Health of Older People Strategy: Consultation draft

Submission form

Submission from:

The Health Committee of the New Zealand Society of Actuaries

Information about the person/organisation providing feedback

This submission was completed by:	(name)	The Health Committee of the New Zealand Society of Actuaries
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Consultation questions

The following questions focus on what the Strategy is trying to achieve, expressed as vision statements, and on the actions we propose could bring about the desired changes. (*Note: a vision statement is a short description of the state of the world that we want to bring about*).

You don't have to answer all the questions below. We also welcome feedback on any other matters relating to the Strategy or more generally to the health of older people.

You are welcome to include or cite supporting evidence in your submission.

Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

> We know that health outcomes are worse for poorer people. It is difficult to achieve a goal of heathy ageing if there is inadequate income in retirement. In our view the health of older people strategy needs to sit alongside a well-structured old age savings and care policy.
>
> We discuss the opportunity for a Social Investment approach being implemented in section 6 below. Such an approach could be used, for example, to evaluate possible initiatives to improve health while people are still young. Investment up front would have a positive outcome for society, support healthy ageing and may also reduce the long-term costs.

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

It is not clear why there should be an emphasis on acute care in this section as at older ages care is more likely to be needed for long-term chronic conditions. It may be that this is intended to refer to the use of acute hospitals rather than acute care. As populations age, hospitals become places of intermittent care for those with chronic disease rather than acute facilities.

A study in Scotland[1] showed that large numbers of acute hospital inpatients have entered the last year of their lives. It was found that almost 1 in 10 patients in teaching or general hospitals at any given time will die during that admission; almost 1 in 3 patients will have died a year later, rising to nearly 1 in 2 for the oldest groups.

In a study in an acute hospital in New Zealand,[2] 19.8% of inpatients included in a census met at least one of the Gold Standards Framework[3] prognostic indicators for palliative care, suggesting they might be in the last year of life.

There will be increased demand for elective health services due to the effect of degenerative conditions. Provision needs to be made to provide high-quality care to meet this demand. See also our comments in section 3 below.

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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[1] Clark, D., Armstrong, M., Allan, A., Graham, F., Carnon, A., & Isles, C. (2014). Imminence of death among hospital inpatients: Prevalent cohort study. Palliative medicine, 28(6), 474-479. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/24637342

[2] Gott, M., Frey, R., Raphael, D., O'Callaghan, A., Robinson, J., & Boyd, M. (2013). Palliative care need and management in the acute hospital setting: a census of one New Zealand Hospital. BMC Palliat Care, 12, 15. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23537092

[3] Gold Standards Framework. (2011). The GSF Prognostic Indicator Guidance, 4th edition. The Gold Standards Framework Centre in End of Life Care Retrieved from http://www.goldstandardsframework.org.uk/home

An important part of living well will be for older people to benefit from healthcare treatment options that already exist and new technologies and medicines that may be expected to be developed. Many "baby boomers"[4] expect to maintain active lifestyles well into older age and will understandably expect treatment options to be available for health conditions they develop. Demand for elective surgery is expected to increase significantly. We expect that overall costs will rise disproportionately due to the combination of both increases in volume of services (population growth plus ageing plus demand pressure) and health price inflation.

We believe the strategy should explicitly include a plan for the increase in capacity required to meet the expected demand and a plan for how it is expected to be funded. The cost for the taxpayer will be significant and it is likely to be necessary to consider public-private funding approaches. In a review of the long-term sustainability of healthcare funding, The Treasury said[5]: "It is likely that a combination of technological advances and fiscal pressure may cause the proportion of private financing of the system to increase over time."

It should be noted that The Treasury projections used an important assumption that there will be a degree of 'healthy ageing', in other words that the projected increase in life-spans will be accompanied by an increase in the number of years lived in good health. The Ministry of Health has produced a report[6] showing that people not only live longer in good health but also, critically, with more years requiring assistance. This alone makes it necessary to redo the projections on the sustainability of future health costs.

Health insurance could play an important role in funding for healthcare services but does not currently have a regulatory framework which enables this. Greater policy attention will need to be given to the public-private mix in healthcare, with the Ministry of Health taking responsibility for the stewardship of both public and private health[7,8].

There are two critical issues which would need to be addressed:

(i) There are currently no controls on the premium rating structure in health insurance. NZ health insurers all charge premiums which increase with age. Premiums at advanced ages are very high and unaffordable for many. People discontinue their insurance just when they need it most.

(ii) Products focus on premium affordability rather than on claims value. Better risks are able to attract lower premiums hence increasing costs for those who develop health conditions. This reduces an element of cross-subsidisation that is implicitly necessary in order to maintain long-term affordability for all.

In a study on the unaffordability of private health insurance for the elderly[9], it was found that the lowest increase from age 55 to age 65 was 174% and the highest was 246%. The decline in coverage for private health insurance at older ages is substantial. Private health insurance covered 44.8% of the population aged 50-55 in 2010, but only 33.1% of those aged 65-69 and 19.1% of those aged 80-84.

We believe an important government strategy could be to introduce a suitably regulated health insurance environment to encourage responsible private provision for a proportion of long-term health costs.

[4] Those born between 1946–65, using the Statistics NZ working definition

[5] New Zealand Treasury. (2013). Health Projections and Policy Options. Background Paper for the 2013 Statement on the Long-Term Fiscal Position. Wellington: New Zealand Treasury. Retrieved from http://www.treasury.govt.nz/government/longterm/fiscalposition/2013 . P4

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

We agree that high quality care and support should be provided to people with high and complex needs. However, it should be noted that the costs of this care will be significant and that this population segment may be expected to grow disproportionately under certain population ageing scenarios.

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

It is pleasing to see that end of life is acknowledged and included in the revised strategy.

[6] Ministry of Health. (2015). Independent Life Expectancy in New Zealand 2013. Wellington: Ministry of Health. Retrieved from http://www.health.govt.nz/publication/independent-life-expectancy-new-zealand-2013-0

[7] Kutzin, J. (2013). Health financing for universal coverage and health system performance: concepts and implications for policy. Bulletin of the World Health Organization 2013, 91, 602-611. Retrieved from http://dx.doi.org/10.2471/BLT.12.113985

[8] Organization for Economic Co-operation and Development. (2004). Private Health Insurance in OECD Countries. Retrieved from http://www.oecd.org/health/privatehealthinsuranceinoecdcountries-theoecdhealthproject.htm

[9] McLeod, H. (2012). Consumer Dissatisfaction with Private Health Insurance for the Elderly: Implications for Public Health and Stewardship Paper presented at the New Zealand Society of Actuaries Conference, Bay of Islands.

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an ✸ are the right actions to begin with?

Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

Other comments

We note New Zealand's ageing population is expected to give rise to a massive increase in cost (and likely debt to fund costs). Projections by Statistics New Zealand show the 65+ population is expected to nearly double to 1.3 million by the year 2038. NZ Treasury's Long-Term Fiscal Model shows a rapid increase in debt to unsustainable levels if current government spending and taxation patterns remain the same.

In this context the strategy document could usefully be extended to include plans for funding of the costs associated with an ageing population – with a primary focus on health and care. We agree with the healthy ageing strategy of growing age-friendly communities but costs in this setting are still significant with infrastructure required to provide care in the community, transport, and equipment in the home. These all require funding as well as the projected increase in residential care, and acute and elective healthcare costs.

The Strategy should acknowledge that, in the absence of new approaches and thinking, resources to provide care and support will be limited and demand on services will exceed supply. There could be a program to articulate clearly to the public what the system can provide and what it won't provide so there is a good public understanding of future short-comings. The aim would be to create some incentive and urgency for people to consider options for private provision (self-funding, insurance). An issue for wider government is whether there can / should be some financial incentive (e.g .tax concession in connection with a suitably regulated health insurance market - see section 3a above) to encourage appropriate provision. As a country we need to find some way to encourage people to consider their future health needs in provisioning for their old age, and provide an environment which supports them in providing for these.

We have seen the way the current Social Investment approach is being adopted in the Ministry of Social Development and also Corrections. The Ministry of Health would also look to be another government agency where this approach would have substantial benefits. We would recommend the consideration, development and use of a Social Investment approach in this area – especially in regard to funding of costs. A key benefit is the structured approach to making decisions that have long term implications which would help consideration of the balance between social outcomes, long-term expected financial costs and budget constraints.

The strategy could then include plans such as:

- understanding social initiatives that deliver maximum long-term health benefits
- interaction with retirement income policy to boost retirement savings
- long-term funding for capacity increase in acute care facilities
- consideration of suitable public/private provision
- long-term funding for additional elective intervention including the role of health insurance and other private funding options.
- Pre-funding and other options to fund the cost arising from the expected increase in residential aged care.