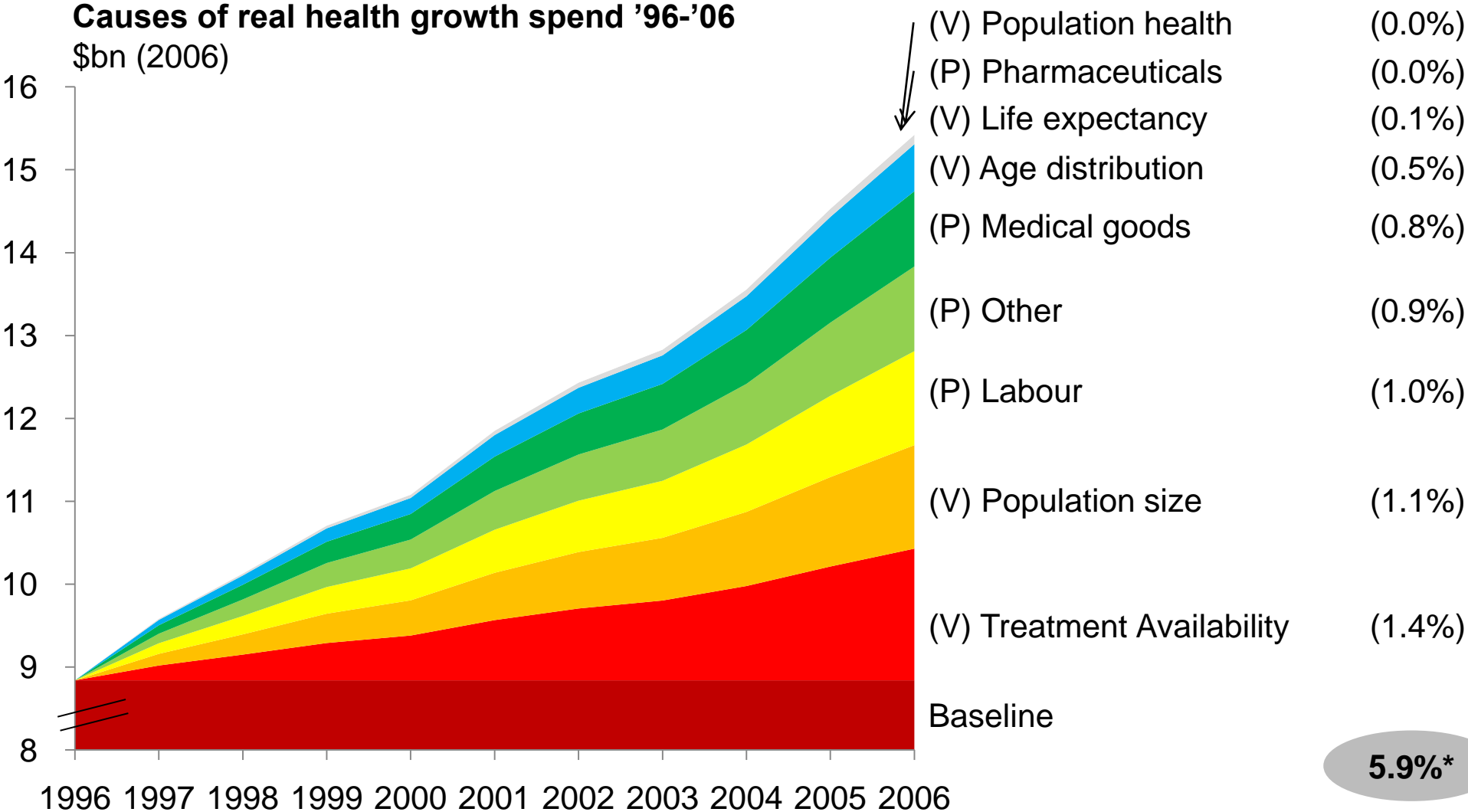
- There is no nationally agreed measure (s) of productivity in health

“A critical issue in New Zealand is developing measures of productivity (outputs per input)...”, 2009 OECD Economic Survey of New Zealand

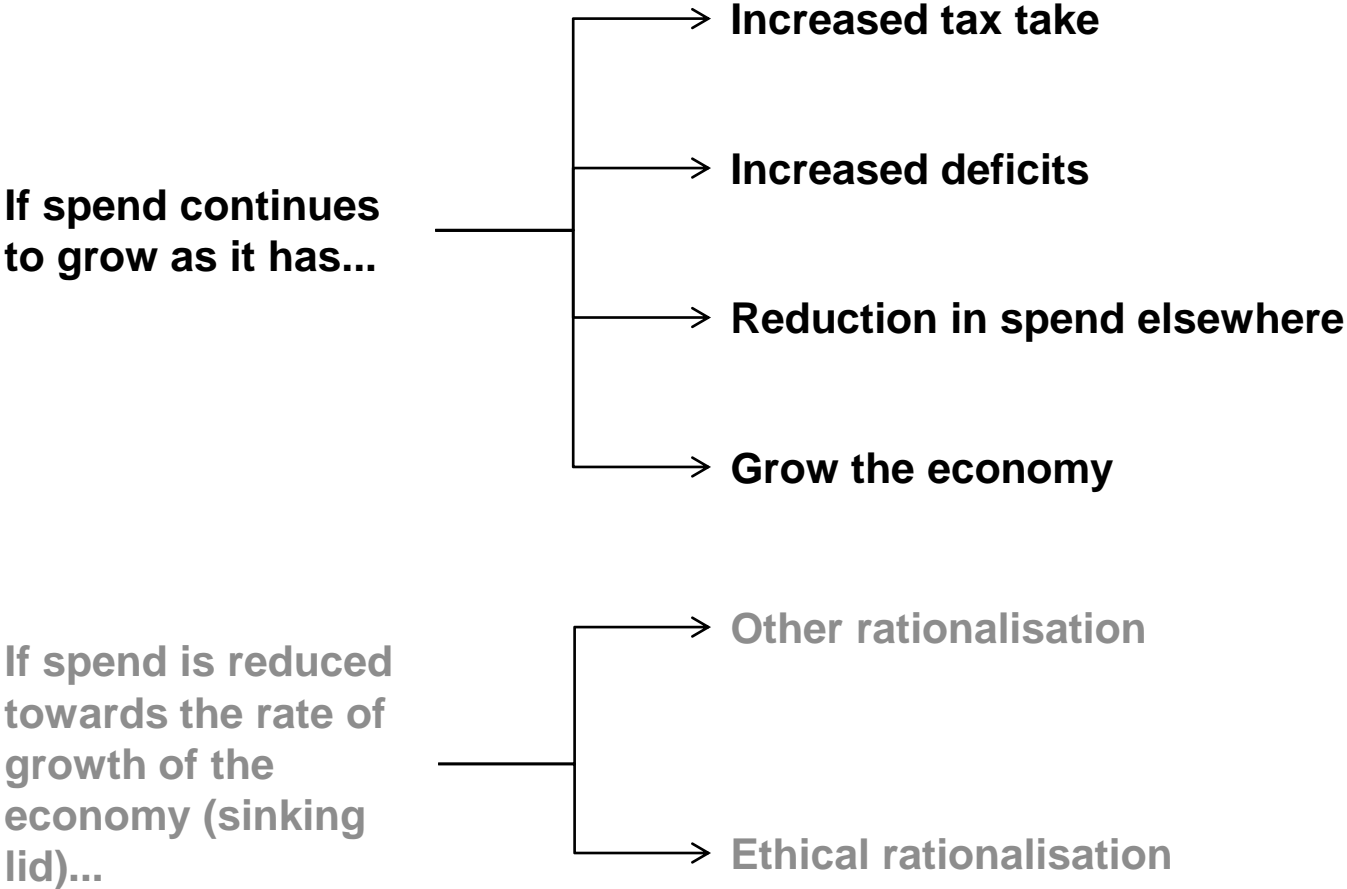
- Sector level data is variable in quality or missing
- **Implied labour productivity: 0%***

*Given increases in spending from the Labour government, no exposure to capital markets or competitive pressure in much of the health sector and low national labour productivity growth; Source: Ministry of Health, OECD Health Data

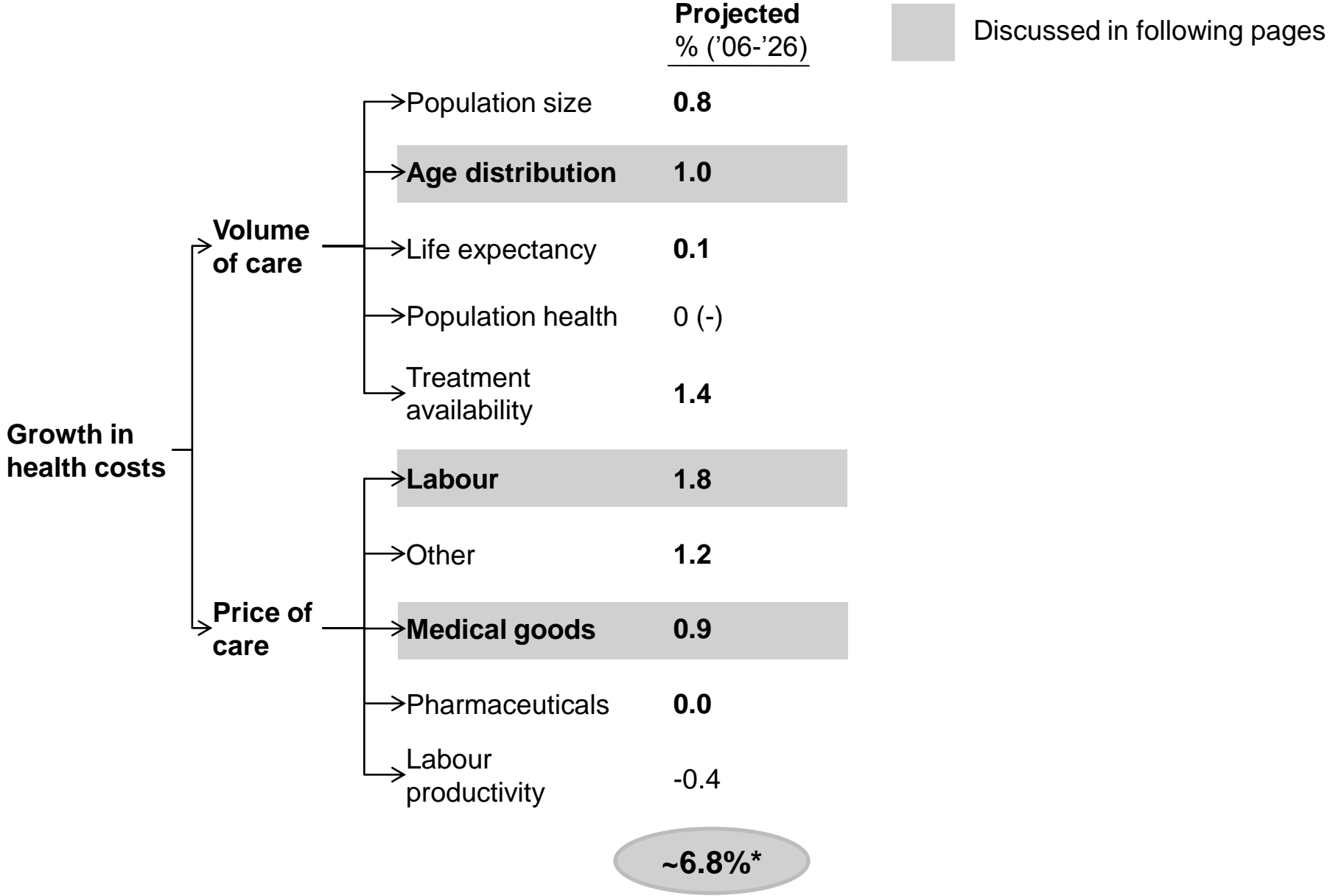
Population growth, increased Treatment Availability and Labour costs accounted for ~60% of growth '96-'06



THE IMPLICATIONS OF CONTINUATION DOWN THIS PATH ARE SIGNIFICANT

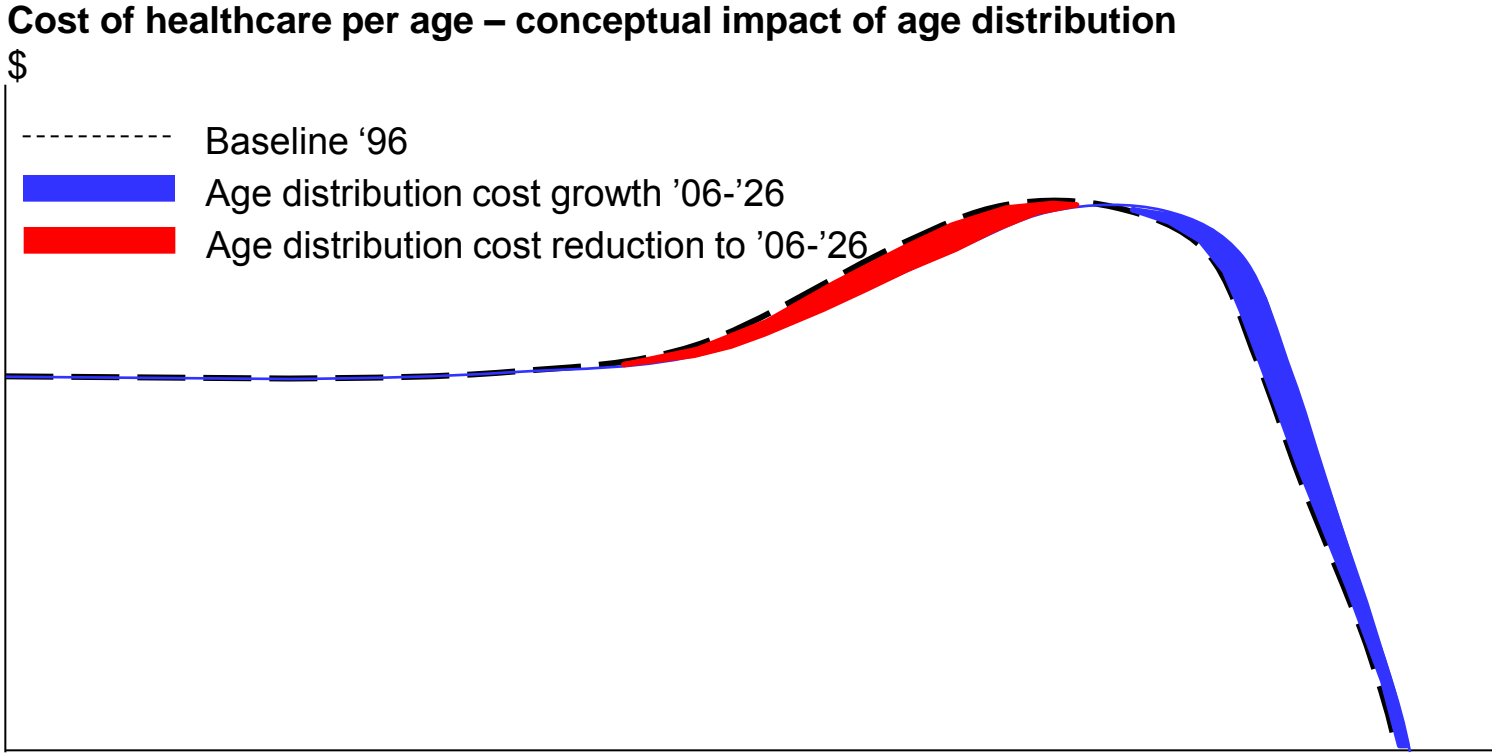


SUMMARY OF A 'CREDIBLE SCENARIO'



* May not add due to rounding

AGE DISTRIBUTION INCREASED HEALTH COSTS 0.5% CAGR '96-'06

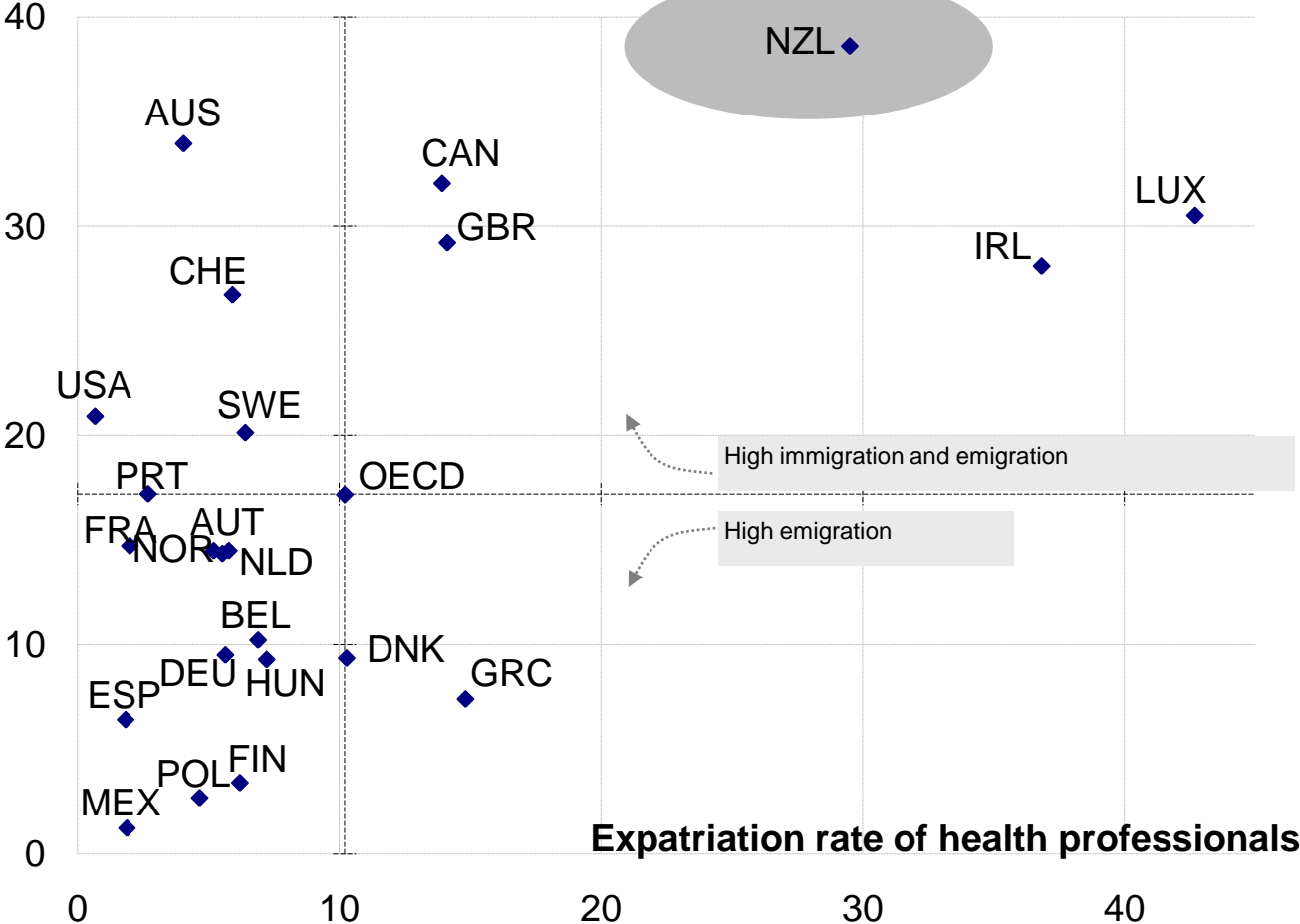


- The number of 65+ people grows from 511 to 955 (Mid range series) doubling the rate of growth contribution from
- **Implied cost growth over the period: 1.0% CAGR**

NEW ZEALAND IS HEAVILY DEPENDENT ON FOREIGN HEALTH PROFESSIONALS

Immigration and expatriation rates of health professionals Percent (selected OECD countries)

Share of foreign-born health professionals



Source: OECD, note this is circa 2000 data from 2008 paper on

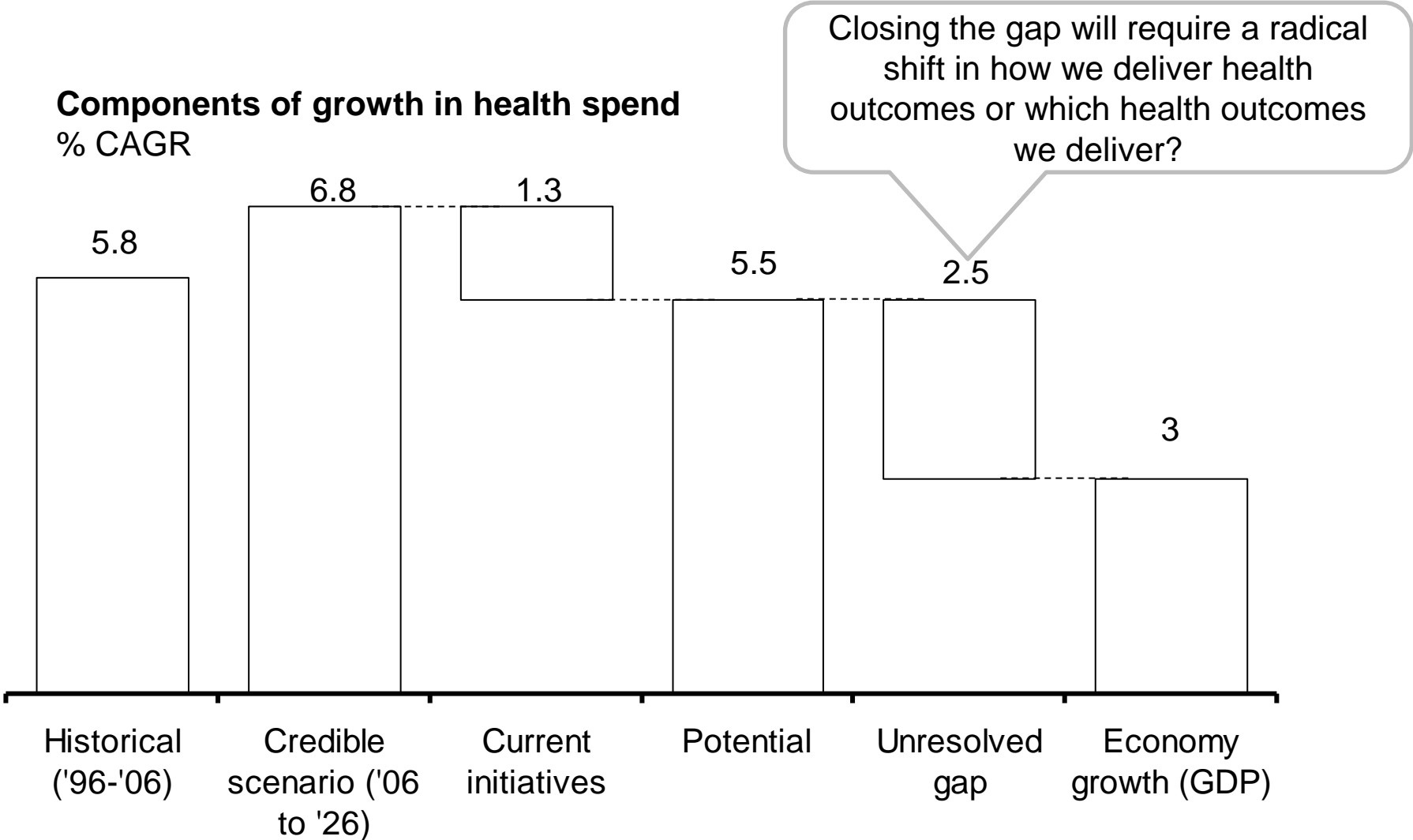
LABOUR COST GROWTH WILL LIKELY ACCELERATE

- **Workforce capacity issues:** the 6th (of 30) lowest number of practicing doctors per population in the OECD (2.2 per 1000 versus 3.1)
- **Dependent on foreign labour flows:** high percentage of foreign born health professionals and one of the highest rate of expatriation.
- **Global labour shortages:** A recent OECD survey of shortage estimates ranges from 0 to 20%+. All studies estimate a growing shortage of some form.
- **Global labour price growth:** A recent US study suggests a 3% CAGR rise in nursing salaries coupled with a 90% increase in graduates to 2020 would keep supply and demand in balance.

We have estimated labour growth at the average of current (2%) and that estimated above for the US (3%) to give 2.5% CAGR

THE THINGS WE'RE DOING OR PLANNING TO DO DON'T MAKE FOR SUSTAINABLE HEALTH

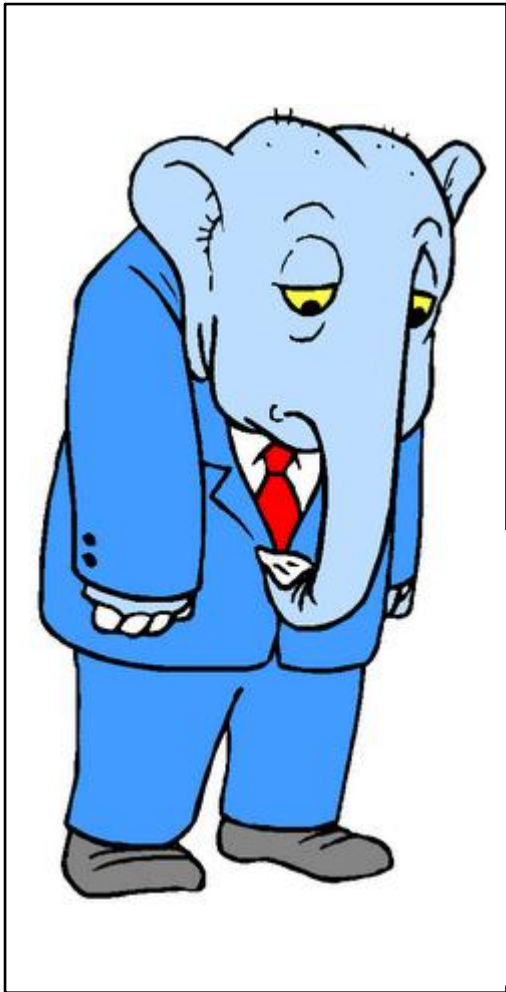
Components of growth in health spend
% CAGR



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THE IMPLICATIONS OF CONTINUATION DOWN THIS PATH ARE SIGNIFICANT



If spend continues to grow as it has...

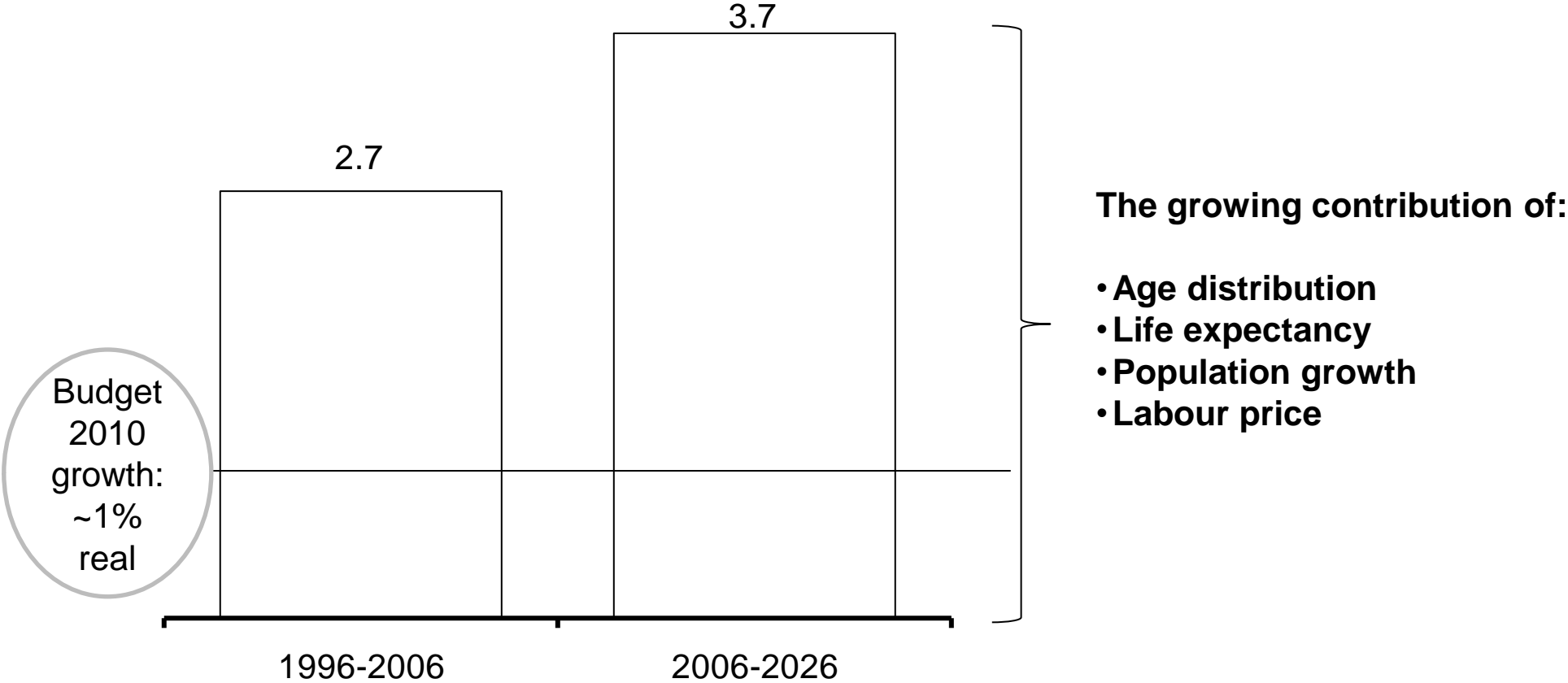
- Increased tax take
- Increased deficits
- Reduction in spend elsewhere
- Grow the economy

If spend is reduced towards the rate of growth of the economy (sinking lid)...

- Other rationalisation
- Ethical rationalisation

'UNSTOPPABLE' CONTRIBUTORS TO HEALTH GROWTH WILL INCREASE AND IS NOT COVERED BY CURRENT FUNDING

'Unstoppable' growth contribution
% CAGR real spend on healthcare



HERCEPTIN STORY IS AN EXAMPLE OF PR WINNING OVER SCIENCE AND ECONOMICS

May 2006:
Pharmac's determines there is not enough evidence to justify a 12 month course

April 2007:
Pharmac Board approves funding for nine weeks treatment with Herceptin

August 2007:
High Court finds in favour of Pharmac and reiterates the courts cannot direct the outcome of the decision

December 2008:
Government announces it will finance a year-long course of Herceptin

2006

2007

2008

Dec 2005:
Pharmac receives an application to fund Herceptin for 12 months

Nov 2006:
Pharmac recommends that a nine week Herceptin treatment be funded

June 2007:
Eight women file proceedings in the High Court seeking twelve months treatment be approved

May-August 2008: Pharmac again consults on Herceptin funding and again opts not to fund a trial of a year-long course

“ [John] Key says he is most proud of the decision to extend Herceptin funding for breast cancer sufferers from nine weeks to a year.”, TVNZ 2009

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THE GOVERNMENT WON'T BE THE WHITE KNIGHT



**Different
timelines**

Three year term for politicians, long term decisions (10+ years) for the health sector

**Political
suicide**

Avoidance of 'political suicide' will make addressing the real issues hard for political leaders

**Stakeholder
complexity**

In spite of owning the budget, the complexity of the stakeholder map means a prescriptive government approach won't work

WHO IS GOING TO PUT THEIR HAND UP AND HAVE THIS CONVERSATION?



HOW CAN THIS INFORMATION BE USED TO MAKE THIS MANAGEABLE?

From...

..to

Talking of 'innovation'

Innovation leadership: Structured investment in changing the way we deliver health services.

Avoidance of critical issues

Discussion leadership: A considered national and / or local discussion on what health services can be expected

Politically driven funding allocation decisions

Clinical leadership: Long term clinical leadership largely decoupled from the political process

Expectation of leadership from the state

Consumer leadership: Leadership from those close to the shop floor including New Zealand's citizens

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