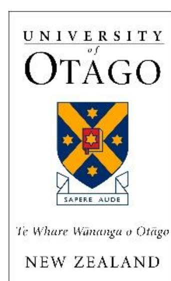

RSNZ Major Issues paper - New Zealand's rapidly changing population: implications for health

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In this initial brief paper I identify three headline health implications of New Zealand's changing demography. I have selected these particular issues as I believe they will have major policy significance over the next twenty to fifty years. At this stage I have limited my comments to defining each issue and describing the high-level policy implications.

Ageing and health care expenditure

In all wealthy countries increasing age is the most powerful direct determinant of health care expenditure: increasing age is associated with increased health care expenditure. Unless the models of health service provision change, the inevitable result of New Zealand's ageing population is that a greater proportion of the nation's wealth will be devoted to health at the expense of other areas of social expenditure.

Health care expenditure trends over past decades have been inexorable in New Zealand (as elsewhere); in 2009 about 10.3% of GDP was committed to health, up from 8% in 1999 (Ministry of Health 2012). In 2009 New Zealand ranked ninth out of twenty-nine OECD countries in relation to the proportion of its national wealth devoted to health care.

Age is not the only driver of increasing health care expenditure. Two other factors have a considerable influence: the increasing cost of health care technologies and ever increasing public expectations of the health care system. The net effect of these two major influences, along with ageing, is a steady increase in public (and private) health care expenditure with the concomitant pressure on other competing areas of social expenditure.

The political and policy implications of upward pressure on government's health budget are intense and are frequently played out in the media and in public debates. At the heart of these debates are the controversial and politically difficult

issues of prioritisation and rationing. New Zealand has a largely publicly funded health care system (around 80% of total health spending (Ministry of Health 2012), which places our country in a relatively strong position to keep downward pressure on health care expenditure through the annual budget setting process. Nevertheless, there is a strong need for well-led public debate about prioritisation and rationing of health care, and for strong political leadership on this issue backed up by robust, publicly accountable, policy frameworks for prioritisation.

Strong political leadership will be required also if New Zealand is to maintain its historically strong focus on equity of access to health care services. With increasing pressure on health care systems it is often the most vulnerable and those most in need who miss out.

Social and economic determinants of health

While age is the most powerful direct determinant of health care expenditure, it is the underlying social and economic conditions which drive patterns of morbidity and mortality across populations. For example, there is an easily-observable national-level relationship between wealth distribution and health distribution: the rule of thumb that poverty is bad for health applies to the vast majority of health outcomes.

Both at a national level and within communities income distributions in New Zealand have markedly increased since the mid-1980s. Along with this strong trend has been, in many cases, a widening of the health experience of population groups. For example, the life expectancy trend for Māori over the post-war decades shows a startlingly different trajectory compared with Pakeha including experiences post the 1980s which are markedly divergent (Blakely, Tobias et al. 2005).

The policy implications of the increasingly unequally-shared burden of disease in New Zealand link strongly to the values of society. For the past hundred-plus years New Zealand has maintained a reasonably strong social consensus around equitable (needs-based) access to health care. With the increasingly divergent health experiences of New Zealand's diverse population groups (for example, rich, poor, Māori, Pacific) the political challenges of maintaining the traditional equity-based social consensus will be magnified and it is possible that our health care system will become increasingly fractured along rich-poor lines.

Population distribution

The distribution of New Zealand's population across large metropolitan, urban, provincial and rural areas poses important challenges for the equitable provision of effective health services to communities. On the one hand Auckland presents the challenges associated with a large sprawling urban area with marked disparities between communities in terms of wealth and health. With ongoing population growth associated with the increasing concentration of economic and commercial activities in Auckland, there will be a tendency, already apparent, to centralise highly specialised and volume-dependent health care services in Auckland. This tendency may increase barriers to access for populations outside

Auckland and increase the country’s vulnerability in the event of a natural disaster affecting the Auckland area.

On the other hand, smaller communities elsewhere in New Zealand, many of which are relatively remote from urban centres, pose a different set of challenges. Access to health services in rural areas is limited and provided by individuals who often have a wide scope of practice, require generalist knowledge and experience a degree of professional isolation. These factors mean that rural residents often have to travel out of their immediate communities to gain specialist services which increases their isolation from family support and requires them to have access to their own transport.

The policy challenge will be to configure health services in such a way which meets the needs of all communities, small, large, urban and rural, which ensures optimal quality (noting that in the quality equation volume and access are often traded off against one another) and which reduces our national vulnerability to national disasters (i.e. services should not be overly concentrated in just a few large urban centres).

Blakely, T., M. Tobias, et al. (2005). "Widening ethnic mortality disparities in New Zealand 1981-99." Social Science & Medicine **61**: 2233-2251.
Ministry of Health (2012). Health Expenditure Trends in New Zealand 2000-2010. Wellington, Ministry of Health.