Health care systems in transition: New Zealand
Part I: An overview of New Zealand’s health care system
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The country and its people

New Zealand is located in the south-west Pacific Ocean, about 2000 km off the south-east coast of Australia. The country comprises two main islands plus a number of smaller islands with a combined land area similar to that of the United Kingdom. Of the 3.6 million inhabitants, 80 per cent of the population is of European descent, predominantly British or Irish; the indigenous Maori people and their descendants make up about 13 per cent of the population, and Pacific Island Polynesians with 4 per cent of the population comprise the third largest ethnic group. A recent wave of immigration from Asian countries is, however, rapidly reshaping the ethnic mix in some areas.

Although New Zealand is often perceived to be a rural country – possibly owing to the historical dominance of the agricultural sector in the economy – 80 per cent of the population now lives in urban areas, with 50 per cent concentrated in the four main cities. The rural population is widely dispersed. Although many farming areas are relatively affluent, other rural areas – particularly those with a high proportion of Maori – are characterized by unemployment, poor housing and poverty.

European settlement from the late eighteenth century had a devastating effect on the health of the Maori population. Infectious diseases – such as typhoid, tuberculosis and venereal diseases – took their toll, as did the introduction of alcohol and firearms. In spite of a recent narrowing in socio-economic and health status differentials between Maori and non-Maori, Maori still have a lower life expectancy, lower average incomes, higher unemployment and generally poorer health compared with non-Maori. Diseases such as obesity, cardiovascular disease and the complications of diabetes mellitus all occur more frequently amongst both Maori and Pacific Islanders compared with the rest of the population.

Central to New Zealand’s constitutional history is the Treaty of Waitangi, signed in 1840 between some Maori tribes and the British Crown, in which Maori people ceded sovereignty to the Crown in exchange for the guaranteed protection of their lands, forests, fisheries and cultural treasures, and the rights and privileges reserved for British subjects. It is widely accepted that the Treaty has not been honoured and that Maori ownership, rights and privileges have been steadily undermined. Recent efforts by the Government are slowly beginning to redress past grievances, and the Treaty is now central to race relations and to issues affecting the social and economic position of Maori, including the health system.

Since the mid-1980s, the Government has implemented a programme of rapid and significant economic and social reform, with a general trend towards a greater reliance on market mechanisms. Major initiatives have included the removal of industrial and export subsidies and the deregulation of industry, the restructuring of government departments, the reduction in and narrower focusing of welfare benefits and access to government-funded services, and the corporatization

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and privatization of state trading departments. The increased emphasis on market-based service provision also encouraged the restructuring of other government-funded services in the early 1990s, including housing, education and the health system.

The New Zealand health care system: an overview

The New Zealand health care system is predominantly (77 per cent) publicly funded, with around 91 per cent of this public funding raised through general taxation. Although there is no special social insurance levy, funding for accident-related injuries is raised separately through a compulsory state-run insurance scheme. Most private funding is out-of-pocket payments. Almost half of the population have some private health insurance but this accounts for only 6 per cent of total health expenditure. Private health insurance does not provide comprehensive cover and is most commonly used to claim reimbursement for primary care user charges, elective surgery in private hospitals and specialist out-patient consultations. Total expenditure has increased only marginally over the last decade although the proportion funded by the state has been falling gradually.

Since the Social Security Act of 1938, separate funding and development of primary and hospital-based services has existed. The original intention of the 1938 Labour Government had been to provide health services free at point of delivery for all subjects, regardless of income. However, opposition from the medical profession resulted in the development of privately owned fee-for-service primary medical services, with varying levels of subsidization, operating alongside a fully subsidized and government-owned public hospital service. Although this general structure still largely remains in place, changes are currently taking place.

In 1992 a new regime of subsidies and user charges for health services was introduced. The primary objective was to improve access for low-income groups by moving away from universal subsidies to a more directed regime. User charges were introduced for public hospital services for higher-income groups and subsidies for general practice services for higher-income adults were withdrawn entirely. The main group to benefit from the changes was low-income working adults. Welfare beneficiaries were also marginally better off. A number of adjustments have since been made to this new user-charge regime. Most significantly, the charges for in-patient hospital services were removed just 13 months after they had been introduced, largely because of strong public opposition, whereas charges for out-patient services have been retained. Eligibility for the higher subsidy levels was also extended to include more low-income families. In spite of these adjustments, anecdotal evidence suggests that the new financial regime has failed to overcome problems of financial barriers governing access to primary care for low-income groups.

Most primary services are delivered by general practitioners (GPs), who act as gate keepers to the public hospital system and the use of other subsidized health services such as laboratory tests, pharmaceuticals, physiotherapy and diagnostic imaging. A range of allied health professionals and voluntary organizations also provide primary health services, including midwives, independent nurse practitioners, public health nurses and the Plunket Society, which provides child health care.

A network of state-owned hospitals provides around 20,000 general, psychiatric and maternity beds (i.e. 5-6 beds per 1000 population). In addition, there are around 7000 private hospital beds, more than 75 per cent of which are geriatric or long-stay beds where patients are eligible for income- and asset-tested government subsidies. The remaining private hospital beds are used primarily for privately funded elective surgery. Doctors and other health professionals working in public hospitals are salaried. Most specialists also work part time as private consultants on a fee-for-service basis.

Recent changes

From July 1993, the public health system was restructured in line with the market-oriented reforms that had been introduced in the wider economy. The central features of this restructuring process were the separation of the purchaser and provider roles – both of which had previously been undertaken by 14 area health boards – and the reconfiguration of public hospitals into more business-like structures. The general tax-based financing arrangements, however, remained unchanged.

Four regional health authorities (RHAs) were set up to purchase all primary, secondary and tertiary health services, including disability support services. In effect, this means that all government funding for personal health services is now integrated into a single budget and that this budget is capped, including the previously open-ended fee-for-service primary care payments. The 14 area health boards were reconfigured into 23 crown health enterprises (CHEs) which enter into contracts with RHAs to provide services alongside private hospitals or other private providers. CHEs, like NHS trusts in the United Kingdom, are independent business entities, governed by a government-appointed board of
directors. Under the legislation, CHEs are required to act as successful and efficient businesses while exhibiting a sense of social responsibility. A National Advisory Committee on Core Health and Disability Support Services (now known as the National Health Committee) was established to advise the Minister of Health which personal health services should be purchased by the RHAs.

Negotiations are currently under way between RHAs and GPs and other primary care providers to develop mechanisms for purchasing primary care services. Many GPs have joined umbrella groups called Independent Practitioner Associations (IPAs) to negotiate contracts. Some of these groups, which range in size up to 300 members, have become budget holders for pharmaceuticals or laboratory tests. As RHA budgets are capped, many GPs are anticipating a move away from the current fee-for-service form of government subsidy towards capitation payments. However, some IPAs strongly support the continuation of fee-for-service payments for general practice services. Regardless of how the public subsidy component is paid to GPs, patient user charges are likely to remain in place for general practice services and pharmaceuticals.

Separate arrangements have been established for the provision of public health services – population-based services such as health education, promotion and disease prevention. Public health services have had a chequered history in recent years. Before 1983, they were centrally funded and organized by the Department of Health through a network of regional offices. The Area Health Boards Act of 1983 provided for the decentralization of these services to the 14 area health boards which were established progressively between 1983 and 1989. By 1989, the organization and provision of public health services had been decentralized although the Department of Health retained a regulatory function.

In 1993, public health services were effectively recentralized as part of the most recent reforms. The original proposal was to apply the purchaser-provider model through the establishment of an independent Public Health Commission (PHC), which would coordinate and purchase public health services, and a Public Health Agency, which would be the major provider of regionally based public health services. In the event, only the PHC was established. Its role was to provide policy advice to the Minister and to purchase public health services. The PHC contracted for services directly with independent service providers and indirectly with CHEs via RHAs.

During the first year after the reforms were enacted and implemented, a number of problems emerged. Confusion existed concerning the conflicting roles of

![Diagram of the health care system in New Zealand after recent modifications](http://jpubhealth.oxfordjournals.org/)

**FIGURE 1** The structure of the health care system in New Zealand after recent modifications. ¹Now known as the National Health Committee. ²Includes independent GPs, IPAs, a range of non-GP primary care providers, and diagnostic and pharmacy services. ³Includes rest homes, home support services, and a range of services provided by voluntary organizations.
the PHC as an independent policy advisor while being part and parcel of central government. There was also confusion about overlapping responsibilities and lines of accountability of the PHC and the Ministry of Health, previously known as the Department of Health. Service delivery problems arose as a result of poor service specification and of the unclear boundaries of responsibility between different government agents. It was also apparent that the Government sometimes felt uncomfortable with some of the issues raised by the PHC. For example, the PHC was critical of poor housing conditions which could be traced directly to changes in government housing policy. After some brief consultation with interested parties, the PHC was abolished on 30 June 1995. Its roles are now undertaken by a public health unit located within the Ministry of Health. The structure which has emerged following these and a number of other modifications to the original reformed structure is depicted in Fig. 1.

Analysis of the 1993 reforms and future developments

It is too early to make any overall judgement about the effect that the reforms have had either on the effectiveness or efficiency of health service provision or the health status of the population. Before the reforms, throughput of surgical services had been steadily increasing, and waiting lists also continued to increase; both of these trends have continued since the changes were introduced. Improved transparency of the CHEs' accounting systems has revealed that many of them are in financial difficulties and the Government has had to inject additional funds into the CHEs. Nevertheless, a number are closing or reducing services, especially relating to rural hospitals, and some have reduced staff numbers significantly. For the public, perceptions of the success of the reforms so far are probably derived mostly from commentaries in the media, most of which tend to focus on negative aspects such as hospital closures and waiting lists. From the patient’s perspective, most services remain largely unchanged.

To date, the focus of evaluation has been on the process itself rather than on the outcome of the reforms in terms of health indices. It is clear that the process itself has been more complicated, has required more modifications and has been more costly to implement than originally envisaged. This applies especially to public health services, where continuous restructuring has undermined staff morale and resulted in confusion and fragmentation of service provision.

Although the structure for personal health services was based upon the notion that providers would compete for contracts, for most services competitive purchasing has been minimal to date. Incumbent providers have usually been awarded contracts and few private hospitals have been successful in their bids. In part, this is because RHAs were required to purchase the same type and level of services in the first year to smooth the transition to the new system. It may also be because RHAs do not have sufficient information to make informed comparisons between the quality, cost and efficiency of services offered by alternative providers. Costings remain crude and there is no standard method for case-mix adjustment for hospitals.

On a more positive note, the contracting process itself has improved the accountability of providers and is encouraging the development of better information about the volume, quality and cost of services. The reforms have also opened up a number of opportunities which have yet to be developed to their full potential. In particular, the integration of funding for all personal health and disability support services opens up the opportunity to provide a more integrated health service and to improve efficiency and effectiveness by shifting resources across services and service providers. It is expected that the RHAs will move towards the development of more co-ordinated care through the expansion of various types of budget-holding arrangements.

Changes are also occurring with respect to services for Maori. Maori have consistently sought to gain autonomy in health services based upon constitutional equity arising from the Treaty of Waitangi. Although such autonomy remains little more than a dream, the new structure has opened up both dialogue and opportunities for Maori to gain better access to and control of health resources. For example, one RHA has negotiated a joint venture with Maori groups to jointly purchase services. New community based health groups which provide more acceptable and appropriate services for Maori are also slowly developing. Nevertheless, some commentators are of the opinion that autonomy cannot be achieved unless a separate Maori Health Authority with its own budget to purchase health services for Maori is established alongside the four RHAs.

A major concern of the reformed health care system in New Zealand is a lack of overall planning for the future. The focus of both the advisory committee on core services and the RHAs is currently on trying to establish service priorities. Questions revolve around what services should be purchased today, rather than what services are likely to be required in future years. The structure of New Zealand’s population is expected to change rapidly over the next 25 years.
Whereas the European population is ageing as the 'baby-boomers' of the 1950s are approaching retirement age, around 60 per cent of the Maori and Pacific Island population are less than 25 years old. This clearly has major implications for future service needs.

There is also a lack of planning with respect to routine implementation of new technology. RHAs are concerned with securing services which meet the health needs of their population. This gives CHEs and other service providers considerable choice as to how their services are provided, and evidence of the unnecessary duplication of technology is already beginning to emerge. In contrast, there is tight control over the subsidy on both existing and new drugs. The four RHAs have set up a joint venture company which decides which drugs should be listed on the pharmaceutical schedule and the price the Government will pay. As a monopoly purchaser, this company has strong bargaining power. However, it appears that the primary objective is cost containment of the drug budget rather than efficiency in its use. Little emphasis seems to be placed on the overall cost-effectiveness of drugs, or on the possibility that increased expenditure on drugs could reduce treatment costs elsewhere.

Containment of health care expenditure has in the past not been an overt concern in New Zealand. Nevertheless, before the reforms it was clear that cost containment was being achieved only by tight control of expenditure on public hospitals. Real expenditure on public hospitals was declining, capital was not being maintained and debts were mounting. In contrast, expenditure on primary health care was increasing at an average rate of 6 per cent per year. The integration of primary care into RHA budgets means that containment of public expenditure should be achieved if both RHAs and CHEs can remain within their budgets. The difficulty is that, as yet, the advisory committee on core services has been unable to provide RHAs with guidelines on what services they should purchase. Until there is some clarification both of the minimum level of services to be provided and the cost of these services, there is a danger that cost containment will be achieved at the expense of reasonable access to health services by the population.

References
4 Scott C. Reform of the New Zealand health care system. Health Policy 1994; 29: 25–40

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