Health Expenditure Trends in New Zealand 1994–2004

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Foreword

This report, *Health Expenditure Trends in New Zealand 1994–2004*, is the latest in a regular series prepared by the Ministry of Health. The primary purpose of the series is to provide information on expenditures in the New Zealand health and disability sector. The focus is on the 2003/04 expenditures. This series differs from other expenditures estimates because it relates to all sources of funding channelled through the public and private sectors.

The report has been prepared for use by interested individuals and agencies to foster informed debate on health funding and expenditure issues. The health system is an important and growing component of the national economy and provides essential services for the people of New Zealand. This document and prior editions in this series can be located on the Ministry of Health website at www.moh.govt.nz/publications.

The information in this report provides a basis for identifying and measuring trends and changes in the patterns of health and disability expenditure in New Zealand. The data are also useful in evaluating policies related to health and disability expenditure levels and patterns. Additionally, the information also provides a basis for comparing New Zealand's expenditure with other nations.

As the purpose of this document is to present an estimate of current expenditures on health, it does not include discussions on health service quality, efficiency or effectiveness. These financial estimates, together with other information supplied by the Ministry of Health and others that do focus on qualitative issues, provide the Ministry's contribution to information resources necessary for the public, researchers and policy-makers to assess the performance of the health system over time. For a reader interested in more qualitative aspects of the New Zealand health system, the quality improvement section of the Ministry of Health website located at www.moh.govt.nz/quality is a good starting place.

This report contains updated expenditure estimates for the total current health and disability services in New Zealand at the aggregate level, on a per capita basis, by source of funds, and in nominal and real terms since 1993/94. The estimates include both public and private health expenditures. The public source of funding is predominately administered by the Ministry of Health, primarily consisting of funding for services provided by the District Health Boards (DHB). Other sources of public funding include other central agencies, such as the Accident Compensation Corporation, and local and regional councils. Private sector sources of health funding include private insurance, household out-of-pocket expenditures, and non-governmental funding of not for profit organizations such as the Royal New Zealand Plunket Society and the National Heart Foundation of New Zealand.

In 2003/04 New Zealand adopted the System of Health Accounts (SHA) promulgated by the Organisation for Economic Co-operation and Development (OECD) for defining and aggregating total current health and health-related expenditures. This approach is a deviation from historical practice in New Zealand and this series of reports. However, New Zealand has not yet incorporated expenditures for capital items in the expenditure estimates. Shifting to the new basis means that the New Zealand estimates, now and in the future will be more comparable with other countries; however, for earlier years some consistency at a detailed level is lost.

The implementation of SHA introduces the concept of and estimates for 'health-related' functions that are distinguished from 'core health care' functions. Health-related functions can be closely linked to health care in terms of operations, institutions and personnel but are, as far as possible, excluded when measuring activities and expenditures belonging to core health care functions. For the most part, they are services that have a direct and beneficial impact on public health and, if reported in historical *Health Expenditure Trends* reports, were included as public health.

The most significant impact on the expenditure estimates due to implementing the SHAs is the broadening of the definition of the 'health sector' to include additional disability and support and long-term care services. There are, however, other changes that partly offset this increase; for example education, training and research are now considered 'health-related' rather than 'core health' functions.

For historical information covering the period 1995/96 to 2002/03, the estimates have been recalculated to include the previously excluded items, primarily disability support services (DSS). The bulk of health expenditure on DSS was previously administered by the Ministry of Social Development (MSD) and was transferred to the Ministry of Health between 1993/94 and 1995/96. For this reason much, but not all, historical and current expenditure comparisons specify information from 1995/96 and 2003/04 and not pre-transfer 1993/94.

The change to SHA has provided an opportunity to review all data collection sources, processes and assumptions involved in compiling health expenditure tables. As a result, several refinements have enhanced the accuracy of the expenditure estimates in this edition of *Health Expenditure Trends*. The nature of the enhancements is covered in detail within the body of this report.

Please note that some of the data in this report have been collected by means of sample surveys and have consequently been estimated conservatively. Therefore, care should be taken in interpreting changes in individual categories of expenditure from year to year. In addition, as this report covers the first year in which the SHA has been used, future refinements in the accuracy of the estimates can be expected.

The report is a variation on previous reports due to the change to OECD SHAs and other refinements in the methodologies used to estimate the expenditures. Therefore for comparative purposes and trend analysis 2003/04 data provides consistent information only at a summary level, comparability at the detailed level is no longer available. This report should be reviewed in part as documentation of the change in methodology used to compile New Zealand current health expenditure for 2003/04. A further purpose of this report is to summarise the methodology behind the data, and changes to the methodology over time.

The Ministry is grateful for the assistance of those who have contributed data and analysis used in preparing this report.

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Acknowledgements

The author is indebted to the many individuals who provided information and gave generously of their time to assist with this study. The people and organisations involved are numerous, and are named in Appendix 8.

The author would like to thank all those people and organisations for their assistance. Special thanks to the Health Funds Association of New Zealand Inc for its invaluable assistance in producing this report. Special thanks also to Jon Foley at the Ministry of Health and Andrew Thompson of the Office of the Minister of Health, who have reviewed the report.

Contents

Foreword iii

Executive Summary xi

Chapter 1: Overview of the New Zealand Health Sector 1

1.1 Purpose 1
1.2 Background 1
1.3 Ministry responsibilities and funding levels 1
1.4 Structure of the New Zealand public health and disability sector 2
1.5 Other funders of the New Zealand public health and disability sector 3

Chapter 2: Definitions 5

2.1 OECD system of health accounts definitions and classifications 5
2.2 Prior HET classifications and definitions 7

Chapter 3: Methods and Conventions 10

3.1 Report coverage 10
3.2 Categories of health expenditure 10
3.3 Funding sources 10
3.4 Sources and assumptions related to Ministry-funded services 11
3.5 Ministry-funded services, exclusive of DHBs 11
3.6 DHB-funded services 11
3.7 Crown Health Enterprise/District Health Board deficit financing 11
3.8 Sources and assumptions related to services funded by other central government agencies 12
3.9 Sources and assumptions related to services funded by local government 12
3.10 Sources and assumptions related to services funded by the private sector 12
3.11 Real dollar health expenditure 13
3.12 Goods and services tax and overhead charges 13
3.13 Populations 13

Chapter 4: Trends in Total Current Health Expenditure by Funding Source 14

4.1 Introduction 14
4.2 Aggregate health expenditure 14
4.3 Trends in real per capita current expenditure on health 17
4.4 Pattern of health care funding by source of funds 20
4.5 Trends in uses of aggregate health and health-related funds 21

Chapter 5: Public Sector Funding – Ministry of Health 22

5.1 Introduction 22
5.2 Ministry of Health funding 22
5.3 Ministry funding by major expenditure category 24

Chapter 6: Other Public Sector Funding 28
6.1 Introduction 28
6.2 Accident Compensation Corporation 28
6.3 Other central government agencies 30
6.4 Local authorities 38
6.5 Trends in uses of public funding 40

Chapter 7: Private Sector Funding 41
7.1 Introduction 41
7.2 Out-of-pocket expenditure 41
7.3 Health insurance 43
7.4 Voluntary and not-for-profit organisations 44
7.5 Trends in uses of private source funding 45

Chapter 8: International Comparisons 47
8.1 Data comparison issues 47
8.2 Per capita health expenditure in US dollar purchasing power parities 47
8.3 Health expenditure as a percentage of GDP 49
8.4 Publicly funded current health expenditure as a proportion of total health expenditure 50
8.5 Health expenditure and GDP per capita 51

Appendices
Appendix 1: OECD System of Health Accounts 54
Appendix 2: Historical Definitions of Health and Disability Support Services 62
Appendix 3: Nominal and Real Health Expenditure (with 'non-health' items included for prior years), 1995/96–2003/04 68
Appendix 4A: *Health Expenditure Trends* in New Zealand (with 'non-health' items included for prior years), 1995/96–2003/04 69
Appendix 4B: *Health Expenditure Trends* in New Zealand (with 'non-health' items included for prior years), Real Dollars 1995/96–2003/04 70
Appendix 5: Private Health Insurance Trends, 1993/94–2003/04 ($000) 71
Appendix 6: Current Expenditure on Health by Function of Care and Provider Industry (SHA Standard Table 2) 72
Appendix 7: Current Expenditure on Health and Health-related by Function of Care and Funder (SHA Standard Table 5) 74
Appendix 8: Contributors 75

References 79

List of Tables

Table 4.1: Real current expenditure trends and gross domestic product, 1995/96-2003/04 18
Table 4.2: Health expenditure by source of funds (%), 1995/96–2003/04 20
Table 4.3: Destinations of total health funding, 2002/03 and 2003/04 (including health-related) 21
Table 5.1: Ministry of Health expenditure 1995/96–2003/04 23
Table 5.2: Destinations of Ministry of Health funding, 2002/03 and 2003/04 24
Table 5.3: Main service category, 2003/04 25
Table 5.4: Ministry of Health expenditure by output class, 2003/04 27
Table 6.1: ACC current health expenditure ($ million), 2000/01–2003/04 29
Table 6.2: Current health expenditure and health-related expenditures by other central government agencies, 2002/03 and 2003/04 36
Table 6.3: Current health expenditure and health-related expenditures by other central government agencies, 2003/04 37
Table 6.4: Current health and health-related expenditures by local authorities, 2002/03 and 2003/04 39
Table 6.5: Destinations of other public funding of health services, 2002/03 and 2003/04 40
Table 7.1: Survey responses ($ million), 2001/02 and 2003/04 42
Table 7.2: Destinations of insurance funding ($ million), 2000/01 and 2003/04 43
Table 7.3: Proportion of the New Zealand population covered by medical insurance (by age group), 2001/02–2003/04 43
Table 7.4: Destinations of private funding of health services, 2002/03 and 2003/04 45
Table 7.5: Current health expenditure and health-related expenditures in the private sector, 2003/04 46
Table 8.1: Per capita current health expenditure, exclusive of investment on medical facilities (US$ PPP) for OECD countries, 1994–2004 48
Table 8.2: Current health expenditure as a percentage of GDP, 1994–2004 50
Table 8.3: Publicly funded health expenditure as a proportion of total health expenditure, 1994–2004 51
Table 8.4: Per capita GDP and per capita health expenditure (US$ PPP) for OECD countries, 2003 and 2004 53

List of Figures

Figure 1.1: Structure of the New Zealand health and disability sector 2004 4
Figure 4.1: Aggregate real ($ million 2003/04) health expenditure, 1925–2004 15
Figure 4.1A: Aggregate real ($ million 2003/04) health expenditure, 1980–2004 15
Figure 4.1B: Aggregate real (per capita 2003/04) health expenditure, 1980–2004 16
Figure 4.2: Publicly and privately funded expenditure shares, 1925–2004 16
Figure 4.2A: Publicly and privately funded expenditure shares, 1980–2004 17
Figure 4.3: Trends in real total current expenditure on health ($ million 2003/04) 19
Figure 4.4: Trends in real per capita current expenditure on health ($ million 2003/04) 19
Figure 4.5: Total health funding (%), 1995/96 and 2003/04 20
Figure 8.1: Relationship between health expenditure and GDP in 30 OECD countries, 2003 52

Executive Summary

This report, *Health Expenditure Trends in New Zealand 1994–2004* (HET), is the latest in a regular series prepared by the Ministry of Health. The primary purpose of the series is to provide information on the estimate of current expenditures in the health and disability sector with a focus on the 2003/04 estimate. This report provides updated estimates for the total current health and disability services expenditure in New Zealand at the aggregate level, on a per capita basis, by source of funds, and in nominal and real terms since 1993/94. In 2003/04 New Zealand implemented the System of Health Accounts (SHA) of the Organisation for Economic Co-operation and Development (OECD) in defining and aggregating total current health expenditures and 'health-related' expenditures for reporting to the OECD and *Health Expenditure Trends*.

This approach is a deviation from historical practice in New Zealand and for the *Health Expenditure Trends*. New Zealand has not yet incorporated expenditures for capital items in the OECD reporting. The New Zealand estimates now enable better comparisons to be made between countries; however, for earlier years some consistency at a detailed level is lost. Therefore this report provides consistent information only at a summary level and should be reviewed in part as a report documenting the change in methodology used to compile New Zealand current health expenditures for 2003/04.

The most significant impact on the estimates due to implementing SHA is the broadening of the definition of health sector to include additional disability and support and long-term care services. Previous reports of *Health Expenditure Trends* identified the funding transfer from social agencies (transfers) to the Ministry of Health, primarily disability support services (DSS), and excluded part of the services from the health expenditures. For historical information covering the period 1995/96 to 2002/03, the estimates have been recalculated to include the previously excluded items. The bulk of health expenditure (mainly disability support services) previously administered by the Ministry of Social Development (MSD) was transferred to the Ministry of Health between 1993/94 and 1995/96. For this reason some, but not all, historical and current expenditure comparisons specify information from 1995/96 and 2003/04, and not pre-transfer 1993/94 information.

From 2003/04 DSS funded directly by the Ministry are considered a 'core health' service. This has the effect of increasing health expenditures. The expanded definition of health functions takes into account recent changes in health care systems, specifically the growing importance of services for older people (long-term care, including home care). Within the OECD the most important factor affecting comparability remains the different treatment of long-term nursing care across countries (OECD 2005). New Zealand will continue to refine and improve estimates in this area in future *Health Expenditure Trends* editions.

There are, however, other changes that partly offset this increase; for example education, training and research are now considered ‘health-related’ and not ‘core health’ functions. In addition, implementing the SHA provided an opportunity to review data collection sources, processes and assumptions involved in compiling health expenditures. As a result, several refinements have enhanced the accuracy of the estimates in this edition of *Health Expenditure Trends*. The nature of these enhancements is covered in detail within the body of this report.

The main focus of this report is on the SHA-based total current health expenditures in 2003/04. Trend information is also provided. Historical and current expenditure comparisons use the most appropriate points in time given changes in methodologies and assumptions. The health and disability expenditures presented in this report include goods and services tax (GST) at its prevailing rate. The GST rate is 12.5%.

Chapter 1 provides an overview of New Zealand’s health sector that establishes the scope of the data in this report.

Chapter 2 sets out the approach and definitions used in preparing the report. It contains a brief overview of the SHA classifications that cover three dimensions: health care by functions of care; providers of health care services; and sources of funding. The set of core tables in the SHA addresses three basic questions.

1. What kind of services are performed and what types of goods are purchased?
2. Where does the money go to (provider of health care services and goods)?
3. Where does the money come from (source of funding)?

The implementation of SHA introduces the concept of and estimates for ‘health-related’ functions that are distinguished from ‘core health’ care functions. Health-related functions can be closely linked to health care in terms of operations, institutions and personnel but are, as far as possible, excluded when measuring activities and expenditures belonging to ‘core health’ care functions. For the most part, they are services that have a direct and beneficial impact on public health and, if reported in historical *Health Expenditure Trends* reports, were included as public health. In this initial year of reporting under SHA, the estimate of health-related functions total nearly $2 billion.

In addition, Chapter 2 also contains a summary of the definitions and classifications used in prior *Health Expenditure Trends* with the disposition of the expenditures in 2003/04. See Appendix 2 for more detailed definitions. The net effect of all changes in definition, data sources and methodology results in an increase of approximately $63.0 million in current health expenditure of which only $7 million is publicly funded. This is relatively immaterial in amount in comparison to the total estimate of approximately $12,681 million; however the impact on individual functions can be material.

In Chapter 3, the methods and conventions followed in the report are presented, along with a description of the types of data collected.

Chapter 4 presents trends in real total current expenditure and in real total per capita current expenditure on health between 1994 and 2004. Summary information on source and final use of funds is also provided. All indicators report significant increased funding of health services; in total, in constant dollar terms (real dollars), on a per capita basis, as a percent of Gross Domestic Product (GDP) and as a percent of government funding. As explained in Chapter 4, total current nominal health and disability expenditure rose 8.2% during 2003/04 to $12,681 million. Of this total, public funding increased in comparison to 2002/03 levels by $492.3 million or 5.3%. Real per capita aggregate expenditure increased by 3.4% to $3,121 per person. Total current health expenditure as a percentage of GDP was 8.5% compared with 8.4% in the previous year.

Chapters 5 to 7 present a more detailed discussion of expenditure by funding source covering the Ministry and other public and private funding channels respectively for the year under review, 2003/04, and for recent years.

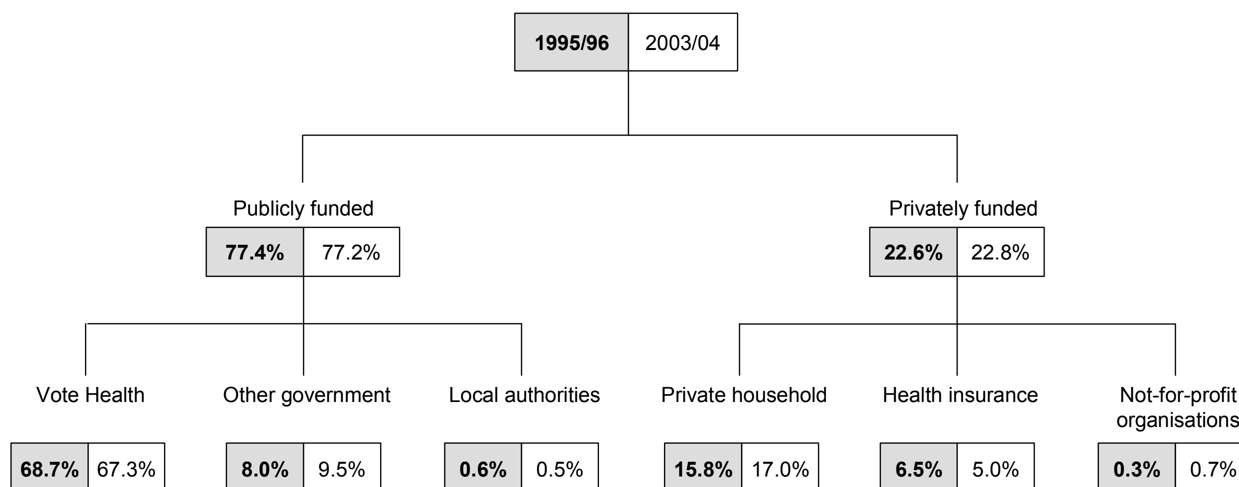
Chapter 5 provides detailed information of the funding of health services by the Ministry of Health. Separate profiles have been detailed for services funded by the Ministry and services funded through DHBs. The government's health funding through the Ministry of Health is the largest contributor to the total health and disability funding, at $8,531 million or 67.3% of total funding. This figure represents an increase of $540.7 million compared to 2002/03. The Ministry funded DHB services represents $6,759.0 million, of which personal health is the largest component at $6,610.3 million.

In Chapter 6 other sources of public funding are discussed. The Accident Compensation Corporation (ACC) is the second largest public funder of health services at $991.7 million in 2003/04 that accounted for 7.8% of total current health expenditures. Other central government agencies contributing to direct health and indirect 'health-related' expenditures that are included in this report are the ministries or departments of Agriculture and Forestry; Education; Internal Affairs; Research, Science and Technology; Defence; Social Development; Corrections; Internal Affairs; Te Puni Kōkiri (Māori Development); and Pacific Island Affairs. Estimates of health and 'health-related' expenditures for this group of agencies were derived from annual reports and direct survey responses. These other central government agency contributions to total current health expenditure total $208.1 in 2003/04. Regional and local councils funded $63.2 million in current health expenditures and a more significant $1,240 million for 'health-related' functions.

As outlined in Chapter 7, private sources of funding consist of household out-of-pocket expenditure, health insurance and non-governmental funding of not-for-profit organisations. Together, they accounted for approximately $2,887.0 million, or 22.8% of total current health expenditure in 2003/04. Within the private funding increase, private health insurance expenditure decreased by 0.3% to $638.6 million and private household spending grew on average 7.1% from 2000/01 to 2003/04 to $2,155.5 million. Expenditure by the not-for-profit sector was $92.9 million.

The following figure presents the major funder groups and their contribution to total current health expenditures in 1995/06 and 2003/04. This shows no significant shift by funder across this period.

Percentage shares of New Zealand's total health funding 1995/96 and 2003/04



Source: Ministry of Health

New Zealand's current expenditure on health and disability services is discussed in Chapter 8 in the context of current health expenditure by other member countries of the OECD. The chapter provides comparisons of the level of current health expenditure, the proportion of current health expenditure to GDP and the percentage of publicly funded current health expenditure in OECD countries. One key finding from this analysis indicates that for New Zealand, the proportion of current health expenditure to GDP increased from 7.3% in 1996 to 8.5% in 2004. In comparison, the OECD weighted average over the same period increased from 8.0% to 9.0%.

Appendices 1 to 7 give more in-depth definitions and provide further detailed historical information on expenditures. Appendices 6 and 7 provide standard SHA forms that present what services are provided by whom, and what services are funded by whom. Appendix 8 lists the organisations and individuals who provided information for this report.

Please note that some of the data in this report have been collected by means of sample surveys and have consequently been estimated conservatively. Care should be taken in interpreting changes in individual categories of expenditure from year to year. In addition, as this report covers the first year in which the SHA have been used, future refinements in the accuracy of the estimates are to be expected. For comparative purposes and trend analysis 2003/04 data provides consistent information only at a summary level, strict comparability between years at the detailed level is no longer available because of changes in scope and category definitions.

Chapter 1: Overview of the New Zealand Health Sector

1.1 Purpose

This *Health Expenditure Trends* is the latest in a regular series prepared by the Ministry of Health. The primary purpose of the series is to provide information, including estimates of current expenditure, in the health and disability sector for use by interested agencies and individuals. The expenditure estimates include all funding of health services in New Zealand as channelled through the public and private sectors and are provided to the OECD.

1.2 Background

Within the context of total funding of health services the role played by the Ministry has remained relatively stable over the past 25 years. The health reforms of the 1980s and 1990s, although more familiar to the reader, where not of the same magnitude as the changes that occurred during the middle of the 20th century. Prior to World War II private funding of health care dominated in New Zealand, accounting for around 57% of total funding in 1925. By 1945, however, the public share had grown to 74% of total expenditure and steadily increased to peak at 88% by the early 1980s.

Over the past 25 years, the percentage of total current funding from public sources gradually reduced from a high of 88% to within the range of 77% to 78% that has persisted since 1992. Within this source, the government's direct health funding through the Ministry of Health is the largest contributor to the total health and disability funding, at approximately 67.3% in 2003/04 compared to 68.7% in 1995/96.

The organisation of publicly funded health and disability support services in New Zealand has undergone a number of changes in the last decade. These have ranged from a 'purchaser/provider' market-oriented model introduced in 1993, to the more community-oriented model that is currently in place. The current system was implemented through the New Zealand Public Health and Disability Act 2000 which allowed for the creation of District Health Boards (DHB) – a key step in moving to a population based health system. Figure 1.1, on page 4, presents a diagram of the structure of the New Zealand health and disability support service.

1.3 Ministry responsibilities and funding levels

DHBs are responsible for providing, or funding the provision of, health and disability services in their geographic district. There are 21 DHBs in New Zealand and they have existed since 1 January 2001. The activities of the DHBs are guided by two overarching strategies for the health and disability sector, the New Zealand Health Strategy and the New Zealand Disability Strategy. The DHBs are supported by the Ministry of Health, which provides national policy advice, regulation, funding, and monitoring the performance of each DHB.[1]

[1] http://www.moh.govt.nz/healthsystem

The majority of the Ministry funding of health services is allocated to DHBs, at 79.2% of the Ministry expenditures, 69.0 % of public expenditures and 53.3% of total current health expenditures.

The Minister of Health has overall responsibility for the health system. The Minister works through the Ministry to enter into accountability arrangements with DHBs and set health and disability strategies. The Minister also agrees, together with government colleagues, how much public money will be spent on the public health system. The Ministry of Health is responsible for ensuring the health and disability system works for New Zealanders. It is the government's primary advisor on health policy and disability support services and is responsible for:

- providing policy advice on improving health outcomes, reducing inequalities and increasing participation
- acting as the Minister of Health's agent
- monitoring the performance of DHBs and other Crown entities in the health sector
- implementing, administering and enforcing relevant legislation and regulations
- providing health information and processing payments
- facilitating collaboration and co-ordination within and across sectors
- nationwide planning and maintenance of service frameworks
- planning and funding public health, disability support services and other service areas that are retained centrally.

To that end, the production and distribution of this document contributes to informed debate on health funding and expenditure issues.

1.4 Structure of the New Zealand public health and disability sector

DHBs are responsible for planning and purchasing health and disability services for their districts and are governed by community boards consisting of a mix of elected and appointed members, with the majority (seven) elected by the community. They are Crown entities whose boards are responsible to the Minister of Health. In recognition of the Crown's relationship with Māori, each board must have at least two Māori members or a greater number if Māori make up a higher proportion of the DHB's population. DHBs also provide certain services – principally secondary and tertiary hospital care.

DHBs are responsible for both funding health care services to a geographically defined population and providing acute hospital services. They are responsible for improving, promoting and protecting the health and independence of their populations. Each DHB must assess the health and disability support needs of the people of its region, and manage its resources appropriately.

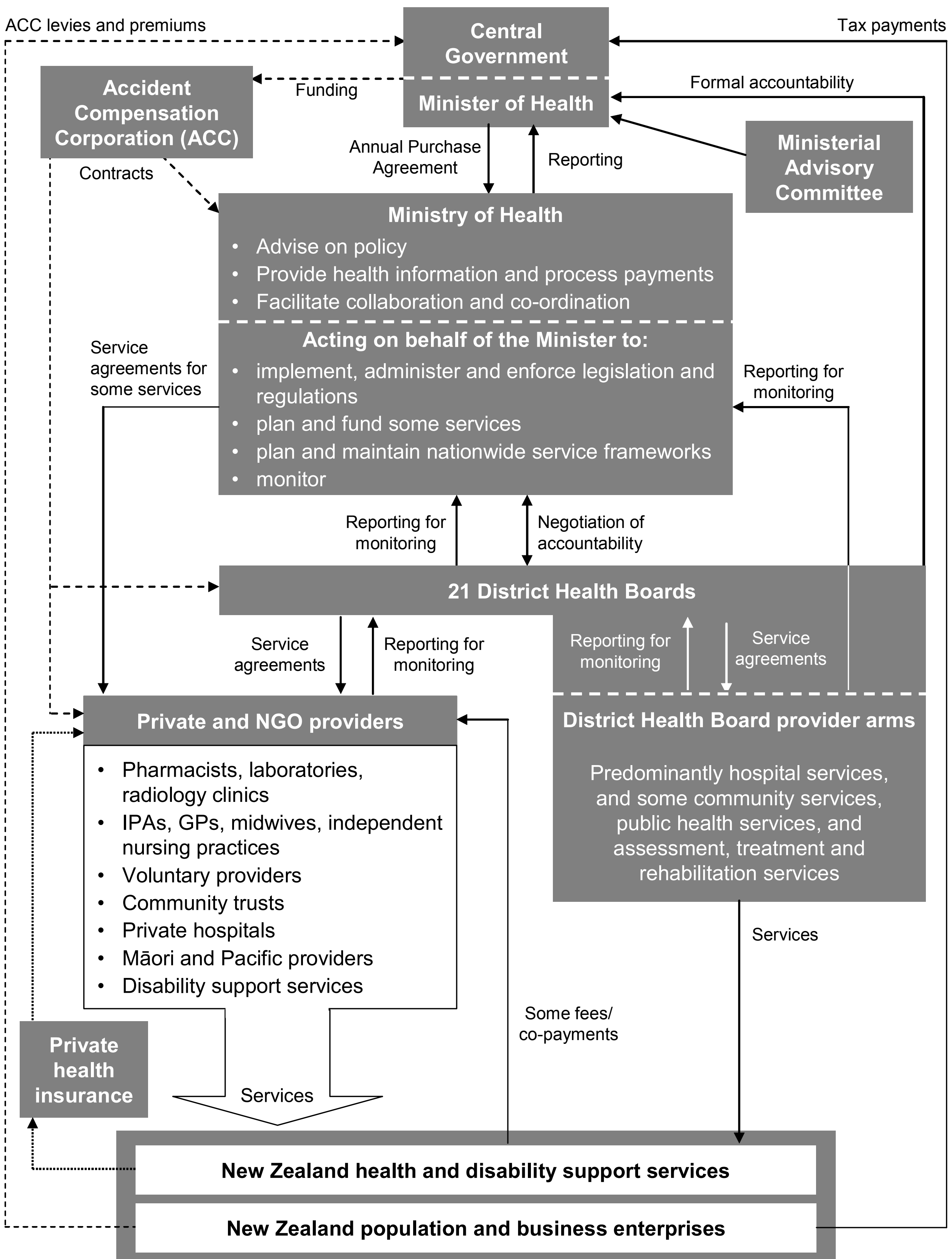
Central government provides broad guidelines on what services the DHBs must provide. National priorities in health have been identified in the New Zealand Health Strategy, Minister's priorities, and health targets and are reflected in DHB plans and accountability arrangements. Service agreements can be entered into with a range of providers, including public hospitals, not-for-profit health agencies, iwi groups and private organisations.

1.5 Other funders of the New Zealand public health and disability sector

In addition to the Ministry, a significant amount of public funding on health services comes from the Accident Compensation Corporation (ACC). ACC is a statutory insurance organisation, owned by the state that provides compulsory, comprehensive, no-fault insurance cover for accident-related injuries to all New Zealanders. In 2003/04, funding from ACC accounted for approximately 7.8%, at $991.7 million, of total health expenditures. In addition, relatively small amounts of personal health are funded by: the Department of Corrections funds in relation to prisoners, the Defence Force in relation to active duty military, and Work and Income in relation to war pensioners. Other central government agencies, as addressed in section 6.3, fund prevention, public health, health administration and health-related services.

Information on the private funding of the health sector includes private insurance, household out-of-pocket spending and non-government funding of not for profit organisations. The expenditures estimates pertaining to private funding is more reliant on surveys and sampling techniques. Consequently this information is less consistent and reliable. Given this qualification however, indications are that the private funding of health services has remained relatively stable over the past decade at approximately 23% of the total funding.

Figure 1.1: Structure of the New Zealand health and disability sector 2004



Chapter 2: Definitions

2.1 OECD system of health accounts definitions and classifications

This section contains brief definitions of the OECD SHA for the expenditures in 2003/04. See Appendix 1 for more detailed definitions. The first half of this chapter, under section 2.1, addresses the OECD SHA definitions and classification. The second half, under section 2.2, contains information on the historical definitions and classifications used by the Ministry in Zealand, of which the underlying foundation was the World Health Organization (WHO).

2.1.1 Health services

At a fundamental level, expenditure on health care and health-related services included in *Health Expenditure Trends in New Zealand* conforms to the definition developed for the WHO (Abel-Smith 1963). In defining health services, Abel-Smith states that:

> The purpose of health services is to promote health; to prevent, diagnose and treat diseases, whether acute or chronic, whether physical or mental in origin, and to rehabilitate people incapacitated by disease or injury.

This general statement does not define what services are, or should be, included in or excluded from the SHA as 'total health expenditure' or 'health-related memorandum items'. Departing from the conventions of earlier *Health Expenditure Trends* reports, data for 2003/04 are inclusive of previously defined 'non-health' items transferred from social agencies to the Ministry of Health. These services are now considered an integral part of health by the Ministry and the OECD.

More detailed definitions of OECD health services and health-related categories (OECD 2000) are provided in Appendix 1. Brief descriptions of the main service categories are given below. The SHA covers three dimensions: health care by functions of care; providers of health care services; and sources of funding. The provision of health care and its funding form a complex, multi-dimensional process. The set of core tables in the SHA addresses three basic questions.

1. What kind of services are performed and what types of goods are purchased (functions of care)?
2. Where does the money go to (provider of health care services and goods)?
3. Where does the money come from (source of funding)?

2.1.2 Functions of health care

The broad underlying concept of OECD-defined health care is consistent with the concept used in historical *Health Expenditure Trends* reports. Health care consists of the sum of activities performed by either institutions or individuals pursuing, through the application of medical, paramedical and nursing knowledge and technology, with the goals of:

- promoting health and preventing disease
- curing illness and reducing premature mortality
- caring for persons affected by chronic illness who require nursing care
- caring for persons with health-related impairment, disability and handicaps who require nursing care
- assisting patients to die with dignity
- providing and administering public health
- providing and administering health programmes, health insurance and other funding arrangements (OECD 2000).

The foundations for the design of the more detailed functional classifications, however, differ from those historically used in the detailed figures and schedules of *Health Expenditure Trends* reports, especially with the inclusion of long-term care. Health care consists of personal health care services provided directly to individuals, and collective health care services covering traditional tasks of public health such as health promotion and disease prevention, including setting and enforcing standards, as well as health administration and health insurance. This definition is consistent with the way the concept was understood in historical *Health Expenditure Trends* reports; however, historical *Health Expenditure Trends* estimates were incomplete.

The primary difference between the two classifications systems, the SHA and the classifications used by New Zealand in earlier *Health Expenditure Trends*, is that the SHA further stratifies personal health care to include long-term nursing and support services. Within the SHA, personal health care services are delineated as curative care, rehabilitative care, services of a (long-term) nursing type care, ancillary services to health care, and medical goods dispensed to outpatients. This latter group includes self-medication and other goods consumed by households with or without a prescription from medical or paramedical professionals. There have also been minor shifts between public health, administration and health-related services. Because this approach to classification contrasts with details in previous *Health Expenditure Trends* reports, a detailed comparison is no longer possible. Appendix 2 contains a complete listing of classifications and definitions used in previous *Health Expenditure Trends* reports.

2.1.3 Health-related functions

The OECD health-related functions are distinguished from core health care functions. They are closely linked to health care in terms of operations, institutions and personnel but are, as far as possible, excluded when measuring activities and expenditures belonging to core health care functions. For the most part, they are services that have a direct and beneficial impact on public health and, if reported in historical *Health Expenditure Trends* reports, were included as public health.

The new *Health Expenditure Trends* categories include separate reporting for the following health-related functions: education and training of health personnel; research and development in health; food, hygiene and drinking water control; and environmental health. The expenditure estimates are conservative as they do not include administration and provision of social services, or provision of health-related cash benefits to private households, in full. Furthermore, no provision has been made at this time for capital expenditures. These are refinements that may be included in subsequent years and could be material in amounts.

2.1.4 Provider industry

The SHA includes a dimension for the provider sector: 'where does the money go' or 'who provides the services'. This dimension represents a new element of expenditure reporting for New Zealand. The classifications used are based on the North American Industrial Classification System (NAICS 1998), a draft common industrial classification system for countries belonging to the North American Free Trade Organization (NAFTA) (OECD 2000). These detailed classifications are summarised in the following groups: hospitals; nursing and residential care facilities; ambulatory care; retail and other providers; administration; and other.

2.1.5 Sources of funding

This edition of *Health Expenditure Trends* contains a breakdown of expenditure on health by funder type including: government-provided health care (the Ministry, including DHBs; ACC; other central government; regional and local government), out-of-pocket expenditure by private households, private insurance and not-for-profit organisations. This classification system corresponds with funder information contained in historical *Health Expenditure Trends* reports. The sum of funder groups, that remain intact, consists of total public and total private funding.

2.2 Prior *Health Expenditure Trends* classifications and definitions

This section contains brief definitions used in the classifications system of prior *Health Expenditure Trends* reports and indicates the disposition of the expenditures in 2003/04. See Appendix 2 for more detailed definitions. These classifications had been based on WHO definitions used in the 1980s. For the sake of consistency New Zealand continued to use these definitions up to the *Health Expenditure Trends* for 2002/03.

2.2.1 Personal health services

All personal health services are included in the WHO definition of 'health services'. They are defined as those goods, services and facilities provided to an individual for the purpose of improving or protecting the health of that individual, regardless of whether they are also provided for another purpose. Most personal health services have the aim of improving, rather than providing ongoing support to, the health status of individuals. These expenditures are included in SHA-based current health expenditures.

2.2.2 Disability support services

A disability support service (DSS) is a service provided to someone with a disability or long-term illness, where 'long-term' is defined as relating to a condition that has been, or is likely to be, present for six months or more. A person with a disability is a person who has been assessed as having a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these) that is likely to continue for a minimum of six months and reduce independent function to the extent that ongoing support is required. The limitations of the data collection system mean that these patients tend to be classified by service type (ie, services for intellectual handicap or older people) as well as those within other services who are discharged after a stay of longer than six months.

The WHO-based definitions used up to 2002/03 of 'health services' includes only part of the current disability support services. For the sake of consistency, previous *Health Expenditure Trends* reports maintained this definition. That definition stated that care to an individual must be provided on medical grounds as distinct from social, educational or legal grounds. Under this earlier system of categorising care, services provided to those diagnosed as mentally ill, whether chronically ill and considered DSS or acutely ill (personal health), were regarded as 'health services'. On the other hand, provision of long-term support care to those with an intellectual disability was classified as outside the definition of 'health services'. Similarly, while rest home care for older people was considered to be within DSS, it was not included within the earlier WHO definition of 'health services' as people in those institutions do not qualify as ill, in a medical sense, any more than older people who remain in their own homes.

All of these expenditures – for curative, rehabilitative and long-term care – if funded by the Ministry, are now included in SHA-based current health expenditures. Future *Health Expenditure Trends* reports will include an expanded estimate of the private funding for long-term nursing care. New Zealand will be refining the reporting for long-term nursing care, the most inconsistently reported function in the OECD SHA (OECD 2005). For historical information covering the period 1995/96 to 2002/03, the estimates have been recalculated to include the previously excluded 'non-health' items, primarily DSS. In this edition, unlike in prior *Health Expenditure Trends* reports, annual expenditures are no longer analysed both inclusive and exclusive of these 'non-health' items. The difference between the two categories amounted to $563 million in 2002/03. These DSS are now considered a core health service.

2.2.3 Public health services

Public health services are those goods, services and facilities that are provided for the purposes of improving, protecting and promoting the health of the whole population or population groups. With this broad focus, public health is distinct from individual personal health services. Within the SHA classification these expenditures are now split, with some expenditure included under health expenditures and others included in health-related accounts, such as environmental health.

2.2.4 Teaching and research

The teaching component of this category of expenditure relates to the cost of formal education as part of a professional course (not as general education). It includes the training of nurses, doctors, ambulance drivers and dental nurses, along with postgraduate medical training and salaries of trainee health inspectors while they are attending courses. For the research component, expenditure relates to biomedical and health services research, including research on social aspects of medicine. With the SHA these expenses are now included under health-related expenditures, rather than under direct health expenditures.

Chapter 3: Methods and Conventions

3.1 Report coverage

This chapter introduces the methods and conventions used in collecting SHA expenditures, and describe the types of data collected. As noted in previous chapters, the analysis in this report is based on the OECD SHA that defines the categories of expenditure that should be included or excluded when comparing current health and health-related expenditures internationally. This report provides information and comments on health and disability expenditure within the OECD definition of 'health services'.

Appendices 6 and 7 present two key OECD tables: expenditures by function of care and provider industry; and total current expenditure on health, including health-related functions, by funder category.

3.2 Categories of health expenditure

Four broad health expenditure categories are examined in this report for comparison with prior years:

1. institutional care, including hospitals, nursing homes and residential facilities
2. community care, including provision of ambulatory services and retail sales and provision of other medical goods
3. other health expenditures consisting of prevention and public health as well as health administration
4. health-related care, of which previous *Health Expenditure Trends* reports gave a partial estimate as core health.

To enable a more detailed examination of expenditure, each of these categories has been disaggregated where possible. Caution, however, should be exercised when interpreting the disaggregated information, as definitions change over time. There is a reasonable degree of consistency across the prior *Health Expenditure Trends* classifications and the new SHA for these four broad categories.

3.3 Funding sources

Public sector health funding includes the government's direct health expenditure through the Ministry (including DHBs), as well as other public sector funding including ACC, other government agencies (Agriculture and Forestry, Defence, Education, Internal Affairs, Corrections, Māori Affairs, Pacific Island Affairs, Research, Science and Technology, and Social Development) and local authorities (regional, district and city councils).

Private sector funding for health-related activities comes from out-of-pocket expenditure by private households, expenditure by health insurance companies on behalf of their policyholders, and health-related expenditure by not-for-profit organisations met by funds from non-governmental sources.

3.4 Sources and assumptions related to Ministry-funded services

The source and values of current expenditures for the Ministry are from internal Ministry financial records. One way that this report differs from prior *Health Expenditure Trends* reports is that it separates Ministry funding between services purchased directly by the Ministry and the purchasing devolved through the DHBs. Ministry departmental ‘head office’ expenditures represent a third category of Ministry health funding.

3.5 Ministry-funded services, exclusive of DHBs

For 2003/04 Ministry non-departmental expenditures for services purchased from providers other than DHBs have been profiled according to SHA function codes in consultation with Corporate Finance within the Ministry. An apportionment was also performed for the SHA provider industry.

3.6 DHB-funded services

For 2003/04 DHB-funded services are profiled directly from the DHB funder arm year-end financial templates as provided to the Ministry by DHBs. Expenditures within the funder arm represent purchases of services from all providers, including the purchase of services from the respective DHB’s own provider arm and other DHBs. Revenues from other third party purchasers, including other central or local government agencies, are not included in the funder arm, thus there is no double-counting of current health expenditures within DHB providers. The financial templates are at line item level and matched with SHA service functions and provider industry.

3.7 Crown Health Enterprise/District Health Board deficit financing

Deficits of DHBs, previously known as Crown Health Enterprises (CHEs) and Hospital and Health Services (HHS), have been included in the *Health Expenditure Trends* since 1996/97 as part of publicly funded health expenditure. The operating deficits incurred by DHBs, HHS and CHEs reflected the difference between operating income and operating expenses. These deficits were incorporated into the government accounts funded by the Ministry. For 2003/04 the deficits have been added to the DHB funder arm expenditures for a more complete estimate.

The inclusion of this deficit funding is necessary in order to provide an accurate picture of the expenditure on current health and health-related expenditures in New Zealand in a given year. This is because DHBs are publicly owned entities and the government is ultimately responsible for their financing. Publicly funded health expenditure amounted to 77.2% of total expenditure in 2003/04. Deficit financing in 2003/04 was equivalent to 0.03% of GDP.

3.8 Sources and assumptions related to services funded by other central government agencies

Prior years' estimates for other central government agencies have been based on either survey responses or estimates using prior expenditure values or patterns. For 2003/04, due partly to a lack of responses, annual reports were used as an alternative source of expenditure data. Most agency estimates did not change materially from those produced in prior years, with the exception of estimates for the Ministry of Education and the Ministry of Agriculture and Forestry. Additional information is provided under sections 6.3.2–6.3.5. These estimates are conservative as they tend not to include an administrative component.

3.9 Sources and assumptions related to services funded by local government

Prior years' estimates for local government have been based on a sample survey extrapolated for the population of New Zealand. Due to a lack of responses for 2003/04, annual reports were used as an alternative source of expenditure data. Furthermore, regional councils had been excluded from the sample. Consequently the current health expenditures did not change materially from previous estimates; however, the health-related category of accounts increased significantly. Additional information is provided under section 6.4.

3.10 Sources and assumptions related to services funded by the private sector

Private sources of funding consist of out-of-pocket expenditures, health insurance and not-for-profit organisations. Data relating to out-of-pocket expenditures for 2003/04 are sourced from the Household Economic Survey (HES) that is produced by Statistics New Zealand.[2] This survey has consistently been the source for out-of-pocket expenditures since the initial *Health Expenditure Trends* report.

Estimates of health insurers' total current expenditure on health care during the review year are based on data provided by the executive director of the Health Funds Association of New Zealand Inc. This data source also remains unchanged.

Historical estimates for the not-for-profit sector have been based on survey responses or estimates using prior expenditure values or patterns. Due to the inadequacy of the sample size and poor responses for 2003/04, annual reports were used as an alternative source of expenditure data. Consequently the estimate for the not-for-profit sector significantly increased. Additional information is provided under section 7.4.

[2] It was an annual survey until 1998; it is now a triennial survey.

3.11 Real dollar health expenditure

New Zealand has no index specific to health expenditure that may be used to remove the effect of price inflation from nominal expenditure on health and disability support services. As with previous reports in this series, the Consumers Price Index (CPI) has been used to inflate nominal to real expenditure to 2004 dollars.

The CPI series used is given as part of Appendix 3. The series is based on the Statistics New Zealand long-term linked series for 'all groups'. Annual changes are based on the change from the previous June quarter.

3.12 GST and overhead charges

The health and disability expenditures presented in this report include GST at its prevailing rate. The GST rate is 12.5%. However, the GST rate for all rest home providers is 10.25% (10.75% for all hospitals). The rate is lower because the residential care accommodation element of rest home services is GST exempt.

Estimates for GST have been included for the regional and local government, tertiary education, and not-for-profit funders because the source data for these estimates are GST exclusive.

3.13 Populations

The population data in this report are based on a definition of population by Statistics New Zealand. The estimated resident population is based on the 'usually resident' population count of the Census, with adjustments for residents missed or counted more than once by the Census (net Census undercount), and for residents temporarily overseas on Census night.[3]

[3] Statistics New Zealand. Estimated resident population (table). URL: http://www.stats.govt.nz/NR/rdonlyres/9C231406-8BE1-494D-9FAF-ECDC88ADC63C/0/alltabls96_06.xls. Accessed 17 August 2007.

Chapter 4: Trends in Total Current Health Expenditure by Funding Source

4.1 Introduction

Trends in New Zealand current health expenditure by aggregate public and private sources are examined in this chapter. This funding split is consistent; the change to SHA definitions has had no impact. The components of both public and private expenditure in the current year are examined in detail in the next three chapters as far as possible, given the magnitude of changes in 2003/04.

4.2 Aggregate health expenditure

Long-term trends (1925–2004) in health expenditure in New Zealand are shown below in relation to funding source (Figure 4.1) and public and private shares (Figure 4.2). The estimates for the years from 1995/96 to 2002/03 include previously excluded 'non-health' items, primarily DSS.

Total current health care expenditure in New Zealand has risen from around $7 million in 1925 to around $12.7 billion[4] in 2004 in nominal terms. In real terms, total current health expenditure rose during this period at an annual average rate of 5.0% (see Figure 4.1). Publicly funded expenditure grew at an annual average rate of 5.8% and privately funded expenditure, starting from a higher base, grew at a slower rate of 3.8% per year during this period.

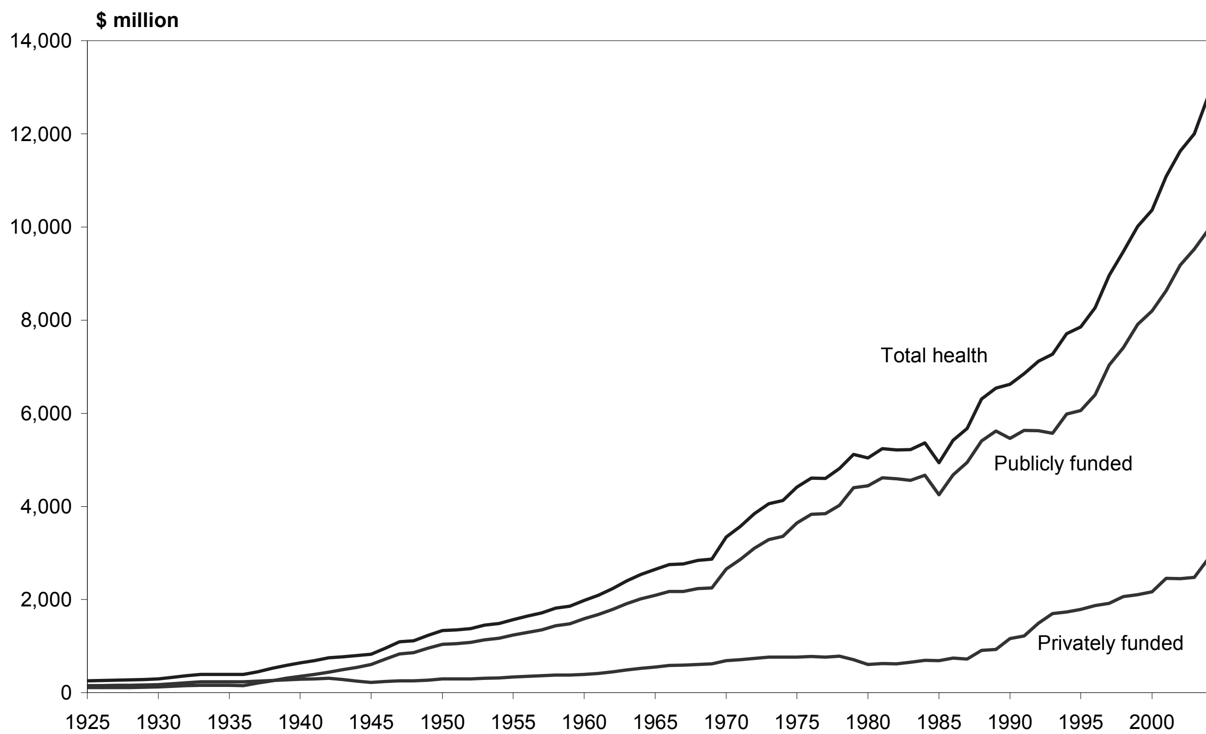
Figure 4.2 shows that prior to World War II private funding of health care dominated in New Zealand; it accounted for around 57% of total funding in 1925. By 1945, however, the public share had grown to 74% of total expenditure and steadily increased to peak at 88% by the early 1980s.

Over the past 25 years, the percentage of total current funding from public sources gradually reduced from a high of 88% in the early 1980s to the range of 77% to 78%, that has persisted since 1992 (see Figures 4.1A and 4.2A). Because the actual average growth rate of 5.0% (see above) exceeded the population growth rate, the impact on a per capita basis reflects the same expenditure pattern as for the entire population, but at a slightly lower rate of growth. Figure 4.1B presents the same information as Figure 4.1A but on a per capita basis. Since 1993/94 total real expenditure on health care has grown at an average annual compound rate of 5.1% per year. Public funding has grown by 5.1% and private funding of health has grown by 5.2%.

Between 1993/94 and 2003/04 publicly funded real expenditure on health care increased by $3.81 billion (76.8% of the total increase). Over the same period, privately funded real expenditure rose by $1.15 billion (23.2% of the total increase).

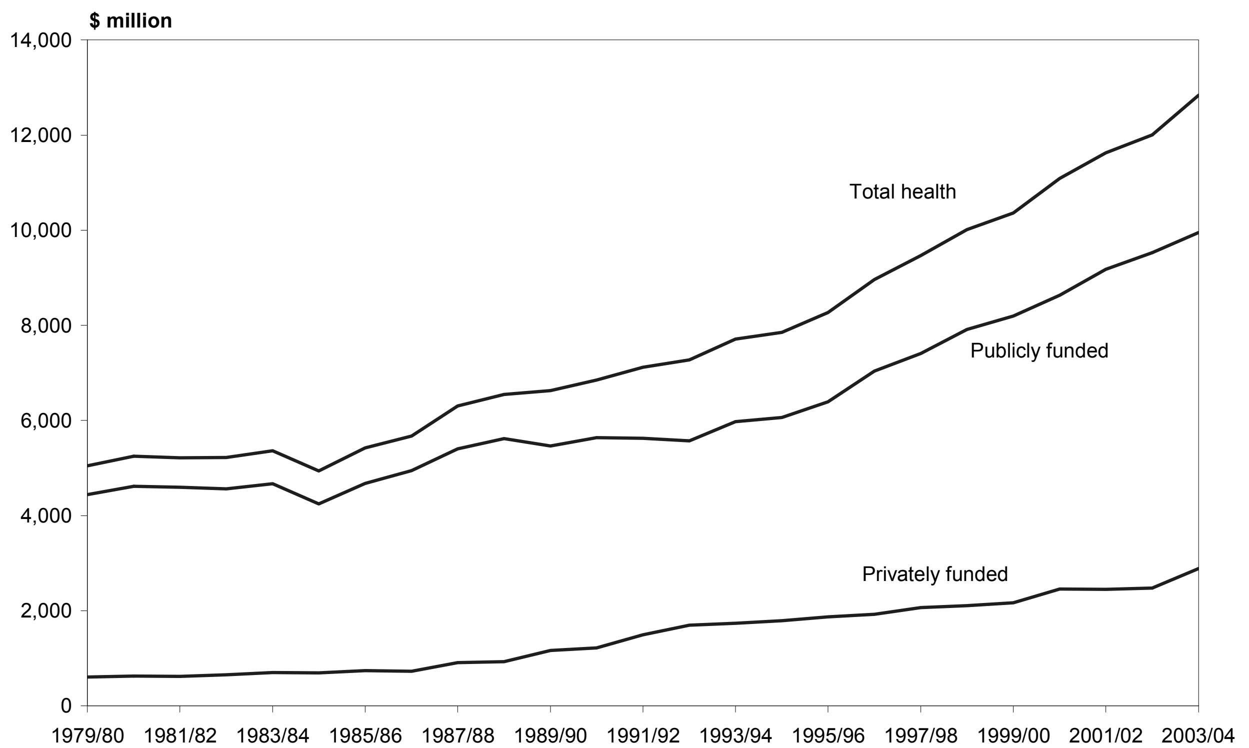
[4] This figure does not include OECD health-related expenditures.

Figure 4.1: Aggregate real ($ million 2003/04) health expenditure, 1925–2004



Source: Ministry of Health

Figure 4.1A: Aggregate real ($ million 2003/04) health expenditure, 1980–2004

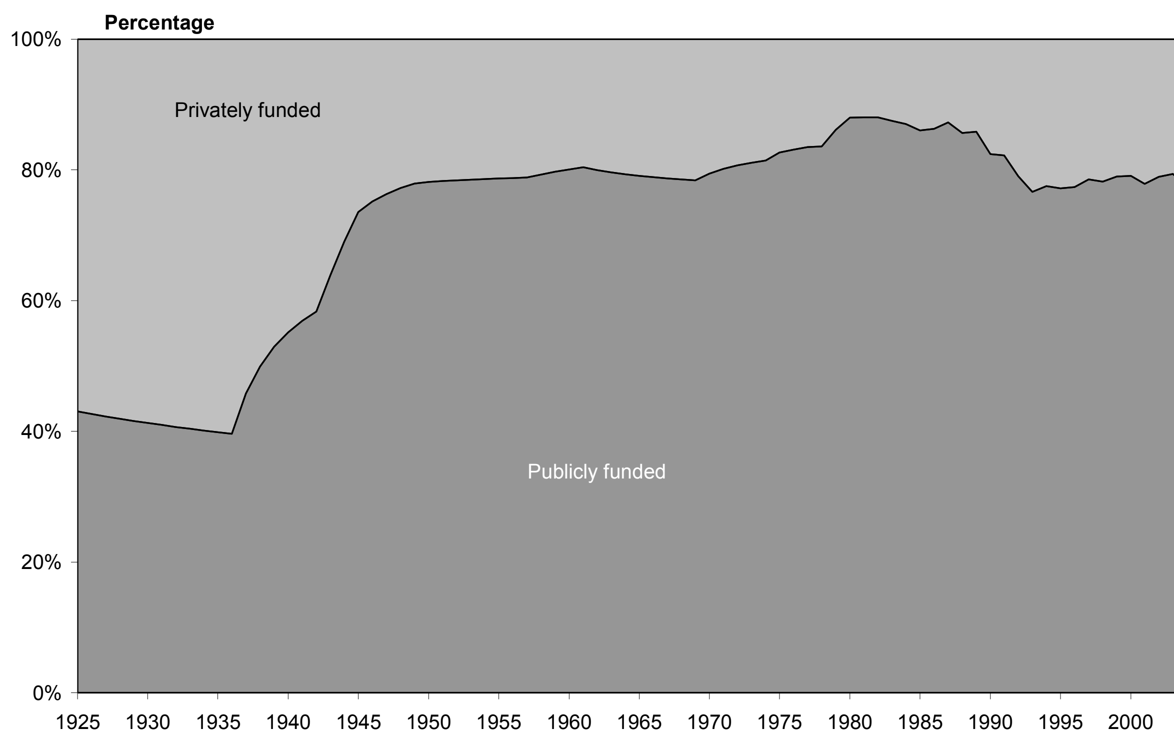


Source: Ministry of Health

Figure 4.1B: Aggregate real (per capita 2003/04) health expenditure, 1980–2004

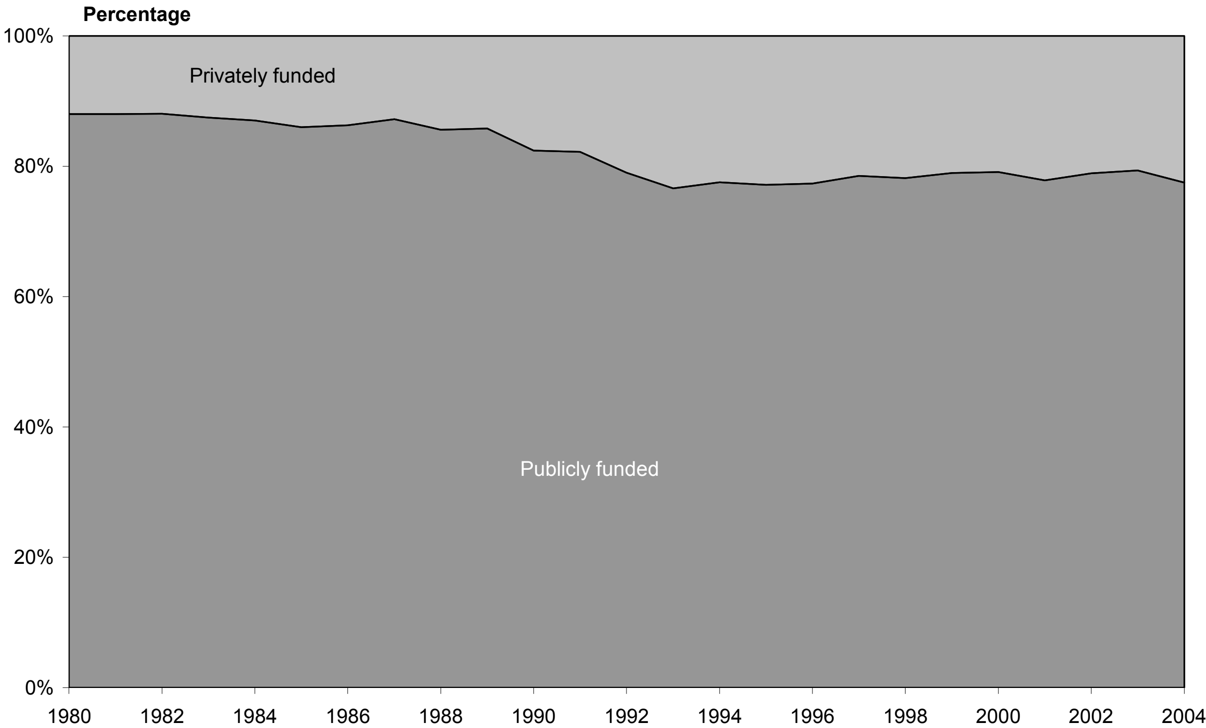
Source: Ministry of Health

Figure 4.2: Publicly and privately funded expenditure shares, 1925–2004



Source: Ministry of Health

Figure 4.2A: Publicly and privately funded expenditure shares, 1980–2004



Source: Ministry of Health

4.3 Trends in real per capita current expenditure on health

Table 4.1 and Figures 4.3 and 4.4 show the trends in real public and private current expenditure on health from 1995/96 to 2003/04. Table 4.1 also shows the GDP and the growth in GDP over this same period. As can be seen, the expenditures per capita are growing considerably faster than the growth in GDP. This table and many of the following tables are limited to the period subsequent to the transfer of funds for DSS services to the Ministry.

Table 4.1: Real current expenditure trends and gross domestic product, 1995/96-2003/04

Year	Total current health expenditure ($ million 2003/04)			Expenditure per capita ($ 2003/04) 'Resident' population			Gross domestic product	
	Public	Private	Total	Public	Private	Total	Total	Per capita
1995/96	6,395	1,870	8,265	1,726	505	2,231	112,758	30,430
1996/97	7,037	1,923	8,960	1,871	511	2,382	115,649	30,751
1997/98	7,406	2,064	9,471	1,948	543	2,491	115,817	30,464
1998/99	7,909	2,105	10,014	2,066	550	2,616	123,276	32,205
1999/00	8,196	2,167	10,363	2,129	563	2,692	127,685	33,169
2000/01	8,630	2,455	11,085	2,229	634	2,863	133,286	34,421
2001/02	9,177	2,452	11,630	2,347	627	2,974	135,945	34,760
2002/03	9,526	2,476	12,002	2,396	623	3,019	142,580	35,861
2003/04	9,794	2,887	12,681	2,411	711	3,121	148,558	36,568
RAAGR[†]	5.47%	5.58%	5.50%	4.27%	4.37%	4.29%	3.51%	2.32%

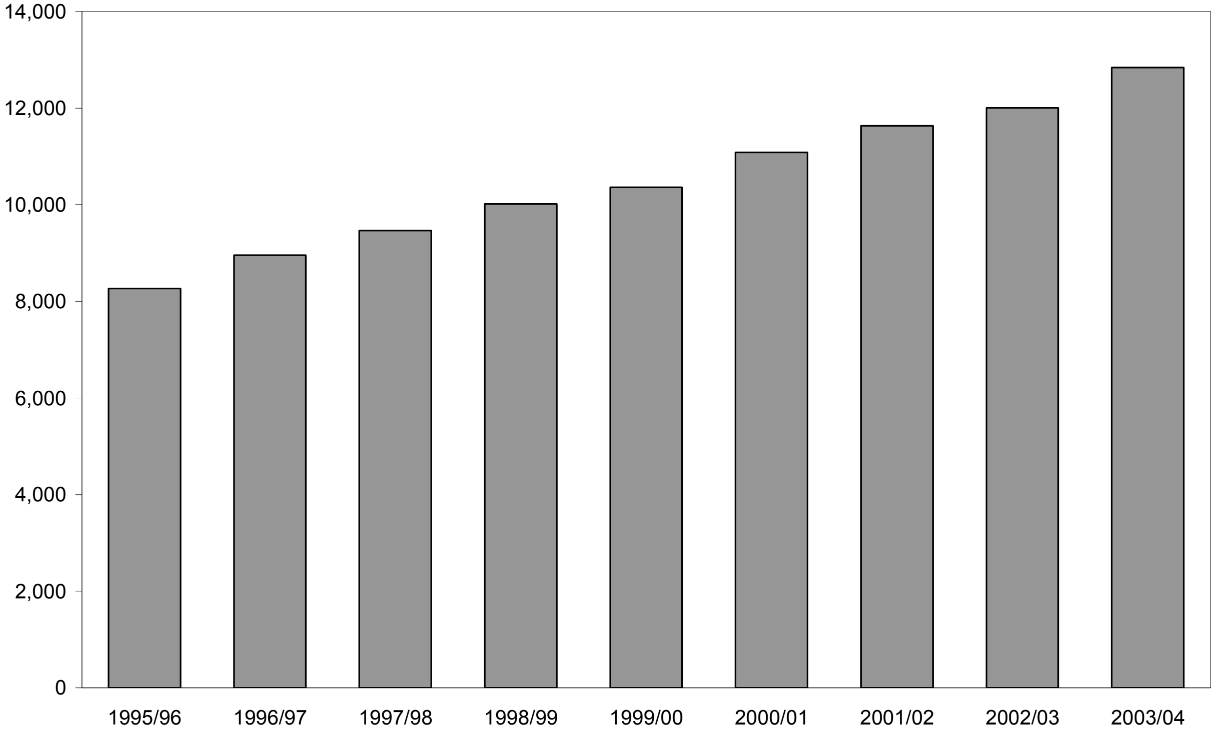
Source: Ministry of Health

Notes: Totals may be affected by rounding; real annual average growth rate (RAAGR) between 1995/06 and 2003/04.

Table 4.1 shows the trends in New Zealand current health expenditure from 1995/96 to 2003/04, including per capita expenditure levels. From 1995/96 to 2003/04 total per capita real expenditure increased at an average annual compound rate of 4.3%, rising at an average annual compound rate of 4.3% per year for public expenditure and 4.4% per year for private expenditure.

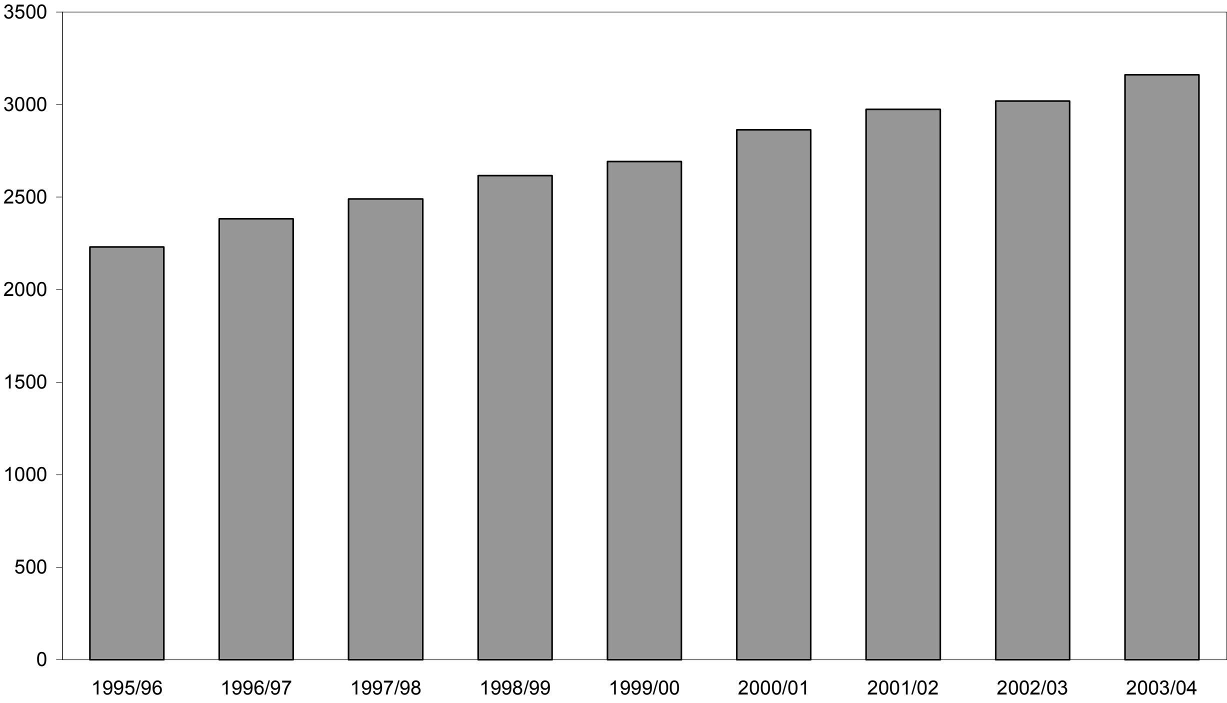
In 2003/04 aggregate current expenditure per capita amounted to $3,121. Of this total, publicly funded current expenditure amounted to $2,411 per capita and privately funded current expenditure was $711 per capita.

Figure 4.3: Trends in real total current expenditure on health ($ million 2003/04)



Source: Ministry of Health

Figure 4.4: Trends in real per capita current expenditure on health ($ million 2003/04)



Source: Ministry of Health

4.4 Pattern of health care funding by source of funds

Table 4.2 shows the expenditure trends by source of funds for the period 1995/96 to 2003/04. Figure 4.5 compares 1995/96 and 2003/04 in particular for their breakdown of funding by source.

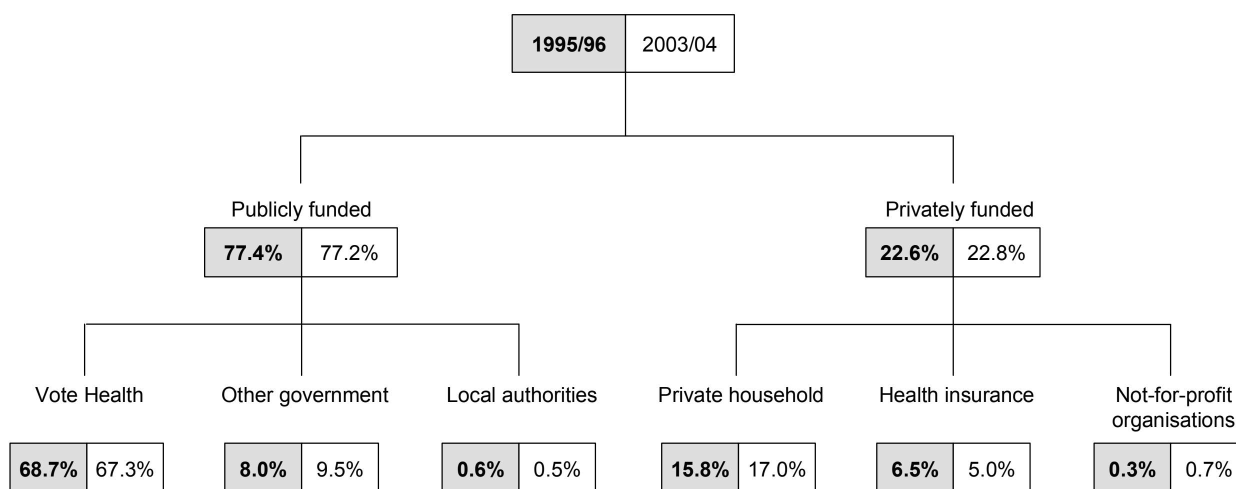
Table 4.2: Health expenditure by source of funds (%), 1995/96–2003/04

	Ministry of Health	Deficit funding	Other government agencies	Local authority	Total public funding	Private household	Health insurance	Not-for-profit organisations	Total private funding	Total
1995/96	68.75	0.00	7.99	0.64	77.32	15.81	6.51	0.30	22.63	100.0
1996/97	67.82	2.99	7.14	0.59	78.54	14.77	6.40	0.29	21.46	100.0
1997/98	67.48	2.34	7.82	0.55	78.21	15.43	6.04	0.32	21.79	100.0
1998/99	69.64	0.44	8.23	0.67	78.98	14.77	5.92	0.34	21.02	100.0
1999/00	69.54	0.07	8.83	0.64	79.09	14.61	5.96	0.34	20.91	100.0
2000/01	66.95	0.74	9.55	0.62	77.85	15.95	5.88	0.32	22.15	100.0
2001/02	66.27	2.18	9.86	0.61	78.91	15.32	5.47	0.30	21.09	100.0
2002/03	66.33	1.85	10.56	0.63	79.37	14.85	5.47	0.31	20.63	100.0
2003/04	67.27	0.00	9.46	0.50	77.23	17.00	5.04	0.73	22.77	100.0

Source: Ministry of Health
Note: Totals may be affected by rounding. Starting in 2003/04 the deficit funding is included in Ministry funding.

Total private funding as a percentage of total funding has remained between 21.5% and 22.8% from 1995/96 to 2003/04. Note, however, that estimates using the CPI as an inflator and not survey results were used for out-of-pocket expenditure for the years 1998/99, 1999/00, 2001/02 and 2002/03.[5] For these years the values have been underestimated, this was not known until the subsequent survey responses became available.

Figure 4.5: Total health funding (%), 1995/96 and 2003/04



Source: Ministry of Health

[5] The HES was conducted annually until 1998; it is now conducted every three years.

4.5 Trends in uses of aggregate health and health-related funds

The trends in total current expenditure on personal health and disability support, provided in private and public institutions and community care services, are presented in Table 4.3.[6] Given the change in definitions and classification system for 2003/04, the most detailed level of comparable data are institutional, community and other.

Table 4.3: Destinations of total health funding, 2002/03 and 2003/04 (including health-related)

	2002/03 (000s)	2003/04 (000s)	Change (000s)	%
Institutional	5,742,624	5,448,115	–294,509	–5.1
Community	5,258,442	6,140,514	882,072	16.8
Subtotal	11,001,066	11,588,629	587,563	5.3
Other health*	718,366	1,092,216	373,850	52.0
Total health (including previously excluded DSS)	11,719,432	12,680,845	961,413	8.2
Health-related	N/A	1,972,767		
Research and education moved from other health to health-related	274,927	638,405		
Biosecurity and food safety, previously reported in public health, are now split between health and health-related. Biosecurity, vector control is a public health function. Food safety moved to food, hygiene and drinking water control, that is a health-related function.				
Central government biosecurity	Part of $22,284	140,257		
Local government biosecurity	0	63,242		
Central government food safety	Part of $22,284	74,187		
Local government food safety	Part of $6,742	Part of $52,469		
Environmental health		1,136,570		

Source: Ministry of Health

Note: * Changes in definitions and boundaries had a significant impact on the category of other health.

The values for 2002/03 are based on historical definitions, classifications, data sources, processes and assumptions. They do, however, include previously defined 'non-health' services, primarily DSS. The 2003/04 values have been estimated and reported in accordance with SHA definitions and the revised data sources, processes and assumptions implemented in 2003/04 (see Chapters 5 to 7 for detailed explanations of the changes).

[6] Separate tables for destinations of public and private sector funding are given in later chapters.

Chapter 5: Public Sector Funding – Ministry of Health

5.1 Introduction

Public sector funding is the major source of health funding in New Zealand, at $9,794 million or 77.2% of total funding in 2003/04. Within this source, the government's direct health funding through the Ministry of Health is the largest contributor to the total health and disability funding, at $8,531 million or 67.3% of total funding. Other government agencies, including regional and local governments, provide an additional $1,263 million that is 10.0% of current health expenditures. Other government agencies also provide a significant amount of funding for health-related functions. Funding of health-related services represents an additional $1,972.8 million, of which $1,752.9 million is publicly funded.

The trends in Ministry funding are discussed in this chapter. Expenditure trends for the other government agencies are presented in Chapter 6.

5.2 Ministry of Health funding

Health expenditure estimates for 2003/04 reflect total current expenditure on health, and health-related accounts, in compliance with SHA conventions. The vast majority of Ministry expenditures pertain to bulk funds devolved to DHBs for purchasing at a local level. For this initial report based on SHA definitions, an estimate for capital expenditure is not included. For historical information covering the period 1995/96 to 2002/03, the estimates have been recalculated to include the previously excluded 'non-health' items, primarily DSS. Unlike in prior *Health Expenditure Trends* reports, annual expenditures are no longer analysed both inclusive and exclusive of these 'non-health' items. The difference between the two categories amounted to $563 million in 2002/03. These DSS are now considered a core health service.

Prior to 1993/94 CHE/health service providers (HSP) deficit financing was also excluded from public health expenditure. However, as noted in section 3.8, it is now included as part of publicly funded health expenditure. Starting in 2003/04 the DHB operating deficit, if any, will be included in the Ministry estimates.

Expenditure growth by the Ministry has accelerated in recent years. To indicate the movements in Ministry current expenditures, Table 5.1 gives details in aggregate and per capita (both nominal and real dollars) and as a percentage of both GDP and government expenses for the period 1995/96 to 2003/04. Ministry current funding of health services has increased by over 0.7% of GDP and has increased as a proportion of total central government funding by 4.0%.

Table 5.1: Ministry of Health expenditure 1995/96–2003/04

	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Total ($ million nominal)	4,936	5,573	5,906	6,245	6,550	7,030	7,662	7,990	8,531
Total real ($ million 2003/04)	5,682	6,345	6,613	7,018	7,214	7,503	7,960	8,183	8,531
Per capita – resident population basis									
Per capita ($ nominal)	1,332	1,482	1,553	1,631	1,702	1,815	1,959	2,010	2,100
Per capita real ($2003/04)	1,533	1,687	1,739	1,833	1,874	1,938	2,035	2,058	2,100
GDP ($ million nominal)	97,952	101,589	103,430	109,696	115,941	124,875	130,856	139,225	148,558
GDP real ($ million 2003/04)	112,758	115,649	115,817	123,276	127,685	133,286	135,945	142,580	148,558
Per capita real GDP ($2003/04)	30,430	30,751	30,464	32,205	33,169	34,421	34,760	35,861	36,568
Total as % of GDP	5.04%	5.49%	5.71%	5.69%	5.65%	5.63%	5.86%	5.74%	5.74%
Total as % of government outlays	16.21%	17.08%	17.63%	18.07%	18.23%	19.06%	20.09%	20.49%	20.19%

Source: Ministry of Health

Note: Totals may be affected by rounding.

Table 5.1 shows the following trends.

- Nominal Ministry current expenditure grew steadily throughout the review period. Expenditures in 2003/04 were 72.8% higher than in 1995/96 (up on average 7.1% per year).
- Reflecting the trend in total current Ministry expenditure, nominal per capita spending increased throughout the period. Estimated 2003/04 per capita spending was 57.7% higher than in 1995/96 (up on average 5.9% per year).
- Total real current expenditure growth averaged 5.3% per year since 1995/96.
- Real per capita growth followed a similar pattern to growth in real spending, averaging 4.0% per year from 1995/96.
- In the review period, Ministry current funding as a percentage of GDP was at its lowest at 5.0% in 1995/96. It was 5.7% during 2003/04.
- Ministry current funding as a percentage of total government expenditure was 16.2% in 1995/96. It has increased steadily since then to 20.2% of government expenses in 2003/04.

Table 5.1 also shows that the total Ministry expenditure over the nine years ended June 2004 grew to $8,531 million. This figure translates to an average annual compound rate of growth of 7.1% for this period.

5.3 Ministry funding by major expenditure category

The change in Ministry funding from 2002/03 to 2003/04, in relation to private and public institutions and community care services by category, are presented in Table 5.2. Discussion of trends in the main expenditure categories outlined in Table 5.2 follows.

Table 5.2: Destinations of Ministry of Health funding, 2002/03 and 2003/04

	2002/03 (000s)	2003/04 (000s)	Change (000s)	%
Institutional	4,668,913	4,500,710	–168,203	–3.6
Community	2,932,868	3,413,282	480,414	16.4
Subtotal	7,601,781	7,913,992	312,211	4.1
Other health*	388,432	616,893	228,461	58.8
Total health (including previously excluded DSS)	7,990,213	8,530,885	540,672	6.8
Health-related	N/A	92,186		
Research and education moved from other health to health-related	72,624	92,116		
Environmental health		70		

Source: Ministry of Health

Note: * Changes in definitions and boundaries had a significant impact on the category of other health. Totals may be affected by rounding.

5.3.1 Personal health

Funding related to health services provided to individuals for the purpose of improving or protecting their health is identified as personal health expenditure. In 2003/04 the Ministry share, at $7,700.5 million, funds 67.4% of personal health. Table 5.3 provides a breakdown of personal health using the SHA categories. Future *Health Expenditure Trends* reports will trend this information.

Table 5.3: Main service category, 2003/04

Health care by function	ICHA-HC code	Non-DHB (000s)	DHB (000s)	Total Ministry funding (000s)
Inpatient care				
Curative and rehabilitative care	HC.1.1; 2.1	161,334	2,367,949	2,529,282
Long-term nursing care	HC.3.1	231,778	624,394	856,172
Services of day care				
Curative and rehabilitative care	HC.1.2; 2.2	0	138,204	138,204
Long-term nursing care	HC.3.2	24,935	62,542	87,477
Outpatient care				
Outpatient curative and rehabilitative care	HC.1.3; 2.3	83,687	1,499,709	1,583,397
Basic medical and diagnostic services	HC.1.3.1	324	1,150,927	1,151,251
Outpatient dental care	HC.1.3.2	25	123,139	123,164
All other specialised health care	HC.1.3.3	0	0	0
All other outpatient care	HC.1.3.9	11,844	0	11,844
Home care				
Curative and rehabilitative care	HC.1.4; 2.4	14,385	253,432	267,817
Long-term nursing care	HC.3.3	557,549	245,905	803,454
Ancillary services to health care	HC.4	110,669	353,668	464,337
Medical goods dispensed to outpatients				
Pharmaceutical and other medical non-durables	HC.5.1	12,321	948,221	960,543
Therapeutic appliances and other medical durables	HC.5.2	1,171	8,635	9,806
Total expenditure on personal health care		**1,197,830**	**6,610,331**	**7,700,489**
Prevention and public health services	HC.6	310,293	141,388	451,681
Health administration and health insurance	HC.7	263,747	114,967	378,715
Total current expenditure on health care		**1,771,870**	**6,759,015**	**8,530,885**
Memorandum items: Further health-related functions				
Education and training of health personnel	HC.R.2	92,116		92,116
Research and development in health	HC.R.3			
Food, hygiene and drinking water control	HC.R.4			
Environmental health	HC.R.5	70		70
Administration and provision of social services in kind to assist living with disease and impairment	HC.R.6			
Administration and provision of health-related cash-benefits	HC.R.7			

Source: Ministry of Health

Notes: Totals may be affected by rounding. ICHA-HC = International Classification for Health Accounts – Health Care.

5.3.2 Disability support services

Individuals are eligible for disability support services funded by the Ministry if they have a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these) that is likely to continue for a minimum of six months and reduce independent functioning to the extent that ongoing support is required. DSS purchased by the Ministry cover personal care services, including assistance with daily activities such as dressing, personal hygiene and eating, and household management services, including assistance with meal preparation, cooking, cleaning and shopping. Personal care may be provided in a hospital, rest home, community residential home, or a person’s own home. DSS services are no longer separately identifiable with the implementation of the SHA.

5.3.3 Public health

Public health funding is for services concerned with the whole population or with particular population groups; this broad focus distinguishes public health funding from funding for individual personal health services. Public health services are primarily concerned with health protection, improvement and/or promotion. With the change to OECD SHA definitions and reporting in 2003/04, certain services historically reported as public health are now reported as administration or included in the health-related areas.

Specific objectives of public health include:

- ensuring that health and disability services meet population needs, and that health gains are maximised and provided efficiently
- improving regulatory frameworks so that they better protect the health and safety of New Zealanders while minimising industry compliance costs
- improving the health status of at-risk groups, especially Māori, by increased responsiveness to their needs.

5.3.4 Ministry of Health – head office

Table 5.4 provides a breakdown of funding by output class for the Ministry of Health in 2003/04; it reflects the Ministry’s ‘head office’ costs incurred in the administration, but not provision, of health services. It shows that information services are the largest output class, accounting for $52.7 million (or 0.002% of total current expenditures). Information services include the cost of administering the HealthPAC system, a claims payment facility. Public health is the next largest output class, with funding at 20.7% of operational expenses. The Ministry also directly funds some biosecurity services at the departmental level.

Table 5.4: Ministry of Health expenditure by output class, 2003/04

Output class	$ million	% of total
Health and disability policy advice	11.4	6.9%
Performance management	15.9	9.7%
Ministerial support services	2.6	1.6%
Māori health	4.1	2.5%
Public health	34.1	20.7%
Disability issues	10.5	6.4%
Health sector development	0.0	0.0%
Mental health	5.6	3.4%
Personal and family services	15.3	9.3%
Screening programmes	12.3	7.5%
Information services	52.7	32.0%
Subtotal	164.5	100.0%
Biosecurity – policy advice	0.5	3.8%
Biosecurity – specific pest and disease responses	12.8	96.2%
Subtotal	13.3	100.0%

Source: Ministry of Health

Note: Totals may be affected by rounding.

Chapter 6: Other Public Sector Funding

6.1 Introduction

As discussed in Chapter 5, the main contribution to public sector funding of health comes from the government through the Ministry of Health. In addition, a significant amount of health expenditure comes from the Accident Compensation Corporation (ACC). ACC is a statutory insurance organisation, owned by the state that provides compulsory, comprehensive, no-fault insurance cover for accident-related injuries to all New Zealanders. Some other government agencies and local authorities also incur expenditure that directly or indirectly affects the health status of New Zealand residents.

Funding from ACC at $991.7 million accounted for 7.8% of total current health expenditures in 2003/04. Other central government agencies (other than the Ministry of Health and ACC) provided an additional $208.1 million or 1.6% and regional and local authorities $63.2 million or 0.5%. In addition, these agencies also contribute to SHA health-related accounts, with a total of $420.9 million from other central government (exclusive of the Ministry of Health and ACC) and $1,239.8 million from regional and local government. In this chapter, trends in expenditure by ACC, other government agencies and the local authorities are discussed in more detail.

Estimates of current health and health-related expenditures by other central government agencies, including ACC, for 2002/03 and 2003/04 are shown in Table 6.2 (section 6.3.14). Details using the SHA for 2003/04 are presented in Table 6.3 (section 6.3.14). Future *Health Expenditure Trends* reports will trend the SHA expenditure estimates. Total current health expenditures from other central government agencies have decreased by $37.9 million, from $1,237.7 million in 2002/03 to $1,199.8 million in 2003/04. These expenditures are net of the $268.9 million transfer from ACC to the Ministry for funding public health acute services now reported in the DHB expenditures. This decrease is also significantly impacted by the changes in methodology and broadening of definition, as discussed in detail in section 6.3 in regard to the Ministry of Agriculture and Forestry (MAF) in the areas of biosecurity and food safety and the Ministry of Education.

Expenditures on personal health account for a small proportion of the total expenditures incurred by other central agencies (exclusive of the Ministry of Health and ACC): the Department of Corrections funds personal health in relation to prisoners, the Defence Force in relation to active duty military, and Work and Income in relation to war pensioners.

6.2 Accident Compensation Corporation

6.2.1 Background

The ACC compensation programme is a 24-hour per day, seven-day per week, no-fault scheme that provides treatment, rehabilitation and compensation for New Zealand citizens and residents and temporary visitors to New Zealand who suffer personal injury through accident in New Zealand. In return, people who have coverage under ACC legislation may not sue for personal injury, other than for exemplary damages.

ACC is the Crown entity responsible for administering the accident compensation scheme. Its responsibilities include:

- preventing injury
- collecting accident levies
- determining whether claims for injury are covered by the scheme and providing entitlements to people who are eligible
- paying compensation
- buying health and disability support services to treat, care for and rehabilitate injured people
- advising the government.

ACC is funded principally by levies collected from a range of sources including employers, self-employed people, employees and motor vehicle licensing. It also receives direct government funding. ACC is not funded from the Ministry of Health. ACC does however provide funding to the Ministry for acute services. This funding is now reported in the funder arm of the DHBs.

Historically, the ACC health expenditure information for *Health Expenditure Trends* reports was obtained by survey; for 2003/04, the estimates are based on the ACC annual report with an adjustment for GST. The estimate for ACC expenditures report has been increased to include components for accident prevention and ACC administration, in the amounts of $33.9 million and $138.1 million respectively. These additional components have been sourced from the 2003/04 annual report. In accordance with SHA definitions, these services should be included and represent an increase in the estimate for current health expenditures funded by ACC.

In a broader context it would be possible to include all ACC expenditure in health or health-related categories; however, this approach has not been taken for the initial estimates based on SHA definitions. Various WHO and OECD documents address how countries could classify various benefits (sickness, accident, age-related, other social benefits). This area might merit some research. For this initial report based on SHA, these services are likewise not included in these estimates. Table 6.1 presents ACC's total current health expenditure from 2000/01 to 2003/04.

Table 6.1: ACC current health expenditure ($ million), 2000/01–2003/04

	2000/01	2001/02	2002/03	2003/04*
Total expenditure	784.1	865.0	950.9	991.7

Source: ACC surveys and 2003/04 annual report

Note: * Includes $151.4 million in expenditures not previously reported and excludes $268.9 million for public health acute services.

6.3 Other central government agencies

6.3.1 Background

Other central government agencies contributing to direct health and indirect health-related expenditures that are included in this report are the ministries or departments of Agriculture and Forestry; Education; Internal Affairs; Research, Science and Technology; Defence; Social Development; Corrections; Internal Affairs; Te Puni Kōkiri (Māori Development); and Pacific Island Affairs. Estimates of current health and health-related expenditures for this group of agencies were derived from annual reports and direct survey responses.

6.3.2 Changes to biosecurity and food safety estimate

Previous estimates for biosecurity and food safety within the Ministry of Agriculture and Forestry were discounted by 85% based on the percentage of local food consumption to total food production. No aspect of biosecurity should be excluded, as the vast majority of this function is associated with limiting damaging imports and vector control. It is debatable what, if any, food safety expenditures should be attributed solely to food exports. For 2003/04 this discounting has not occurred. Additionally, funding has increased significantly for both Vote Biosecurity and Vote Food Safety. This change increases the total estimates by approximately $194.0 million: biosecurity in public health by $130.8 million and food safety in health-related expenditures by $63.6 million.

6.3.3 Biosecurity

Vote Biosecurity brings together the biosecurity activities of the ministries or departments of Agriculture and Forestry, Health, Fisheries, and Conservation. Expenditures by the Ministry of Health are included in Chapter 4. Current expenditures incurred by Fisheries and Conservation, that total approximately $10 million in 2003/04, appear to pertain more directly to biodiversity than to public health. These expenditures have been excluded from this edition of *Health Expenditure Trends*.

Current expenditures by MAF are sourced from its annual report for 2003/04. Historically, *Health Expenditure Trends* reports became increasingly reliant on obsolete information originally sourced from the annual survey preceding a period of considerable growth at MAF.

One of the strategic areas receiving a large proportion of MAF expenditures is vector control. Key responsibilities for this service include:

- monitoring the effectiveness of policy and legislative frameworks for managing risks posed by pests, weeds and diseases to the economy, biological diversity and people’s health
- developing and implementing strategies for managing risks posed by pests, weeds and diseases to the economy, biological diversity and people’s health.

Current health expenditures incurred by MAF in 2003/04 totalled $140.3 million and cover the costs of the following services and activities.

- **Border inspection and quarantine services** control quarantine risks at the border and in undertaking post-entry quarantine in line with the provisions of the Biosecurity Act 1993. Among the health activities are border clearance procedures for aircraft and vessels, including for passengers, the investigation of suspected illegal imports, and the identification of intercepted organisms. In 2003/04 expenditure in this area amounted to $49.7 million by MAF.
- **Pest and disease surveillance services** maintain the health of domestic animal and plant populations, report internationally on the health status of domestic animals and plants, and detect unwanted organisms. Pest and disease emergency response services maintain a capability (personnel and diagnostic capacity) to respond to the introduction of unwanted organisms that are harmful to animals and plants. In 2003/04 combined expenditure on these services by MAF was $58.4 million.
- **Control of tuberculosis vectors** covers the government contribution to implementation of the Bovine Tuberculosis National Pest Management Strategy. The objective of the strategy is to reduce the number of cattle and deer herds infected by bovine tuberculosis and is jointly funded by government and industry. MAF current expenditures in 2003/04 totalled $32.1 million.

These activities are reported as prevention and public health services in the SHA. This classification change represents a significant increase on the 2002/03 estimate (refer section 6.3.4 below).

6.3.4 Food safety

MAF also administers food safety. The food safety brief is outlined in the MAF annual report as follows.

- Provide a coherent and seamless food regulatory regime.
- Reduce the incidence of domestic food-borne illness.
- Retain and develop policy and technical expertise in food safety.
- Create a centre for excellence in risk-management based food safety administration.
- Provide advice and acknowledge the whole-of-government interest in food administration.

Expenditure on food safety amounted to $74.2 million in 2003/04. The most significant spending was on regulatory programmes and regulatory standards, at $35.8 million and $31.5 million respectively. Other expenditures included food safety policy advice, response to food safety emergencies, consultation and food safety information. These activities are reported as a health-related service under ‘food, hygiene and drinking water control’ in the SHA. This approach represents a change from 2002/03, when this service was categorised as public health.

6.3.5 Education

Ministry of Education spending on current health-related activities includes the cost of providing tertiary training and education for doctors, nurses, dentists, dieticians, physiotherapists, clinical psychologists, audiologists, pharmacists, midwives and occupational and speech therapists. The expenditure estimate of $159.2 million ($127.4 million on teaching and $31.8 million on research) for the prior year was limited to the bulk grant to tertiary institutions and therefore was not complete. In addition, this estimate was included in the total current health expenditure.

The estimate for 2003/04 represents a significant change in the estimated expenditures on educating health professions and clinical research, in terms of the dollar values, data sources and SHA reporting classification. For 2003/04 the full cost of tertiary education for health professionals is now included in the estimate and the function is included in the SHA as a health-related service. Additionally, the source for these estimates has changed to the tertiary education statistics on the Ministry of Education website[7] and the annual reports from four leading tertiary institutions:[8] Massey University, Auckland University of Technology, University of Auckland and Otago University. An estimate for GST has been included at 12.5%.

This estimate is conservative as only Otago University provided a separate cost for its medical programme and these costs are significantly higher per student than those incurred for other programmes. For all other tertiary institutions, an unweighted cost per student was used.

The total estimates for 2003/04 are $383.9 million for educating health professionals and $91.2 million for clinical research undertaken by tertiary institutes, compared with $127.4 million and $31.8 million respectively for 2002/03. An estimate for the non-government portion of this funding is attributed to out-of-pocket private funding. In accordance with SHA definitions and classification, this function has moved from a current health to a health-related expenditure. This change consequently represents a reduction in direct current health expenditure of $159.2 million (the 2002/03 estimate).

6.3.6 Research, science and technology

In July 1997 part of the public investment in health research was transferred from the Ministry of Health to the Ministry of Research, Science and Technology (MoRST). Health research is now included in the priority setting and management process applied to other public-good science and technology investments. In 2003/04 expenditure on health research was $48.8 million, in comparison with $39.4 million in 2002/03.

[7] Ministry of Education. *Education Counts*. URL: http://educationcounts.edcentre.govt.nz. Accessed 17 August 2007.

[8] Prior estimates were sourced from the annual survey and included Ministry of Education bulk subsidies only.

The 2003/04 estimate is sourced from the MoRST annual report. Previous estimates were obtained from direct survey responses. In compliance with SHA definitions and classifications, research is now reported as a health-related function rather than a core health service. Consequently this change represents a reduction in core health expenditure of $39.4 million (the 2002/03 estimate).

6.3.7 Defence

The Ministry of Defence provides funding for health care services to army, navy, and air force personnel. The estimate of current health expenditures includes the cost of medical and dental treatments carried out within the defence service branches as well as payments for services obtained from external professionals and organisations; it excludes expenditure related to medical examinations.

The estimated expenditure relating to health care for 2003/04 is $24.7 million, in comparison with $25.1 million in 2002/03. Estimates for both years have been sourced by direct response. The total expenditure was distributed to SHA personal health functions in proximity to expenditure patterns in the prior year.

6.3.8 Social development

As mentioned in earlier chapters, the bulk of health expenditure (mainly disability support services) previously administered by the Ministry of Social Development (MSD) was transferred to the Ministry of Health between 1993/94 and 1995/96.[9] However, a provision remains within the MSD for Vote Veterans' Affairs to fund assistance to war pension recipients by meeting the costs of medical treatment or equipment required as a result of a disability caused or aggravated by war service.

The estimated total expenditure in 2003/04 was $12.5 million, in comparison with $10.9 million in 2002/03. The 2003/04 estimate is sourced from the MSD annual report whereas previous estimates were obtained from direct survey responses. For 2003/04 the expenditures have been distributed across SHA health functions of outpatient and home care for acute, rehabilitative and long-term care services and represent a slight increase in personal health of $1.6 million.

In addition to war pension recipients' medical costs, MSD contributed $0.383 million to youth suicide prevention. This service was transferred from the Ministry of Youth Affairs that reported related expenditure as $0.509 million in 2002/03. In accordance with SHA definitions, this activity is considered a public health function within core health services. This estimate was sourced from the 2003/04 annual report.

MSD also administers the Community Service Card programme. Expenditure in 2003/04 for the administration of this programme amounted to $6.1 million. In accordance with SHA definitions, this activity is considered part of government administration of health services and a core health expenditure. This estimate was sourced from the 2003/04 annual report and constitutes an increase in health expenditure as it has not been included in prior estimates.

[9] MSD Work and Income, however, retains a significant disability funding capacity.

6.3.9 Corrections

The Department of Corrections incurs costs relating to the provision of health care services for prison inmates and those held in judicial custody. The total estimated cost of $17.9 million for 2003/04 includes expenditures on general medical treatment ($9.1 million) and psychiatric treatment ($8.8 million). This expenditure represents a slight increase of $1.8 million from 2002/03 expenditure of $16.1 million.

The current health expenditure estimate is consistently sourced by direct survey. For 2003/04 the expenditures have been distributed across SHA health functions of outpatient and home care for acute, rehabilitative and long care services. There was no change in methodology for this estimate.

6.3.10 Internal Affairs

The Lottery Grants Board that is administered by the Department of Internal Affairs, funded health and health-related projects amounting to $7.9 million during 2003/04. This total value is the same as in the prior year. The data source for 2003/04 is the Department of Internal Affairs annual report, whereas the estimate for the prior year was from a direct survey response.

Included in the above estimate are direct grants made to individuals with disabilities to purchase disability support equipment, not funded by other sources, to increase and maintain their participation, fulfilment, enjoyment and achievement in the community. These grants totalled $3.0 million. Grants totalling $3.0 million have also been provided to seniors. These grants have been distributed across SHA health functions of outpatient and home care for acute, rehabilitative and long-term care services.

Additional lottery grants totalling $1.9 million were distributed to fund health research and attributed to a health-related function. This classification change constitutes a slight decrease in health expenditures of $1.9 million.

6.3.11 Te Puni Kōkiri (Māori Development)

Health expenditure under Māori Development contributes to the Government's objective of reducing inequalities between Māori and non-Māori in the delivery of health and disability support services. Expenditure in 2003/04 for policy advice that aimed to improve Māori health outcomes amounted to $0.276 million, in comparison with $0.8 million in 2002/03. This value has been sourced from direct survey, consistent with prior years, and is attributed to SHA government administration of health, that is a core health expenditure.

The policy advice has focused on three main areas.

1. How to make progress towards reducing inequalities in health status between Māori and non-Māori.
2. How to improve Māori health outcomes by increasing Māori participation in the purchase and provision of health services.

3. The development of new Māori health initiatives for the wellbeing of Māori, including the development of strategies to increase Māori access to health services and the adoption of healthy lifestyle choices.

6.3.12 Pacific Island Affairs

During 2003/04 the Ministry of Pacific Island Affairs incurred health expenditures of $0.143 million in the provision of health policy advice. In accordance with SHA definitions, this service has been attributed to SHA government administration of health, that is a core health expenditure. No expenditures were reported for 2002/03. For 2003/04 this information is sourced from the Ministry of Pacific Island Affairs annual report whereas prior estimates were from direct survey responses.

6.3.13 Labour

The SHA specifically does not recognise occupational health and safety services pertaining to improving the working environment, such as ergonomy, environmental protection and accident prevention. Consequently, removal of this function represents a slight reduction in direct health expenditures based on the 2002/03 of $16.1 million. The Department of Labour is focused on reducing the overall workplace injury rate by targeting initiatives aimed at hazards in industry sectors and workplaces with the highest level of risk.

6.3.14 Other central government expenditure trends

Total current health expenditure by all other central government agencies, excluding both the Ministry of Health and ACC, was $208.1 in 2003/04. This total compares with $316.0 million in 2002/03, and represents a decrease of approximately $110 million or 34.0%.[10] The change in data source, expansion of service boundaries and move to SHA definitions and classifications impact on these figures by:

- reducing the estimate for health services based on SHA reclassification to health-related services by $271.1 million (the inverse is an increase in the estimate for health-related functions)
- reducing health services based on SHA specific exclusion by $16.1 million
- increasing health expenditure due to change or expansion in definition by approximately $125.0 million for biosecurity.

[10] These figures correct an error that exists in the 2002/03 *Health Expenditure Trends*, in which the sum of the other agency expenditures exceeds the total reported figure of $316 million by approximately $90 million.

Table 6.2: Current health expenditure and health-related expenditures by other central government agencies, 2002/03 and 2003/04

	2002/03 (000s)	2003/04 (000s)	Change (000s)	%
Institutional	461,904	435,478	–26,426	–5.7
Community	527,500	445,118	–82,382	–15.6
Subtotal	989,404	880,596	–108,808	–11.0
Other health*	248,235	319,170	70,935	28.6
Total health (including previously excluded DSS)	1,237,639	1,199,766	–37,873	–3.1
Health-related	N/A	420,895		
Research and education moved from other health to health-related	200,779	326,375		
Biosecurity and food safety, previously reported in public health, are now split between health and health-related. Biosecurity, vector control is a public health function. Food safety moved to food, hygiene and drinking water control, that is a health-related function.				
Central government biosecurity	Part of $22,284	140,257		
Central government food safety	Part of $22,284	74,187		
Environmental health		20,333		

Source: Relevant government agencies (as identified in section 6.3.1).

Note: ACC funding for acute public services through the Ministry is now reported in the DHB Funder Arm.
* Changes in definitions and boundaries had a significant impact on the category of other health. Totals may be affected by rounding.

As presented in Table 6.3, personal health expenditure represents the majority of current health expenditures by other central government agencies, at $880.6 million or 74.0% of the total. This pattern is heavily influenced by ACC.

Table 6.3: Current health expenditure and health-related expenditures by other central government agencies, 2003/04

Health care by function	ICHA-HC code	(000s)
Inpatient care		
Curative and rehabilitative care	HC.1.1; 2.1	43,856
Long-term nursing care	HC.3.1	9,296
Services of day care		
Curative and rehabilitative care	HC.1.2; 2.2	43,856
Long-term nursing care	HC.3.2	9,296
Outpatient care		
Outpatient curative and rehabilitative care	HC.1.3; 2.3	311,217
Basic medical and diagnostic services	HC.1.3.1	85,582
Outpatient dental care	HC.1.3.2	16,024
All other specialised health care	HC.1.3.3	67,854
All other outpatient care	HC.1.3.9	113,406
Home care		
Curative and rehabilitative care	HC.1.4; 2.4	200,565
Long-term nursing care	HC.3.3	163,115
Ancillary services to health care	HC.4	40,641
Medical goods dispensed to outpatients	HC.5	58,752
Pharmaceutical and other medical non-durables	HC.5.1	17,053
Therapeutic appliances and other medical durables	HC.5.2	41,699
Total expenditure on personal health care		880,596
Prevention and public health services	HC.6	174,615
Health administration and health insurance	HC.7	144,555
Total current expenditure on health care		1,199,766
Memorandum items: Further health-related functions		
Education and training of health personnel	HC.R.2	184,290
Research and development in health	HC.R.3	142,085
Food, hygiene and drinking water control	HC.R.4	74,187
Environmental health	HC.R.5	20,333
Administration and provision of social services in kind to assist living with disease and impairment	HC.R.6	
Administration and provision of health-related cash-benefits	HC.R.7	

Source: Ministry of Health

Note: ICHA-HC = International Classification for Health Accounts – Health Care

6.4 Local authorities

Historical estimates for local government were based on a sample survey, with the results then extrapolated to calculate an estimate for the total population of New Zealand. If a survey was not completed for a given year, expenditures were estimated using values or patterns from the prior year. Due to a lack of response from local governments for the 2003/04 expenditures, annual reports were used as an alternate source to compile 2003/04 expenditures.

Furthermore, regional governments, that are largely responsible for environmental services and in some cases water and sewage, were excluded from the sample. Consequently the expenditure estimates for local government services were significantly undervalued.

As has been consistently stated from the inception of *Health Expenditure Trends* reporting in the early 1980s, health-related expenditures have been significantly under-reported due to the use of the narrow WHO definition of public health in all earlier reports. Examples of services excluded were control of foul water drainage, sewer overflow prevention, stagnation of flood water, and water purification. The estimate now includes these and other services. Specific services not included based on the SHA definitions are civil defence and road safety. With these changes from the original definitions, internal consistency with previous *Health Expenditure Trends* reports has been lost in this report. The estimates have, however, gained greater international comparability, are more accurate and are based on thorough definitions.

With the expansion of the sample to include regional councils combined with an expansion in the boundary for environmental health to match current WHO and OECD definitions,[11] the estimate of local government expenditures has increased significantly to in excess of $1.1 billion. The vast majority of the increase is reflected in SHA health-related functions and does not materially impact on the magnitude of current health expenditures.

The 2003/04 estimates are sourced from annual reports, augmented by survey responses as appropriate and necessary. An estimate for GST has been included by increasing the stated values by 12.5%. Significant activities are easily identified in annual reports, such as sewage systems and rubbish collection and disposal. Other activities, more on a 'line item' level, are not consistently identified in all regional or local government annual reports. Examples of this latter group are swimming pool testing and treatment and road cleaning costs. These less material services are included in the overall estimates using the survey results if they did not appear to be duplicative.

The estimates are conservative as most annual reports do not include an allocation of support and administration costs to services. In addition, if there was doubt as to whether a service should be included in the estimate, it was excluded. Appendix 8 contains a complete list of the regional and local authorities included in the 2003/04 sample.

[11] Boundary and coverage were expanded by WHO in the mid-1990s.

The sample represents regional authorities covering approximately 94% and the local authorities covering approximately 66% of the total New Zealand population. There is currently a mix of services, primarily for water and sewage, being provided at regional and local levels. It was therefore necessary to estimate intermediate per capita expenditures on a regional basis prior to the final extrapolation of the single national per capita estimate to a total national value.

6.4.1 Local government expenditure trends

As Table 6.4 presents, total current health and health-related expenditure by regional and local authorities increased from $73.8 million in 2002/03 to $1,303.0 million in 2003/04. Of the total for 2003/04, only $63.2 million in expenditures relates to direct current health expenditure; this amount pertains to vector control and is reported in public health. Historical expenditures amounting to $73.8 million in 2002/03 have moved to health-related categories.

The adoption of SHA definitions changes the classification from health to health-related for all services previously classified as public health. As a result of broadening the definition for food, hygiene and drinking water control and environmental health reported under health-related services, the total estimate has increased by $1,240 million. There is no material impact on current health expenditures due to these revisions.

Table 6.4: Current health and health-related expenditures by local authorities, 2002/03 and 2003/04

	2002/03 (000s)	2003/04 (000s)	Change (000s)	%
Institutional	0	0	0	N/A
Community	0	0	0	N/A
Subtotal	0	0	0	N/A
Other health*	73,792	63,242	–10,550	–14.3
Total health (including previously excluded DSS)	73,792	63,242	–10,550	–14.3
Food, hygiene and drinking water control		123,604		
Environmental health		1,116,167		
Health-related	N/A	1,239,771		
Biosecurity and food safety, previously reported in public health, are now split between health and health-related. Biosecurity, vector control is a public health function. Food safety moved to food, hygiene and drinking water control, that is a health-related function.				
Local government biosecurity	0	63,242		
Local government food safety	Part of $6,742	Part of $52,469		
Environmental health		1,116,168		

Source: Relevant agencies (as identified in Appendix 8).

Note: * Changes in definitions and boundaries had a significant impact on the category of other health. Totals may be affected by rounding.

6.5 Trends in uses of public funding

Table 6.5 presents the trends in other public funding for central government agencies, excluding the Ministry of Health, and regional and local government. Given the change in data sources and move to SHA reporting, care should be taken in interpreting the change in estimates from 2002/03 to 2003/04. In summary, other public funding for current health expenditures decreased by $48.4 million or 3.7%.

Table 6.5: Destinations of other public funding of health services, 2002/03 and 2003/04

	2002/03 (000s)	2003/04 (000s)	Change (000s)	%
Institutional	461,904	435,478	–26,426	–5.7
Community	527,500	445,118	–82,382	–15.6
Subtotal	989,404	880,596	–108,808	–11.0
Other health*	322,027	382,412	60,385	18.8
Total health (including previously excluded DSS)	1,311,431	1,263,008	–48,423	–3.7
Health-related	N/A	544,499		
Research and education moved from other health to health-related	273,403	418,491		
Biosecurity and food safety, previously reported in public health, are now split between health and health-related. Biosecurity, vector control is a public health function. Food safety moved to food, hygiene and drinking water control, that is a health-related function.				
Central government biosecurity	Part of $22,284	140,257		
Local government biosecurity	0	63,242	203,499	
Central government food safety	Part of $22,284	74,187		
Local government food safety	Part of $6,742	Part of $52,469		
Environmental health		1,136,570		

Source: Ministry of Health, regional and local government annual reports.

Note: ACC funding for acute public services through the Ministry is now reported in the DHB funder arm.
* Changes in definitions and boundaries had a significant impact on the category of other health. Totals may be affected by rounding.

Chapter 7: Private Sector Funding

7.1 Introduction

Private sector funding sources were the major contributors to total current health funding in the early years of New Zealand health services. However, since the end of World War II, public sector funding has dominated.

Private sources of funding consist of out-of-pocket expenditure, health insurance and not-for-profit organisations. Together, they accounted for approximately 22.8% of total current health expenditure in 2003/04, considerably more than the low of 12% in 1979/80 (see Tables 4.2 and 4.2A). Out-of-pocket expenditure by private households is the largest component of private sector funding, contributing approximately 17.0% of total current health expenditure in 2003/04, while health insurance and not-for-profit organisations contributed 5.0% and 0.7% respectively.

For this edition of *Health Expenditure Trends*, that uses the SHA for the first time, a minimal estimate has been included for privately funded long-term nursing care. This estimate is likely to be understated and will become more accurate in subsequent years.

7.2 Out-of-pocket expenditure

Data relating to out-of-pocket expenditures for 2003/04 are sourced from the Household Economic Survey produced by Statistics New Zealand.[12] Surveys were conducted for 2000/01 and 2003/04. The figures for out-of-pocket expenditures in 2001/02 and 2002/03 were based on 2000/01 survey results inflated by the CPI that did not adequately address the growth in out-of-pocket expenditures.

Household consumption expenditures cover expenditures by resident households, whether this expenditure occurs in New Zealand or overseas. Resident households include individuals living in private dwellings and those in non-private dwellings, such as boarding houses, rest homes and prisons.[13]

Through the survey design, expenditure data are collected in three ways:

1. a 12-month recall (for single payments of $200 or more), $100 for medical services
2. latest payment (for regular commitments such as electricity, telephone, rates, rent)
3. 14-day diary keeping.

[12] HES was an annual survey until 1998; since then, it has been conducted every three years.

[13] Statistics New Zealand. URL: http://www2.stats.govt.nz. Accessed 17 August 2007.

It is believed that the HES underestimates expenditures in a number of areas, such as contributions to health insurance. This underestimate can arise because payments are often 'deducted at source' from salary, etc, and are sometimes overlooked in the survey data collection.[14] Health insurance payments are covered in the HES under the 'health service costs nec' (not elsewhere classified).

Consequently the HES produces conservative estimates. Use of this survey as a data source for out-of-pocket expenditure remains unchanged in this report. Table 7.1 presents the results of the survey for 2000/01 and 2003/04. During this three-year period, total out-of-pocket expenditure on health services increased by 7.1% per year. Specific expenditure on the fees of medical and other health practitioners increased more significantly, by 11.8% and 7.6% respectively. During 2003/04 the major components of out-of-pocket expenditure on health were medicaments including pharmaceuticals (24.1%), other health practitioner care (primarily dental care) (29.9%) and general practitioner care (19.4%); most of these services were provided by the private sector.

Table 7.1: Survey responses ($ million), 2001/02 and 2003/04

	2000/01	2003/04	Increase	Average annual growth rate (%)
Medical goods				
Pharmaceutical supplies	431.168	519.804	88.636	6.4
Medical equipment	23.691	28.769	5.078	6.7
Medical goods subtotal	454.859	548.573	93.714	6.4
Health services				
Medical practitioners' fees	298.189	417.083	118.894	11.8
Other health practitioners' fees	517.062	644.247	127.185	7.6
Hospital and nursing fees	66.369	80.156	13.787	6.5
Health service costs nec	418.098	465.390	47.292	3.6
Health services subtotal	1,299.718	1,606.876	307.158	7.3
Medical goods and health services*	1,754.577	2,155.449	400.872	7.1

Source: Statistics New Zealand, Household Economic Survey, tri-annual basis.

Note: * 2000/01 value differs slightly from the historical value of 1,656,853.

7.2.1 Out-of-pocket expenditure trends

The trends in total out-of-pocket expenditure from 1995/96 to 2003/04 are reported in Appendix 4A. Total out-of-pocket expenditure on health increased from $1,135 million in 1995/96 to $2,155 million in 2003/04. In nominal terms, the rate of this increase was approximately 8.3% per year (6.5% in real terms).

In 2003/04 the total out-of-pocket funder category increased by $199.7 million to include the cost of educating health professionals not covered by the government

[14] Ibid.

subsidy. This is a health-related function that is not included in the current health expenditure.

7.3 Health insurance

Estimates of health insurers' total current expenditure on health care during the review year are based on data provided by the executive director of the Health Funds Association of New Zealand Inc. The 2003/04 estimates show that current health expenditure by the insurance industry has decreased by 0.3% in comparison with 2002/03. During 2003/04 health insurance accounted for around 5.0% of all current spending on health, compared with 5.5% in 2002/2003 and 6.5% in 1995/96. Table 7.2 provides comparable estimates for the three-year period 2001/02 to 2003/04.

There has been no change to the health insurance expenditure data source or the methodology. This estimate has been and is solely made based on an annual survey conducted by the Ministry. For the 2003/04 responses it was necessary to convert from historical Ministry categories to SHA functions and provider classifications.[15] This estimate is probably conservative as it does not appear to include components for research or administration.

Table 7.2: Destinations of insurance funding ($ million), 2000/01 and 2003/04

	2001/02	2002/03	2003/04	Change 2001/02–2003/04	Average annual growth rate (%)
Public institutions	0.415	0.714	0.640	0.225	24.2
Private institutions	385.552	421.007	431.890	46.338	5.8
Community care	226.348	221.648	206.062	–0.286	–4.6
Total	612.315	643.369	638.592	26.277	2.1

Source: Health Funds Association

Note: Expenditure for 2002/03 vary slightly from the previously reported response of $640.632 million used in the trend analysis.

Table 7.3 gives details of insurance coverage by age group across the population for 2001/02 to 2003/04. There has been no material change in age distribution over these three years.

Table 7.3: Proportion of the New Zealand population covered by medical insurance (by age group), 2001/02–2003/04

	Age (years)						
	0–4	5–14	15–24	25–39	40–59	60+	All ages
2001/02	19	31	30	32	47	31	34
2002/03	21	31	28	31	45	28	33
2003/04	21	30	27	31	45	28	33

Source: Health Funds Association

[15] In future the survey will be conducted using the SHA categories.

7.3.1 Expenditure trends

Aggregate health insurance expenditure grew from $382.7 million in 1993/94 to $638.6 million in 2003/04. The average annual compound growth in nominal insurance expenditure during the period was 5.3% (3.1% in real terms). A breakdown by category of trends in health insurance expenditure since 1993/94 is given in Appendix 5.

7.4 Voluntary and not-for-profit organisations

Historical estimates for the not-for-profit sector are based on survey responses or estimates using prior expenditure values or patterns. Only a sample of the sector was surveyed, with the universe of organisations unknown and not estimated. There was no extrapolation from the sample to a total New Zealand estimate of not-for-profit organisations and therefore historical estimates have been significantly undervalued.

In order to improve the accuracy of this estimate, a larger sample was compiled and data were sourced from a compilation of annual reports[16] (see Appendix 8 for the list of organisations). The not-for-profit estimate represents funding from non-governmental sources, primarily contributions, donations, corporate grants, and earnings on investments.[17] An estimate for GST has been included by factoring at 12.5%. The majority of this estimate has been attributed to SHA health expenditures as the main contributions of not-for-profit organisations are in primary health, disability support, and public health promotion and protection. Some organisations also contribute to health research, a health-related activity that has been recognised on an organisational basis. For example, a portion of the Cancer Society of New Zealand's total funding has been allocated to research.

This estimate remains conservative as it still reflects only a sample of the sector, with the universe unknown. The sample may be missing some key organisations providing significant levels of service. For example, it is likely that patient transportation, especially fixed wing and rotary flight air transportation, is underestimated. In addition, if in doubt as to whether a revenue source should be included in the estimates, they have been excluded.

Major non-profit organisations providing voluntary health and health-related services include the Cancer Society of New Zealand, the Royal New Zealand Plunket Society, the National Heart Foundation, CCS Disability Action (formerly Crippled Children's Society), Presbyterian Support Services, Arthritis New Zealand, Barnardos, the Asthma and Respiratory Foundation and many others.

[16] Sourced from Ministry of Economic Development. *Companies Office: Other registers search*. URL: http://www.companies.govt.nz/cms/banner_template/OBNAME. Accessed 17 August 2007.

[17] Many of these organisations received income from the Ministry, DHBs, and other central or local government bodies. To avoid double counting, revenues from these sources are not included.

7.4.1 Expenditure trends

Estimates for the not-for-profit sector have increased from $21.7 million in 1995/96 to $92.9 million in 2003/04. The value reported for 2002/03 ($36.3 million) is considered an underestimate. Because the historical estimates are most likely to be inaccurate and incomplete, no further analysis has been performed.

7.5 Trends in uses of private source funding

The estimates for private source funding from 2002/03 and 2003/04 in private and public institutions and community care services, other health and health-related expenditures are presented in Table 7.4. Details for 2003/04 using the SHA are presented as Table 7.5. Future *Health Expenditure Trends* reports will trend the SHA expenditure estimates. Institutional care does not include all clinical input that may be provided by clinicians working in a private capacity.

As Table 7.4 shows, personal health expenditure on community care in 2003/04 increased by 26.9% over the previous year, and comprises 79.0% of total private health funding. Note that personal health expenditure on community care includes expenditure on general practitioners and pharmaceuticals.

Table 7.4: Destinations of private funding of health services, 2002/03 and 2003/04

	2002/03 (000s)	2003/04 (000s)	Change (000s)	%
Institutional	611,807	511,927	99,880	16.3
Community	1,798,074	2,282,114	484,040	26.9
Subtotal	2,409,881	2,794,041	384,160	15.9
Other health*	7,908	92,911	85,003	1074.9
Total health (including previously excluded DSS)	2,417,789	2,886,952	469,163	19.4
Health-related	N/A	219,914		
Research and education moved from other health to health-related	1,524	199,648		

Source: Ministry of Health

Note: * Changes in definitions and boundaries had a significant impact on the category of other health.

As presented in Table 7.5, personal health care is the primary area of private health expenditure. The majority of expenditure on personal health care was on outpatient care and pharmaceuticals that together totalled $1,522.8 million or 52.7% of total private funding.

Table 7.5: Current health expenditure and health-related expenditures in the private sector, 2003/04

Health care by function	Private sector (000s)
Inpatient care	
Curative and rehabilitative care	554,862
Long-term nursing care	12,825
Services of day care	
Curative and rehabilitative care	132,392
Long-term nursing care	1,620
Outpatient care	
Outpatient curative and rehabilitative care	973,407
Basic medical and diagnostic services	133,714
Outpatient dental care	88,923
All other specialised health care	131,637
All other outpatient care	617,236
Home care	
Curative and rehabilitative care	119,258
Long-term nursing care	141,035
Ancillary services to health care	331,526
Medical goods dispensed to outpatients	584,773
Pharmaceutical and other medical non-durables	549,422
Therapeutic appliances and other medical durables	35,351
Total expenditure on personal health care	2,851,698
Prevention and public health services	35,254
Health administration and health insurance	0
Total current expenditure on health care	2,886,952
Memorandum items: Further health-related functions	
Education and training of health personnel	199,648
Research and development in health	20,266
Food, hygiene and drinking water control	0
Environmental health	0
Administration and provision of social services in kind to assist living	0
Administration and provision of health-related cash-benefits	0

Source: Ministry of Health

Chapter 8: International Comparisons

8.1 Data comparison issues

Health expenditure is the result of a mix of social, political and economic factors; no single figure represents the 'right' amount to spend on health. Care should therefore be exercised when comparing data on international health expenditure, as these comparisons do not indicate whether:

- a country should spend more or less on health
- the mix of health care services is appropriate or directly comparable
- the production of health care services is technically efficient
- quality of care, equity and access considerations are appropriate
- the right quantity of health care reaches the right consumers.

Technical issues mean that these data should be interpreted cautiously. The most important limitation is the lack of consistent and reliable time series information on health expenditure for some countries. Some of the factors contributing to such technical limitations are that:

- differences in definition of the variables are built into the categories of health expenditure, leaving open the possibility of differing interpretations between countries, especially in relation to long-term nursing
- countries do not have formal requirements to report health expenditure
- it is difficult to measure and control for social, medical, cultural, demographic and economic differences among countries
- there are problems in measuring health outcomes.

The following comparisons of health expenditure in OECD countries should be viewed with these limitations in mind.

Two modifications have been made to the historical OECD data. The first modification is to remove the capital component from total health expenditures for those countries reporting capital expenditures. This result is greater comparability with New Zealand. The second modification is to recalibrate the values reported for New Zealand to include previously excluded 'non-health' expenditures, primarily DSS services funded directly by the Ministry. These modifications have been made for all the following OECD data.

8.2 Per capita health expenditure in US dollar purchasing power parities

The concept of purchasing power parities (PPPs) provides a mechanism to compare the health spending of different countries on a common basis. PPPs are the rates of currency conversion that equalise the purchasing power of different currencies.

In 2003 and 2004 the United States had the highest health expenditure per capita of the OECD countries; it was followed by Luxembourg, Switzerland and then Norway. In 2003 New Zealand ranked 21st, after Greece but before Spain and 16th in 2004 of 25 countries who had reported by June 2006. The complete listing of countries can be found in Table 8.1.

New Zealand experienced an average growth rate of 5.9% per year from 1994 to 2004 that is comparable with the unweighted OECD average growth rate of 6.1% per year over the same period.

Table 8.1: Per capita current health expenditure, exclusive of investment on medical facilities (US$ PPP) for OECD countries, 1994–2004

Country	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Rank 2003	Rank 2004
Australia	1,535	1,640	1,733	1,826	1,937	2,070	2,259	2,411	2,600	2,876	n/a	9th	
Austria	1,635	2,118	2,179	2,156	2,293	2,393	2,525	2,610	2,727	2,822	2,980	11th	8th
Belgium	1,634	1,695	1,797	1,821	1,910	2,008	2,169	2,330	2,492	2,928	n/a	7th	
Canada	1,989	1,991	1,997	2,084	2,240	2,311	2,398	2,599	2,733	2,856	3,020	10th	7th
Czech Republic	716	800	845	847	840	887	930	1,045	1,134	1,245	1,316	24th	20th
Denmark	1,782	1,793	1,897	1,963	2,072	2,232	2,319	2,481	2,587	2,620	2,751	14th	10th
Finland	1,363	1,390	1,476	1,530	1,559	1,591	1,665	1,793	1,940	2,035	2,168	19th	15th
France	1,868	1,977	2,039	2,106	2,180	2,256	2,393	2,553	2,821	2,970	3,068	6th	6th
Germany	2,030	2,186	2,325	2,345	2,409	2,484	2,596	2,704	2,834	2,926	n/a	8th	
Greece	1,167	1,206	1,240	1,282	1,316	1,402	1,532	1,721	1,880	2,035	2,082	20th	17th
Hungary	673	641	653	653	732	783	823	937	1,065	1,217	1,285	25th	21st
Iceland	1,741	1,803	1,933	2,011	2,226	2,419	2,575	2,691	2,896	3,107	3,280	5th	5th
Ireland	1,053	1,142	1,181	1,307	1,364	1,476	1,626	1,887	2,129	2,226	2,414	16th	13th
Italy	1,480	1,469	1,542	1,634	1,708	1,758	1,931	2,027	2,119	2,141	2,271	18th	14th
Japan	1,404	1,445	1,560	1,602	1,654	1,752	1,896	2,012	2,080	2,176	n/a	17th	
Korea	474	511	578	609	578	669	736	886	919	1,009	1,087	26th	22nd
Luxembourg	1,905	2,033	2,136	2,143	2,286	2,715	2,947	3,233	3,678	4,518	4,976	2nd	2nd
Mexico	429	388	372	407	434	464	497	543	574	605	657	29th	24th
Netherlands	1,660	1,717	1,781	1,839	1,953	2,034	2,145	2,405	2,645	2,761	2,895	12th	9th
New Zealand	1,193	1,246	1,272	1,356	1,449	1,522	1,605	1,705	1,850	1,902	2,083	21st	16th
New Zealand restated	n/a	n/a	1,311	1,435	1,527	1,619	1,687	1,815	1,939	1,998	2,112	21st	16th
Norway	1,688	1,784	1,939	2,208	2,364	2,598	2,870	3,048	3,386	3,527	3,706	4th	4th
Poland	369	400	459	461	521	546	568	626	706	717	768	28th	23rd
Portugal	893	1,063	1,139	1,207	1,255	1,381	1,554	1,611	1,720	1,649	1,741	23rd	19th
Slovak Republic	n/a	n/a	n/a	546	559	564	583	630	711	743	n/a	27th	
Spain	1,085	1,160	1,217	1,246	1,312	1,406	1,473	1,553	1,661	1,890	2,029	22nd	18th
Sweden	1,580	1,652	1,761	1,781	1,871	2,005	2,162	2,297	2,473	2,627	2,714	13th	11th
Switzerland	2,398	2,481	2,594	2,751	2,891	2,931	3,095	3,273	3,552	3,760	3,993	3rd	3rd
Turkey	187	187	233	267	312	376	431	441	459	490	557	30th	25th
United Kingdom	1,264	1,310	1,383	1,524	1,596	1,713	1,858	2,029	2,228	2,347	2,546	15th	12th
United States	3,422	3,579	3,723	3,867	4,031	4,229	4,481	4,824	5,206	5,586	5,970	1st	1st
Unweighted mean	1,401	1,476	1,543	1,575	1,657	1,761	1,882	2,023	2,185	2,333	2,481		
Weighted mean	1,716	1,810	1,877	1,935	2,036	2,155	2,297	2,457	2,658	2,866	3,101		

Source: OECD Health Data 2006,[18] and the Ministry of Health

Note: Highlighted data do not report investment on medical facilities for this period. 'New Zealand restated' includes previously reported 'non-health' items that are now part of core health, primarily DSS funded by the Ministry.

[18] The most recent information for OECD Health Data typically is for the period two years prior to publication; for example the OECD Health Data 2006 contains information for 2004.

8.3 Health expenditure as a percentage of GDP

New Zealand spent 8.4% of GDP on health in 2003 as compared with 8.5% in 2004; both percentages were just below the weighted OECD average that was 9.0% in 2003 and 8.7% in 2004. The actual weighted average for 2004 will most likely exceed 9.0% once all countries report (Germany and Belgium were ranked third and seventh in 2003). Table 8.2 shows that New Zealand's health expenditure as a percentage of GDP was the 16th highest of the 30 OECD member countries in 2003 and 12th of the 25 reporting for 2004. In 2003 the United States had the highest proportion of current health expenditure to GDP at 15.0%; Korea, at 5.3%, had the lowest proportion. This ranking remains unchanged for the countries reporting to date for 2004.

For New Zealand, the proportion of current health expenditure to GDP increased from 7.3% in 1996 to 8.5% in 2004. In comparison, the OECD weighted average over the same period increased from 8.0% to 9.0%.

Current health expenditure as a proportion of GDP is often used in international comparisons. However, as expenditure contains price and volume components, high ratios of health expenditure to GDP could reflect a higher price rather than a higher volume of health care services, so this measure should be used with caution. Partly for this reason, there is no 'right' or 'wrong' proportion of a country's GDP to be spent on health.

Table 8.2: Current health expenditure as a percentage of GDP, 1994–2004

Country	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Rank 2003	Rank 2004
Australia	7.4	7.5	7.7	7.7	7.8	7.9	8.3	8.5	8.8	9.2	n/a	12th	
Austria	7.4	9.2	9.1	8.9	9.1	9.1	8.9	9.0	9.1	9.2	9.2	11th	8th
Belgium	7.7	7.6	7.9	7.7	7.9	8.1	8.2	8.4	8.5	9.7	n/a	7th	
Canada	9.2	8.9	8.7	8.7	8.9	8.6	8.5	9.0	9.3	9.4	9.4	10th	7th
Czech Republic	6.0	6.2	6.2	6.2	6.1	6.4	6.4	6.7	6.9	7.2	7.1	25th	22nd
Denmark	8.2	7.9	8.0	7.9	8.1	8.3	8.1	8.4	8.6	8.5	8.5	15th	12th
Finland	7.5	7.2	7.4	7.0	6.6	6.7	6.5	6.7	6.9	7.2	7.3	24th	21st
France	9.0	9.2	9.2	9.0	8.9	9.0	9.0	9.1	9.8	10.1	10.2	5th	3rd
Germany	9.5	9.9	10.2	10.1	10.1	10.2	10.1	10.3	10.5	10.6	n/a	3rd	
Greece	9.3	9.3	9.3	9.0	9.0	9.2	9.4	9.9	9.8	10.0	9.6	6th	5th
Hungary	7.6	6.9	6.8	6.5	6.9	7.0	6.8	7.0	7.4	8.0	8.1	17th	16th
Iceland	8.0	8.2	8.1	8.1	8.4	8.8	9.0	9.1	9.8	10.3	10.0	4th	4th
Ireland	6.5	6.3	6.0	5.8	5.6	5.6	5.7	6.1	6.4	6.5	6.6	26th	23rd
Italy	7.2	6.8	7.0	7.2	7.1	7.2	7.5	7.6	7.8	7.8	8.0	19th	17th
Japan	6.4	6.4	6.6	6.5	6.8	7.1	7.3	7.5	7.7	7.7	n/a	20th	
Korea	4.1	4.0	4.2	4.2	4.2	4.4	4.5	5.1	5.0	5.2	5.3	30th	26th
Luxembourg	5.3	5.6	5.7	5.6	5.7	5.8	5.7	6.3	6.7	7.5	7.8	22nd	19th
Mexico	5.8	5.6	5.1	5.3	5.4	5.5	5.5	5.9	6.2	6.3	6.5	27th	24th
Netherlands	7.7	7.6	7.6	7.4	7.6	7.6	7.5	7.9	8.5	8.6	8.8	14th	10th
New Zealand	7.1	7.2	7.1	7.3	7.8	7.6	7.7	7.8	8.2	8.0	8.4	16th	13th
New Zealand restated	n/a	n/a	7.3	7.7	8.2	8.1	8.1	8.3	8.6	8.4	8.5	16th	12th
Norway	7.5	7.4	7.4	8.0	8.6	8.7	7.9	8.3	9.3	9.4	9.1	9th	9th
Poland	5.3	5.3	5.6	5.2	5.6	5.7	5.5	5.8	6.3	6.2	6.2	28th	25th
Portugal	7.1	8.0	8.1	8.2	8.1	8.4	9.0	8.9	9.2	9.4	9.6	8th	6th
Slovak Republic	n/a	n/a	n/a	5.8	5.7	5.7	5.4	5.4	5.6	5.6	n/a	29th	
Spain	7.1	7.2	7.3	7.1	7.1	7.1	7.0	6.9	7.0	7.6	7.9	21st	18th
Sweden	7.7	7.7	7.9	7.7	7.9	8.0	8.0	8.3	8.7	8.9	8.7	13th	11th
Switzerland	9.2	9.4	9.8	9.9	10.0	10.2	10.1	10.6	10.8	11.2	11.4	2nd	2nd
Turkey	3.6	3.4	3.9	4.2	4.8	6.1	6.3	7.2	7.0	7.3	7.4	23rd	20th
United Kingdom	6.6	6.6	6.6	6.8	6.9	7.1	7.3	7.5	7.7	7.9	8.3	18th	15th
United States	12.9	13.0	12.9	12.8	12.8	12.8	13.0	13.7	14.4	14.9	15.0	1st	1st
Unweighted mean	7.4	7.4	7.5	7.4	7.5	7.7	7.7	8.0	8.3	8.5	8.6		
Weighted mean	7.8	7.9	8.0	7.9	7.9	8.1	8.1	8.4	8.7	9.0	8.7		

Source: OECD Health Data 2006

Note: Highlighted data do not report investment on medical facilities for this period. 'New Zealand restated' includes previously reported 'non-health' items now included in core health, primarily DSS funded by the Ministry.

8.4 Publicly funded current health expenditure as a proportion of total health expenditure

Table 8.3 shows the trends in publicly funded current health expenditure as a proportion of total current health expenditure. Overall, in the OECD, current public health expenditure accounts for about three-quarters of total health expenditure. In 2004 Luxembourg had the highest public expenditure as a proportion of total current health expenditure (90.4%), and the United States had the lowest (44.7%). New Zealand is ranked ninth, with public funding for 77.2% of total health spending.

During the 1960s there was a shift among OECD countries towards more public funding of health care. This pattern stabilised during the late 1970s and early 1980s, and then reversed slightly in more recent years. Since 1992 New Zealand has remained within the narrow range 77% to 78%.

Table 8.3: Publicly funded health expenditure as a proportion of total health expenditure, 1994–2004

Country	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Rank 2003	Rank 2004
Australia	65.8	66.7	66.1	67.8	67.4	69.5	68.9	67.8	68.1	67.5	n/a	23rd	n/a
Austria	74.4	69.3	68.2	70.3	69.7	70.0	69.9	69.5	70.5	70.3	70.7	20th	16th
Belgium	0.0	78.5	79.4	76.7	76.1	75.8	75.8	76.4	75.0	71.1	n/a	18th	n/a
Canada	72.0	71.4	70.9	70.1	70.6	70.0	70.3	69.9	69.6	70.1	69.8	21st	17th
Czech Republic	93.9	90.9	90.7	90.3	90.4	90.5	90.5	89.9	89.7	89.8	89.2	2nd	2nd
Denmark	82.2	82.5	82.4	82.3	82.0	82.2	82.4	82.7	82.9	n/a	n/a	n/a	n/a
Finland	75.5	75.6	75.8	76.1	76.3	75.3	75.1	75.9	76.1	76.2	76.6	13th	10th
France	76.0	76.3	76.1	76.2	76.0	76.0	75.8	75.9	78.1	78.3	78.4	10th	8th
Germany	80.2	80.5	80.6	79.1	78.6	78.5	78.6	78.4	78.6	78.2	n/a	11th	n/a
Greece	50.2	52.0	53.0	52.8	52.1	53.4	52.6	55.5	54.1	53.6	52.8	26th	21st
Hungary	87.3	84.0	81.6	81.3	74.8	72.4	70.7	69.0	70.2	72.4	72.5	16th	12th
Iceland	83.6	83.9	83.3	82.1	82.0	83.6	82.6	82.7	83.2	83.5	83.4	7th	6th
Ireland	71.9	71.6	71.4	74.6	76.5	72.8	73.3	75.6	75.2	78.0	79.5	12th	7th
Italy	74.4	71.9	71.5	71.9	71.6	72.0	73.5	75.8	75.4	75.1	76.4	14th	11th
Japan	78.6	83.0	82.8	81.5	80.8	81.1	81.3	81.7	81.5	81.5	n/a	8th	n/a
Korea	33.4	35.3	38.1	40.1	45.9	45.9	46.2	51.9	50.6	50.7	51.4	27th	22nd
Luxembourg	91.7	92.4	92.8	92.5	92.4	89.8	89.3	87.9	90.3	90.6	90.4	1st	1st
Mexico	45.0	42.1	41.4	44.7	46.0	47.8	46.6	44.9	43.9	44.1	46.4	29th	23rd
Netherlands	72.9	71.0	68.2	67.8	64.1	62.7	63.1	62.8	62.5	63.0	62.3	24th	19th
New Zealand	77.5	77.2	76.7	77.3	77.0	77.5	78.0	76.4	77.9	78.3	77.5	9th	9th
New Zealand restated	n/a	n/a	77.4	78.5	78.2	79.0	79.1	77.9	78.9	79.4	77.2	9th	9th
Norway	84.6	84.2	84.2	81.3	82.2	82.6	82.5	83.6	83.5	83.7	83.5	6th	5th
Poland	72.8	72.9	73.4	72.0	65.4	71.1	70.0	71.9	71.2	69.9	68.6	22nd	18th
Portugal	63.4	62.6	65.3	65.7	67.1	67.6	72.5	71.5	72.2	72.6	71.9	15th	14th
Slovak Republic	0.0	0.0	0.0	91.7	91.6	89.6	89.4	89.3	89.1	88.3	n/a	3rd	n/a
Spain	75.5	72.2	72.4	72.5	72.2	72.0	71.6	71.2	71.3	70.4	70.9	19th	15th
Sweden	87.1	86.6	86.9	85.8	85.8	85.7	84.9	84.9	85.1	85.4	84.9	5th	4th
Switzerland	54.2	53.8	54.7	55.2	54.9	55.3	55.6	57.1	57.9	58.5	58.4	25th	20th
Turkey	68.9	70.3	69.2	71.6	71.9	61.1	62.9	68.2	70.4	71.6	72.1	17th	13th
United Kingdom	83.9	83.9	82.9	80.4	80.4	80.6	80.9	83.0	83.4	85.4	85.5	4th	3rd
United States	45.0	45.3	45.7	45.3	44.3	43.8	44.0	44.8	44.8	44.6	44.7	28th	24th
Weighted mean	75.1	74.8	74.5	75.0	74.5	74.1	74.1	74.5	74.8	74.6	73.8		

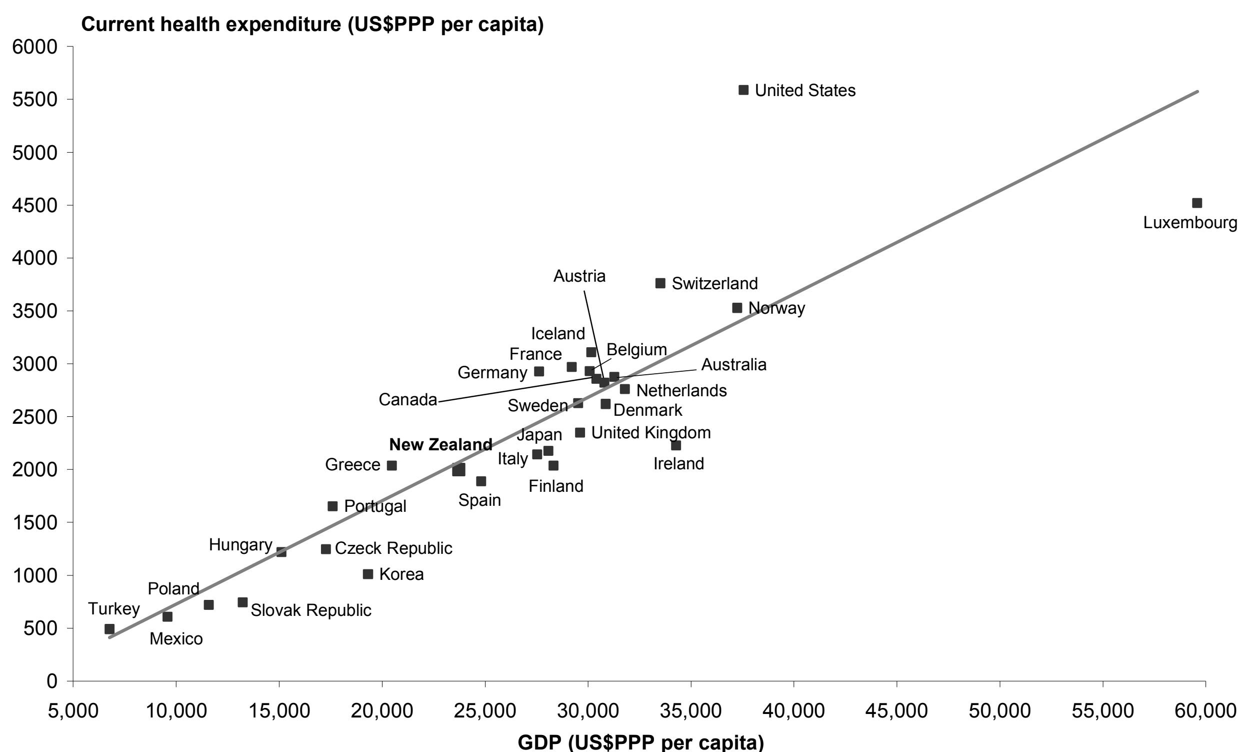
Source: OECD Health Data 2006

Note: 'New Zealand restated' includes previously reported 'non-health' items now included in core health, primarily DSS funded by the Ministry.

8.5 Health expenditure and GDP per capita

Figure 8.1 and Table 8.4 show the positive relationship between health expenditure and GDP for 30 OECD countries. There is a well-established relationship between GDP per capita and health expenditure per capita. Specifically, the higher a country's GDP per capita, the greater its health expenditure per capita is likely to be, compared with other countries. As Figure 8.1 shows, New Zealand expenditure on health care is similar to the amount that could be expected for another OECD country with a similar level of GDP. Note there is no agreed optimal level of health care spending relative to GDP. As New Zealand's economy continues to grow, it is expected that health expenditure per capita will increase proportionately.

Figure 8.1: Relationship between health expenditure and GDP in 30 OECD countries, 2003



Source: OECD Health Data 2006 and Ministry of Health

Note: 2003 data is used in this figure as it is the most recent year with complete data.

Reasons for differences in international health spending and performance are outlined below.

- Some differences result from health service cost (and price) variations. Richer countries pay a higher price per unit of medical care consumed, given their higher labour costs and higher prices for services.
- The intensity of treatment differs among countries.
- The rates at which various invasive procedures are performed differ widely among countries.
- The rapid and extensive introduction of new medical technologies in the United States, in particular, explains a significant part of the difference in growth of expenditure outlays between the United States and elsewhere.
- As major determinants of health expenditure, demographic characteristics also vary significantly among countries. Some countries have high life expectancies and relatively old populations and therefore need to spend more on older people, whose health care costs are the highest per capita. (The converse is true of countries with younger populations.)
- Cultural and religious factors cause differences not only in the perception of morbidity, but also in the choice of therapeutic responses.
- Variations in welfare philosophies and private insurance coverage affect public provision and the level of health care assistance provided in different countries.

- Differences among countries in the origin of funding can also significantly affect the demand for health care and expenditure.
- Incidence of litigation against health providers varies among countries. In countries with a higher incidence (as in the United States, in particular), providers of health care are more likely to take out expensive insurance cover.

Table 8.4: Per capita GDP and per capita health expenditure (US$ PPP) for OECD countries, 2003 and 2004

Country	GDP per capita 2003	GDP per capita 2004	Health expenditure per capital 2003	Health expenditure per capita 2004
Australia	31,273	32,573	2,876	n/a
Austria	30,796	32,519	2,822	2,980
Belgium	30,082	31,381	2,929	n/a
Canada	30,404	31,828	2,856	3,020
Czech Republic	17,283	18,634	1,246	1,317
Denmark	30,853	32,304	2,620	2,752
Finland	28,334	29,778	2,034	2,168
France	29,210	29,945	2,970	3,067
Germany	27,625	28,816	2,926	n/a
Greece	20,479	21,586	2,035	2,082
Hungary	15,112	15,948	1,217	1,285
Iceland	30,152	32,527	3,108	3,280
Ireland	34,275	36,479	2,226	2,414
Italy	27,537	28,352	2,141	2,272
Japan	28,071	29,567	2,176	n/a
Korea	19,317	20,668	1,009	1,088
Luxembourg	59,580	63,453	4,518	4,976
Mexico	9,586	10,242	605	657
Netherlands	31,792	32,978	2,760	2,895
New Zealand	23,728	24,744	1,902	2,083
New Zealand restated			1,998	2,112
Norway	37,245	40,715	3,527	3,706
Poland	11,583	12,409	717	769
Portugal	17,603	18,125	1,650	1,741
Slovak Republic	13,241	14,060	743	n/a
Spain	24,812	25,875	1,889	2,030
Sweden	29,522	31,139	2,626	2,714
Switzerland	33,516	35,149	3,760	3,993
Turkey	6,762	7,562	490	556
United Kingdom	29,609	30,822	2,347	n/a
United States	37,548	39,772	5,587	5,970

Source: OECD Health Data 2006 and Ministry of Health

Note: Highlighted data do not report investment on medical facilities for this period. 'New Zealand restated' includes previously reported 'non-health' items now included in core health, primarily DSS funded by the Ministry.

Appendix 1: OECD System of Health Accounts

A1.1 Functions of health care

Health care consists of the sum of activities performed by either institutions or individuals pursuing, through the application of medical, paramedical and nursing knowledge and technology, the goals of:

1. promoting health and preventing disease
2. curing illness and reducing premature mortality
3. caring for people affected by chronic illness who require nursing care
4. caring for people with health-related impairment, disability and handicaps who require nursing care
5. assisting patients to die with dignity
6. providing and administering public health
7. providing and administering health programmes, health insurance and other funding arrangements.

Health care consists of personal health care services provided directly to individuals, and collective health care services covering traditional tasks of public health such as health promotion and disease prevention, including setting and enforcing standards, as well as health administration and health insurance.

Within the SHA, personal health care services are delineated as curative care, rehabilitative care, services of a (long-term) nursing type care, ancillary services to health care, and medical goods dispensed to outpatients, that include self-medication and other goods consumed by households with or without a prescription from medical or paramedical professionals.

Much of personal health (goals 1–5 above) is two-dimensional, combining the ‘basic function of service’ (curative, rehabilitative and long-term) with the ‘mode of production’ or settings of care (in, day, out or home based care).

A1.1.1 Basic function of care

The basic criterion for classifying the ‘basic function of care’ is based on definitions developed by the Australian Health Data Committee and the United States Joint Commission on Accreditation of Healthcare Organisations (OECD 2000).

Curative

An episode of curative care has the purpose of relieving symptoms of illness or injury, reducing the severity of an illness or injury, or protecting against exacerbation and/or complication of an illness or injury that threatens life or normal function.

Rehabilitative

An episode of rehabilitative care has the purpose of improving the functional level of the individual, where the limitations either are due to a recurrent event of illness or injury or are of a recurrent nature. Rehabilitative care is generally less intensive than curative care but more so than long-term care. It requires frequent and recurrent patient assessment, and progresses in accordance with a treatment plan for a limited period.

Long-term

Long-term care is not episodic. It consists of ongoing care to individuals who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence, including in activities of daily living. Long-term care is typically a mix of clinical and social services. It is the intent that only clinical care expenditures in this type of care are included as health expenditures.

A1.1.2 Mode of production

SHA functions of care are further stratified into modes of care due to the essential differences in the technical and managerial organisations of care. The fundamental differences pertain to the substantially different information systems, including the administrative paperwork and statistics that are in place within these types of organisations.

Inpatient

The inpatient function consists of care provided to patients who are admitted to an institution for treatment and stay for a minimum of one night. Accommodation in institutions providing social services where health care is an important but not predominant component of care should not be included as a health function.

Day care

The day care function consists of care delivered to patients who are formally admitted to an institution and the intention is to discharge the patient on the same day. These patients are usually admitted and discharged after staying between three and eight hours.

Outpatient

The outpatient function consists of care delivered to patients who are not formally admitted and do not stay overnight. The boundary is wider than for institutional care and covers services provided at physician offices and ambulatory care centres.

Home care

The home care function consists of care delivered to individuals in their own home. The New Zealand interpretation is that an individual's home is not limited to a private residence.

A1.1.3 Other personal health functions

Ancillary

The ancillary function consists of a variety of services mainly performed by paramedical or medical technical personnel, including diagnostic imaging, laboratory, and patient transport. These services can be provided either with or without referral and direct supervision by a medical doctor.

Medical goods dispensed to outpatients

These services are concerned with goods bought by private households at their own initiative for the purpose of home care. They cover items purchased with and without prescription.

A1.1.4 Other health functions

Health functions undertaken for the public, as opposed to the individual, are described below.

Prevention and public health

Public health services are primarily preventative in nature and consist of a wide range of services with intended benefits for the public, or groups within the public, rather than the individual. Examples include epidemiological surveillance, disease prevention and the promotion of good health.

Not covered under prevention and public health are the safety elements of 'health and safety'. Examples of functions specifically excluded are: occupational health services pertaining to improving the working environment, such as ergonomy, environmental protection and accident prevention; road safety; product safety monitoring; and civil defence (OECD 2000). Some 'safety' services are covered in Section A1.3 below ('Health-related functions').

Administration and health insurance

Administration and health insurance services include planning, managing, regulating and collecting funds, and handling claims of the health delivery system. They include the activities of both public governmental agencies and the private insurance sector.

Functions of health care

HC.1 Services of curative care

- HC.1.1 Inpatient curative care
- HC.1.2 Day cases of curative care
- HC.1.3 Outpatient curative care
  - HC.1.3.1 Basic medical and diagnostic services
  - HC.1.3.2 Outpatient dental care
  - HC.1.3.3 All other specialised health care
  - HC.1.3.9 All other outpatient curative care
- HC.1.4 Services of curative home care

HC.2 Services of rehabilitative care

- HC.2.1 Inpatient rehabilitative care
- HC.2.2 Day cases of rehabilitative care
- HC.2.3 Outpatient rehabilitative care
- HC.2.4 Services of rehabilitative home care

HC.3 Services of long-term nursing care

- HC.3.1 Inpatient long-term nursing care
- HC.3.2 Day cases of long-term nursing care
- HC.3.32Long-term nursing care: home care

HC.4 Ancillary services to health care

- HC.4.1 Clinical laboratory
- HC.4.2 Diagnostic imaging
- HC.4.3 Patient transport and emergency rescue
- HC.4.9 All other miscellaneous ancillary services
- HC.5.1 Pharmaceuticals and other medical non-durables
  - HC.5.1.1 Prescribed medicines
  - HC.5.1.2 Over-the-counter medicines
  - HC.5.1.3 Other medical non-durables
- HC.5.2 Therapeutic appliances and other medical durables
  - HC.5.2.1 Glasses and other vision products
  - HC.5.2.2 Orthopaedic appliances and other prosthetics
  - HC.5.2.3 Hearing aids
  - HC.5.2.4 Medico-technical devices, including wheelchairs
  - HC.5.2.9 All other miscellaneous medical durables

HC.6 Prevention and public health services

- HC.6.1 Maternal and child health; family planning and counselling
- HC.6.2 School health services
- HC.6.3 Prevention of communicable diseases
- HC.6.4 Prevention of non-communicable diseases
- HC.6.5 Occupational health care
- HC.6.9 All other miscellaneous public health services

HC.7 Health administration and health insurance

- HC.7.1 General government administration of health
  - HC.7.1.1 General government administration of health (except social security)
  - HC.7.1.2 Administration, operation and support activities of social security funds
- HC.7.2 Health administration and health insurance: private
  - HC.7.2.1 Health administration and health insurance: social insurance
  - HC.7.2.2 Health administration and health insurance: other private

A1.2 Health-related functions

The OECD health-related functions are distinguished from the core of health care functions. They are closely linked to health care in terms of operations, institutions and personnel but are, as far as possible, excluded when measuring activities and expenditures belonging to core health care functions. For the most part these services are those that have a direct and beneficial impact on public health.

Capital formation

This health-related function encompasses gross capital formation of domestic health care provider institutions (not all facilities), for example hospitals and nursing homes. At this time New Zealand has not conducted an estimate of capital costs.

Education and training

This health-related function covers the education and training of health professionals. The expenditures should include administration, inspection and support services but should distinguish between training and health service provision.

Research and development

This health-related function covers many programmes directed towards the protection and improvement of human health, including but not limited to: good hygiene, biochemical engineering, medical information, rationalisation of treatment and pharmacology as well as research relating to epidemiology, prevention of industrial diseases and drug addiction (OECD 2000, p125). Government involvement in health research and development is often classified as a health function and is split between health administration and research and development.

Food, hygiene and drinking water control

This health-related function consists of a variety of activities of a public health concern. The boundary between health-related and non-health, as applied in New Zealand, distinguishes between supply and safety. For example, provision of the water supply is not included, but water testing and treatment to ensure safety for human consumption are included in this health-related function. The same boundary applies to other testing and treatment services.

Environmental health

This health-related function covers a number of activities, including monitoring the environment and environmental control when the specific focus of the service is a public health concern. Examples of these types of services are waste management, waste water and pollution abatement.

Administration and provision of social services in kind to assist living with disease and impairment

This health-related function consists of non-medical social services in kind provided to people with health problems, functional impairments or limitations, where the primary goal is the social or vocational rehabilitation or integration of the individual. At this time New Zealand has not calculated an estimate for this function.

Administration and provision of health-related cash-benefits

This health-related function consists of health-related cash benefits in the form of transfers to individuals and households. These benefits include but are not limited to sickness and disability benefits, health-related early retirement and maternity leave. At this time New Zealand has not calculated an estimate for this function.

Health-related functions

- HC.R.1 Capital formation of health care provider institutions
- HC.R.2 Education and training of health personnel
- HC.R.3 Research and development in health
- HC.R.4 Food, hygiene and drinking water control
- HC.R.5 Environmental health
- HC.R.6 Administration and provision of social services in kind to assist living with disease and impairment
- HC.R.7 Administration and provision of health-related cash-benefits

A1.3 Provider industry

The SHA includes a dimension for the provider sector ‘where does the money go’, or ‘who provides the services’. The classifications used are based on the North American Industrial Classification System, a draft common industrial classification of NAFTA countries (NAICS 1998).

OECD SHA provider industry

- HP.1 Hospitals
  - HP.1.1 General hospitals
  - HP.1.2 Mental health and substance abuse hospitals
  - HP.1.3 Speciality (other than mental health and substance abuse) hospitals

- HP.2 Nursing and residential care facilities
  - HP.2.1 Nursing care facilities
  - HP.2.2 Residential mental retardation, mental health and substance abuse facilities
  - HP.2.3 Community care facilities for the elderly
  - HP.2.9 All other residential care facilities
- HP.3 Providers of ambulatory health care
  - HP.3.1 Offices of physicians
  - HP.3.2 Offices of dentists
  - HP.3.3 Offices of other health practitioners
  - HP.3.4 Outpatient care centres
  - HP.3.5 Medical and diagnostic laboratories
  - HP.3.6 Providers of home health care services
  - HP.3.9 Other providers of ambulatory health care
- HP.4 Retail sale and other providers of medical goods
  - HP.4.1 Dispensing chemists
  - HP.4.2 Retail sale and other suppliers of optical glasses and other vision products
  - HP.4.3 Retail sale and other suppliers of hearing aids
  - HP.4.4 Retail sale and other suppliers of medical appliances (not glasses and hearing aids)
  - HP.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods
- HP.5 Provision and administration of public health programmes
- HP.6 Health administration and insurance
  - HP.6.1 Government administration of health
  - HP.6.2 Social security funds
  - HP.6.3 Other social insurance
  - HP.6.4 Other (private) insurance
  - HP.6.9 All other providers of health administration
- HP.7 Other industries (rest of the economy)
  - HP.7.1 Establishments as providers of occupational health care services
  - HP.7.2 Private households as providers of home care
  - HP.7.9 All other industries as secondary producers of health care
- HP.9 Rest of the world

A1.4 Sources of funding

The SHA provides a breakdown of expenditure on health into a range of third-party-payment arrangements plus direct payments by households or other direct funders, for example government-provided health care.

OECD SHA sources of funding[19]

- HF.1 General government
  - HF.1.1 General government excluding social security funds
    - HF.1.1.1 Central government
    - HF.1.1.2 State/provincial government
    - HF.1.1.3 Local/municipal government
  - HF.1.2 Social security funds
- HF.2 Private sector
  - HF.2.1 Private social insurance
  - HF.2.2 Private insurance (other than social insurance)
  - HF.2.3 Private households
  - HF.2.4 Non-profit institutions serving households (other than social insurance)
  - HF.2.5 Corporations (other than health insurance)
- HF.3 Rest of the world

[19] These sources are directly comparable with New Zealand historical funder groups.

Appendix 2: Historical Definitions of Health and Disability Support Services

Institutional care – public institutions
Personal health
Surgical and medical
Mental health
Dental
Maternity
Other
Subtotal – public institutions personal health
Disability support
Age-related disability
Psychiatric disability
Intellectual disability
Physical/sensory disability
Subtotal – public institutions disability support
Subtotal – public institutions
Institutional care – private institutions
Personal health
Surgical and medical
Mental health
Dental
Maternity
Other
Subtotal – private institutions personal health
Disability support
Age-related disability
Psychiatric disability
Intellectual disability
Physical/sensory disability
Subtotal – private institutions disability support
Subtotal – private institutions
Subtotal – total institutional care

Community care personal health
General practitioner
Midwife
Specialist
Referral services
Diagnostic
Physiotherapy
Laboratory
Other
Dental
Mental health
Medicaments
Other
Subtotal – community care personal health
Community care disability support
Age-related disability
Psychiatric disability
Intellectual disability
Physical/sensory disability
Subtotal – community care disability support
Public health services
Teaching and research
Teaching
Research
Subtotal – teaching and research
Ministry of Health
Ministry of Health – non-public health
Ministry of Health – public health
Other payments
Subtotal – Ministry of Health
Total expenditures

A2.1 Institutional care

This section includes both privately and publicly owned institutions.

Public institutions

This category corresponds to publicly owned hospitals, such as those managed by health service providers in New Zealand, that are defined as 'establishments that offer accommodation and provide medical and nursing care to persons who are sick or injured or are suspected of being sick or injured, or to women during childbirth'. The category also includes appropriate parts of hospices or inpatient community treatment centres, but not rest homes. In New Zealand, public institutions either are managed by health service providers or operate as community trusts.

Once the institution has been defined, all its operational costs – for example, for laboratories, medicines, home nursing, ambulance services and administration – are included in the category.

Private institutions

This category includes all private hospitals, rest homes, and community homes providing disability services.

A2.2 Community care

Personal health care services provided under the category of community care correspond to ambulatory and domiciliary services provided other than through public and private institutions. They include the services of general practitioners, medical specialists, nurses, midwives, dentists and various other health care practitioners. Note that some services provided by public hospitals and health services are given in people's homes but are included under institutional services (eg, community nursing services, occupational therapy and domiciliary physiotherapy).

Transport and administration costs associated with the provision of these services are also included.

Disability support services include needs assessment and service co-ordination, personal care services, home support, environment support and household management services.

General practice

This category includes all personal health services provided in general primary care settings, by both doctors and nurses. Among such settings are solo and group practice, health centres (eg, union health centres and marae-based centres), accident and medical centres, student health centres, family planning centres, and health services provided in prisons, barracks and factories.

Specialist medical services

This category covers services provided by private medical and allied health care specialists outside the hospital setting. It includes services provided by medical and surgical specialists, psychologists, chiropractors, osteopaths, optometrists, podiatrists and dieticians. Note that it does not include services provided by DHBs.

Referred services

This category covers the range of diagnostic and treatment services outside the hospital setting that can be obtained only following referral by a relevant health care practitioner. It includes laboratory services, other diagnostic services (eg, X-ray and other imaging, and electrocardiograms – ECGs), physiotherapy and other referred services (eg, occupational therapy, speech therapy).

Medicaments

This category includes medicines, dressings, syringes and other therapeutic devices, along with associated dispensing costs. It covers prescription medicaments as well as those available over the counter from doctors, pharmacists and other outlets. Items such as sanitary towels, sunglasses and cotton wool for ordinary purposes of daily living are excluded.

Dental services

This category covers all dental care services provided outside the hospital setting. It includes the school dental care scheme.

A2.3 Public health

The term ‘public health’ refers to the specific measures taken to improve the health of the community. It involves protecting people against ill health and promoting good health. Public health programmes aim to improve people’s health and minimise the risk of disease. They are targeted at whole populations, or groups such as children, rather than at individuals, though all individuals can benefit. Although some benefits are immediate, many public health programmes have a longer-term focus so do not produce instant results.

Some examples of everyday public health services are:

- checking the drinking water supply for giardia
- improving dental health
- issuing hygiene certificates to restaurants
- immunising children
- planting trees for shade from the sun at beaches and parks
- testing shellfish for toxins caused by algal blooms
- promoting healthy lifestyles, such as smokefree living, a healthy, low-fat diet and regular physical activity

- reducing road injuries and deaths
- monitoring the use of pesticides and insecticides
- reducing food poisoning
- reducing injuries, both at work and in the home
- reducing the consumption of alcohol
- promoting screening for cervical cancer
- promoting the checking of children for glue ear
- running needle swap programmes to prevent the spread of HIV/AIDS.

A2.4 Teaching and research

Teaching costs relate to the expenditure on formal education as part of professional courses (not as general education), including the training of nurses, doctors, ambulance drivers and dental nurses, and postgraduate medical training.

The research component of this category covers the costs of biomedical and health services research, including research on social aspects of medicine.

A2.5 Total health care expenditure

Total health expenditure is the sum of all expenditures under the categories described in sections A2.1 to A2.4 above.

> Note: Overhead expenses
>
> The overhead expenses of each organisation surveyed (depreciation and interest on loans) should be allocated to each category (apportioned according to a reasonable ratio of expenditure between categories, if no other more appropriate method is possible).
>
> Abel-Smith's (1963) definition of health expenditure excludes capital expenditure because it does not make a clear-cut distinction between outlays whose benefits are immediately obtained and those whose benefits continue to accrue after the end of the accounting period.

A2.6 Disability support services

The following definition has been adopted to identify those individuals who are eligible for disability support services funded by the Ministry.

> A person with a disability is a person who has been identified as having a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these) that is likely to continue for a minimum of six months and result in a reduction of independent functioning to the extent that ongoing support is required.
>
> Where a person has a disability that is the result of an accident that took place on or after 1 April 1974, their eligibility for entitlements from the Accident Compensation Corporation should be determined.

Where a person has both a disability and a personal health need, the services provided to address those needs are disability support services and personal health services respectively.

Disability support services include:

- services that provide in a suitable form information on disability support services to people with disabilities and/or their caregivers
- needs assessment services, and service co-ordination services
- personal care services, including assistance with daily activities such as dressing, personal hygiene, eating, taking medication, seating, positioning and toileting
- household management services for people with disabilities, including assistance with domestic functions such as meal preparation, cooking, cleaning, laundering and shopping
- caregiver support services that provide relief to primary informal caregivers
- rehabilitation and habilitation services including (age-related) multidisciplinary assessment, treatment and rehabilitation services
- residential care services that provide short- and long-term care
- environmental support services that supply people with disabilities with:
  - equipment and aids to meet a range of needs, including mobility, incontinence, household management, communication, personal care
  - housing modifications
  - vehicles and vehicle modifications.

Appendix 3: Nominal and Real Health Expenditure (with 'non-health' items included for prior years), 1995/96–2003/04

	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Nominal expenditure ($ million)									
Public	5,555	6,181	6,614	7,037	7,442	8,086	8,834	9,302	9,794
Private	1,625	1,689	1,843	1,873	1,968	2,300	2,361	2,418	2,887
Total	7,180	7,871	8,458	8,910	9,410	10,386	11,194	11,719	12,681
Percentage change		9.25	7.46	5.35	5.60	10.37	7.79	4.69	8.20
Real expenditure (2006 $ million)									
Public	6,395	7,037	7,406	7,909	8,196	8,630	9,177	9,526	9,794
Private	1,870	1,923	2,064	2,105	2,167	2,455	2,452	2,476	2,887
Total	8,265	8,960	9,471	10,014	10,363	11,085	11,630	12,002	12,681
Percentage change		8.41	5.70	5.73	3.49	6.97	4.91	3.20	5.66
Real per capita expenditure (2006 $ million) – resident population									
Public	1,726	1,871	1,948	2,066	2,129	2,229	2,347	2,396	2,411
Percentage change		8.41	4.12	6.05	3.05	4.69	5.28	2.10	0.62
Private	509	511	543	550	563	634	627	623	711
Percentage change		1.33	6.17	1.28	2.38	12.60	–1.10	–0.68	14.11
Total	2,235	2,382	2,491	2,616	2,692	2,863	2,974	3,019	3,121
Percentage change		6.81	4.56	5.01	2.91	6.34	3.87	1.51	3.41

Source: Ministry of Health

Notes: Totals may be affected by rounding. GST inclusive. CPI for June quarter.

Appendix 4A: *Health Expenditure Trends* in New Zealand (with 'non-health' items included for prior years), 1995/96–2003/04

Sources of funds	1995/96		1996/97		1997/98		1998/99		1999/00		2000/01		2001/02		2002/03		2003/04	
	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total
Ministry of Health	4,936,038	68.7	5,337,616	67.8	5,707,629	67.5	6,205,456	69.6	6,543,778	69.5	6,952,914	66.9	7,418,078	66.3	7,773,876	66.3	8,530,885	67.3
Deficit financing	0	0.0	235,600	3.0	198,032	2.3	39,600	0.4	6,413	0.1	76,837	0.7	244,125	2.2	216,337	1.8	0	0.0
Other government agencies	573,485	8.0	561,918	7.1	661,791	7.8	732,992	8.2	831,308	8.8	991,787	9.5	1,103,341	9.9	1,237,639	10.6	1,199,766	9.5
Local authorities	45,956	0.6	46,186	0.6	46,900	0.6	59,292	0.7	60,374	0.6	64,243	0.6	68,381	0.6	73,792	0.6	63,242	0.5
Public total	5,555,479	77.4	6,181,320	78.5	6,614,352	78.2	7,037,340	79.0	7,441,873	79.1	8,085,781	77.9	8,833,925	78.9	9,301,644	79.4	9,793,893	77.2
Out-of-pocket	1,135,099	15.8	1,162,807	14.8	1,305,404	15.4	1,316,021	14.8	1,375,165	14.6	1,656,853	16.0	1,714,843	15.3	1,740,565	14.9	2,155,449	17.0
Health insurance	467,700	6.5	503,496	6.4	510,871	6.0	527,114	5.9	560,857	6.0	610,198	5.9	612,315	5.5	640,632	5.5	638,592	5.0
Not-for-profit organisations	21,721	0.3	23,120	0.3	27,055	0.3	29,954	0.3	31,952	0.3	32,943	0.3	33,355	0.3	36,591	0.3	92,911	0.7
Private total	1,624,520	22.6	1,689,423	21.5	1,843,330	21.8	1,873,089	21.0	1,967,974	20.9	2,299,994	22.1	2,360,513	21.1	2,417,788	20.6	2,886,952	22.8
Total from all sources	7,179,999	100.0	7,870,743	100.0	8,457,682	100.0	8,910,429	100.0	9,409,847	100.0	10,385,775	100.0	11,194,438	100.0	11,719,432	100.0	12,680,845	100.0
% of GDP	7.3%		7.7%		8.2%		8.1%		8.1%		8.3%		8.6%		8.4%		8.5%	

Source: Ministry of Health

Notes: Starting in 2003/04 the DHB operating deficits, if any, are reported in the Ministry estimates. Totals may be affected by rounding. GST inclusive.

Appendix 4B: *Health Expenditure Trends* in New Zealand (with 'non-health' items included for prior years), Real Dollars 1995/96–2003/04

Sources of funds	1995/96		1996/97		1997/98		1998/99		1999/00		2000/01		2001/02		2002/03		2003/04	
	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total	($000)	% of total
Ministry of Health	5,682,129	68.7	6,076,329	67.8	6,391,177	67.5	6,973,680	69.6	7,206,634	69.5	7,421,204	66.9	7,706,559	66.3	7,961,198	66.3	8,530,885	67.3
Deficit financing	0	0.0	268,206	3.0	221,748	2.3	44,502	0.4	7,063	0.1	82,012	0.7	253,619	2.2	221,550	1.8	0	0.0
Other government agencies	660,168	8.0	639,686	7.1	741,047	7.8	823,735	8.2	915,516	8.8	1,058,585	9.5	1,146,249	9.9	1,267,462	10.6	1,199,766	9.5
Local authorities	52,902	0.6	52,578	0.6	52,517	0.6	66,632	0.7	66,490	0.6	68,570	0.6	71,040	0.6	75,570	0.6	63,242	0.5
Public total	6,395,199	77.4	7,036,799	78.5	7,406,490	78.2	7,908,549	79.0	8,195,702	79.1	8,630,371	77.9	9,177,467	78.9	9,525,780	79.4	9,793,893	77.2
Out-of-pocket	1,306,671	15.8	1,323,737	14.8	1,461,740	15.4	1,478,942	14.8	1,514,463	14.6	1,768,445	16.0	1,781,531	15.3	1,782,506	14.9	2,155,449	17.0
Health insurance	538,394	6.5	573,179	6.4	572,053	6.0	592,370	5.9	617,669	6.0	651,296	5.9	636,127	5.5	656,069	5.5	638,592	5.0
Not-for-profit organisations	25,004	0.3	26,320	0.3	30,295	0.3	33,662	0.3	35,189	0.3	35,162	0.3	34,652	0.3	37,473	0.3	92,911	0.7
Private total	1,870,069	22.6	1,923,235	21.5	2,064,088	21.8	2,104,974	21.0	2,167,321	20.9	2,454,902	22.1	2,452,311	21.1	2,476,048	20.6	2,886,952	22.8
Total from all sources	8,265,269	100.0	8,960,034	100.0	9,470,578	100.0	10,013,523	100.0	10,363,023	100.0	11,085,274	100.0	11,629,777	100.0	12,001,828	100.0	12,680,845	100.0

Source: Ministry of Health

Notes: Starting in 2003/04 the DHB operating deficits, if any, are reported in the Ministry estimates. Totals may be affected by rounding. GST inclusive. CPI for June quarter.

Appendix 5: Private Health Insurance Trends, 1993/94–2003/04 ($000)

	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Institutional care											
Public	5,229	2,967	2,974	3,202	389	624	643	227	415	714	640
Private	180,633	210,989	234,776	252,745	300,091	307,093	339,616	371,350	385,552	418,270	431,890
Subtotal – institutional care	185,862	213,956	237,750	255,947	300,480	307,717	340,259	371,577	385,967	418,984	432,530
Community care											
General practitioners and maternity	70,548	70,419	72,247	77,776	73,732	67,767	69,025	70,880	66,074	63,349	52,039
Specialist services and referral services	62,128	72,563	84,467	90,932	88,233	87,099	88,971	108,322	106,651	109,367	110,645
Dental services	23,170	26,923	28,201	30,359	3,809	22,311	21,164	18,277	16,541	16,389	13,760
Medicaments	40,437	42,166	45,035	48,482	44,617	42,211	41,424	41,142	37,082	32,543	29,618
Subtotal – community care	196,283	212,071	229,950	247,549	210,390	219,387	220,584	238,621	226,348	221,648	206,062
Public health	34	34									
Teaching and research	34										0
Total	**382,179**	**426,027**	**467,700**	**503,496**	**510,871**	**527,104**	**560,842**	**610,198**	**612,315**	**640,632**	**638,592**

Source: Ministry of Health and Health Funds Association of New Zealand

Notes: Totals may be affected by rounding. GST inclusive.

Appendix 6: Current Expenditure on Health by Function of Care and Provider Industry (SHA Standard Table 2)

Health care by function	Function and industry codes	Hospitals HP 1	Nursing and residential care facilities HP 2	Providers of ambulatory health care HP 3	Offices of physicians HP 3.1	Offices of dentists HP 3.2	Offices of other health practitioners HP 3.3	Outpatient care centres HP 3.4	Medical and diagnostic laboratories HP 3.5	Providers of home health care services HP 3.6	All other providers of ambulatory health care HP 3.9	Retail sale and other providers of medical goods HP 4	Dispensing chemists HP 4.1	All other sales of medical goods HP 4.2–4.9	Provision and administration of public health programmes HP 5	General health administration and insurance HP 6	Government administration of health HP 6.1	All other health administration HP 6.9	All other industries HP 7	Rest of the world HP 9
Inpatient care																				
Curative and rehabilitative care	HC.1.1; 2.1	2,875,443	85,733	166,825	166,833	0	0	-8	0	0	0	0	0	0	0	0	0	0	0	0
Long-term nursing care	HC.3.1	36,101	842,191	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Services of day care		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Curative and rehabilitative care	HC.1.2; 2.2	163,379	76,415	74,659	41,708	0	0	32,951	0	0	0	0	0	0	0	0	0	0	0	0
Long-term nursing care	HC.3.2	14,104	70,179	14,111	0	0	0	14,111	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient care		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient curative and rehabilitative care	HC.1.3; 2.3	836,267	79,475	1,920,563	514,244	162,011	716,628	439,920	74,419	0	13,342	4,536	0	4,536	0	0	0	0	0	0
Basic medical and diagnostic services	HC.1.3.1	596,019	0	774,528	315,008	0	21,310	365,465	68,466	0	4,279	0	0	0	0	0	0	0	0	0
Outpatient dental care	HC.1.3.2	10,738	0	217,373	0	152,948	64,425	0	0	0	0	0	0	0	0	0	0	0	0	0
All other specialised health care	HC.1.3.3	36,572	6,785	156,133	142,523	3,393	3,412	3,412	0	0	3,393	0	0	0	0	0	0	0	0	0
All other outpatient care	HC.1.3.9	59,348	11,341	644,619	22,681	5,670	599,383	11,214	0	0	5,670	0	0	0	0	0	0	0	0	0
Home care		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Curative and rehabilitative care	HC.1.4; 2.4	208,309	-21,205	373,305	24,684	0	1,416	139,403	0	207,802	0	0	0	0	0	0	0	0	0	0
Long-term nursing care	HC.3.3	30,415	126,077	929,319	0	0	0	19,919	0	868,159	41,240	0	0	0	0	0	0	0	0	0
Ancillary services to health care	HC.4	21,150	0	806,669	0	0	50,153	-23	696,019	945	59,575	0	0	0	0	0	0	0	0	0
Medical goods dispensed to outpatients	HC.5	0	0	0	0	0	0	0	0	0	0	1,613,874	1,516,224	97,651	0	0	0	0	0	0
Pharmaceutical and other medical non-durables	HC.5.1	0	0	0	0	0	0	0	0	0	0	1,527,018	1,516,224	10,795	0	0	0	0	0	0
Therapeutic appliances and other medical durables	HC.5.2	0	0	0	0	0	0	0	0	0	0	86,856	0	86,856	0	0	0	0	0	0

Health care by function	Function and industry codes	Hospitals	Nursing and residential care facilities	Providers of ambulatory health care	Offices of physicians	Offices of dentists	Offices of other health practitioners	Outpatient care centres	Medical and diagnostic laboratories	Providers of home health care services	All other providers of ambulatory health care	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	All other health administration	All other industries	Rest of the world
		HP 1	**HP 2**	**HP 3**	**HP 3.1**	**HP 3.2**	**HP 3.3**	**HP 3.4**	**HP 3.5**	**HP 3.6**	**HP 3.9**	**HP 4**	**HP 4.1**	**HP 4.2–4.9**	**HP 5**	**HP 6**	**HP 6.1**	**HP 6.9**	**HP 7**	**HP 9**
Total expenditure on personal health care		4,185,169	1,258,865	4,285,451	747,469	162,011	768,196	646,273	770,438	1,076,906	114,157	1,618,411	1,516,224	102,187	0	0	0	0	0	0
Prevention and public health services	HC.6	4,082	0	216,660	54,075	177	35,302	125,808	0	0	1,298	0	0	0	389,801	3,714	3,714	0	0	0
Health administration and health insurance	HC.7	0	0	19,993	0	0	0	19,993	0	0	0	0	0	0	0	500,345	479,964	0	0	0
Total current expenditure on health care		4,189,251	1,258,865	4,522,103	801,543	162,188	803,499	792,074	770,438	1,076,906	115,455	1,618,411	1,516,224	102,187	389,801	504,058	483,678	0	0	0

Appendix 7: Current Expenditure on Health and Health-related by Function of Care and Funder (SHA Standard Table 5)

	ICHA-HC code Function and funder codes	Total public HF 1	Ministry of Health HF 1.1.1	Other central government HF 1.1.2	Regional and local government HF 1.1.3	Total private HF 2	Private insurance HF.2.1 + HF.2.2	Private household out-of-pocket payments HF.2.3	Non-profit institutions (other than social insurance) HF.2.4
Services of curative and rehabilitative care	HC.1, HC.2	5,118,193	4,518,698	599,495	0	1,779,921	532,605	1,220,138	27,178
Services of long-term nursing care	HC.3	1,928,811	1,747,103	181,708	0	155,480	26,180	107,506	21,793
Ancillary services to health care	HC.4	504,978	464,337	40,641	0	331,526	43,607	279,234	8,685
Medical goods dispensed to outpatients	HC.5	1,029,101	970,349	58,752	0	584,773	36,200	548,573	0
Pharmaceuticals and other medical non-durables	HC.5.1	977,596	960,543	17,053	0	549,422	29,618	519,804	0
Therapeutic appliances and other medical durables	HC.5.2	51,505	9,806	41,699	0	35,351	6,582	28,769	0
Personal medical services and goods	HC.1–HC.5	8,581,083	7,700,487	880,596	0	2,851,700	638,592	2,155,452	57,657
Prevention and public health services	HC.6	689,539	451,681	174,615	63,242	35,254	0	0	35,254
Health administration and health insurance	HC.7	523,269	378,715	144,555	0	0	0	0	0
Total current expenditure on health		9,793,891	8,530,883	1,199,766	63,242	2,886,954	638,592	2,155,452	92,911
Gross capital formation	HC.R.1	0	0	0	0	0	0	0	0
Total expenditure on health		9,793,891	8,530,883	1,199,766	63,242	2,886,954	638,592	2,155,452	92,911
Memorandum items: Further health-related functions									
Education and training of health personnel	HC.R.2	276,406	92,116	184,290	0	199,648	0	199,648	0
Research and development in health	HC.R.3	142,085	0	142,085	0	20,266	0	0	20,266
Food, hygiene and drinking water control	HC.R.4	197,791	0	74,187	123,604	0	0	0	0
Environmental health	HC.R.5	1,136,570	70	20,333	1,116,167	0	0	0	0
Administration and provision of social services in kind to assist living with disease and impairment	HC.R.6	0	0	0	0	0	0	0	0
Administration and provision of health-related cash-benefits	HC.R.7	0	0	0	0	0	0	0	0

Note: ICHA-HC = International Classification for Health Accounts – Health Care

Appendix 8: Contributors

The following organisations contributed information used in the compilation of this edition of *Health Expenditure Trends in New Zealand*.

Annual reports for central government agencies

Organisation	Supplemental information from survey
Accident Compensation Corporation	No
Department of Conservation	N/A
Department of Corrections	Yes
New Zealand Defence Force	Yes
Ministry of Education	No
Ministry of Health	N/A
Department of Labour	No
New Zealand Lottery Grants Board	No
Ministry of Agriculture and Forestry	No
Ministry of Research, Science and Technology	No
Ministry of Pacific Island Affairs	
Ministry of Social Development	No
Te Puni Kōkiri	No
Ministry of Women’s Affairs	No
Auckland University of Technology	No
Massey University	No
University of Otago	No
University of Auckland	No

Health insurance industry

Faye Pulley of the Health Funds Association of New Zealand Inc undertook the difficult task of collating data from member organisations that are health insurers and provided estimates of total expenditure by the health insurance industry. The following health insurers are member organisations of the Health Funds Association of New Zealand.

Health Funds Association members in 2003/04

AA GIO Insurance Ltd
Manchester Unity Friendly Society
American International Assurance
Police Health Plan Ltd
EBS Health Care
Southern Cross Healthcare
Health Service Welfare Society
Sovereign Assurance Company Ltd
ING Life (NZ) Limited
Tower Health and Life

IOOF Friendly Society
Union Medical Benefits Society Ltd
IAG New Zealand Limited

Annual reports for regional and local government authorities

Authority	Supplemental information from survey
Auckland City Council	Yes – health inspectors
Auckland Regional Council	No
Watercare	No
Christchurch City Council	Yes – street cleaning
Dunedin City Council	Yes – health inspectors, street cleaning, public conveniences and pool treatment
Environment Bay of Plenty	No
Environment Canterbury	No
Environment Southland	N/A – excluded from sample
Environment Waikato	No
Gisborne District Council	N/A – excluded from sample
Greater Wellington Regional Council	No
Hamilton City Council	Yes – street cleaning and pool treatment
Hawkes Bay Regional Council	No
Horizons	No
Hutt City Council	Yes – street cleaning and public conveniences
Kapiti Coast District Council	No
Manawatu Regional Council	No
Manukau City Council	Yes – street cleaning, public conveniences and pool treatment
Marlborough District Council	N/A excluded from sample
Napier City Council	Yes – street cleaning and pool treatment
Nelson City Council	Yes – street cleaning
New Plymouth District Council	Yes – street cleaning and pool treatment
Northland Regional Council	No
North Shore City Council	Yes – street cleaning, public conveniences and pool treatment
Otago Regional Council	No
Palmerston North City Council	Yes – street cleaning and pool treatment
Porirua City Council	Yes – street cleaning and public conveniences
Rodney District Council	Yes – street cleaning, public conveniences and pool treatment
Rotorua District Council	Yes – street cleaning
Taranaki Regional Council	No
Tasman District Council	Yes – public conveniences
Taupo District Council	Yes – street cleaning
Tauranga District Council	No
Timaru District Council	Yes – street cleaning

Authority	Supplemental information from survey
Waikato District Council	No
Waimakariri District Council	Yes – street cleaning and public conveniences
Wanganui District Council	N/A – excluded from sample
Wellington City Council	No
Western Bay of Plenty District Council	N/A excluded from sample
West Coast Regional Council	N/A excluded from sample
Whangarei District Council	Yes – health inspectors

Annual reports for not-for-profit organisations

Key organisations	Annual reports
Alzheimers	2004 multiple branches
Ambulance – Wellington Free	Found
Ambulance – St Johns	Not found, used Lions Grants
Ambulance and other patient transport	Not found, used Lions Grants
Arthritis	2004 multiple branches
Asthma	2004 multiple branches
Barnardos	2003 report
Brain Injury	2004 multiple branches
Cancer Society	2004 multiple branches
CCS Disability Action (formerly Crippled Children's Society)	2004 or 2005 multiple branches
Cerebral Palsy	2004 report
Deaf	2004 report
Deafblind	2004 report
Diabetes	2004 multiple branches
Disabled Persons	2004 report
Downtown Community	2004 report
Epilepsy Association	2004 report
Epilepsy Foundation	2003 report
Family Planning	2004 report
Heart Foundation	2005 report
Hearing Association	2004 multiple branches
IHC (Intellectual Handicapped)	2004 report
Lion Foundation	Grants awarded from October 2003 to December 2004 (used half value from six-month report covering October 2003 to March 2004)
Medic Alert	2004 report
Multiple Sclerosis	2004 multiple branches
Muscular Dystrophy	2004 multiple branches
NZ Breastfeeding	2004 report
Parkinsonism	2004 multiple branches
Patients Aid and Community Trust	2004 report

Key organisations	Annual reports
Plunket	2004 reports and 1 March 2007 meeting
Presbyterian Support	2004 multiple branches
Spinal Cord	2004 report
Stroke Foundation	2004 multiple branches

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