HiT summary New Zealand

Introduction

Government and recent political history

New Zealand is a parliamentary democracy with a unicameral legislature. The country adopted a "mixed member proportional" voting system from 1993 that ushered in more frequent elections and coalition governments. The government in recent years has sought to address longstanding native Māori grievances, underpinned by recognition of the 1840 Treaty of Waitangi, signed by some Māori groups and the British Crown.

Population

The population numbered 3.79 million in 2001. The main ethnic groups include people of European descent mostly from the United Kingdom and Ireland (79.6%), Māori (14.5%), Pacific Island people (5.6%) and Asian (3.4%). New Zealand has a younger population than many western European countries with 23% aged below 15 years with higher fertility rates among Māori and Pacific Island populations.

Average life expectancy

Life expectancy is 80.4 years for women and 75.2 for men, comparable to European Union averages.

Leading causes of death

The crude death rate for all causes per 1000 population has decreased from 8.8 in 1970 to 7.2 in 1999. The five major causes of death are ischaemic heart disease, cerebrovascular disease (stroke), chronic obstructive pulmonary disease, lung cancer and colorectal cancer. Despite a significant improvement over the past four decades, Māori health continues to lag behind European New Zealanders, as does that of people from the Pacific Islands.

Recent history of the health care system

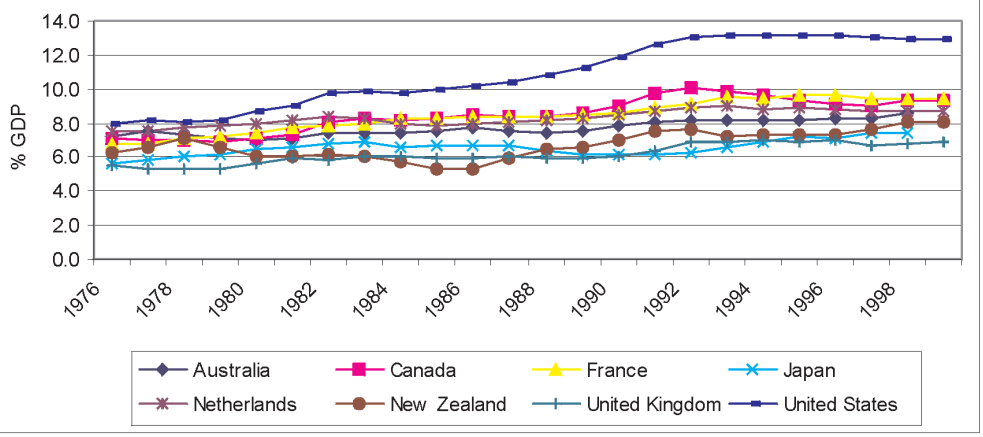
The New Zealand health sector has undergone four major phases of reform over the last two decades. In the 1980s, funding and service management was decentralized to 12 area health boards. In the early 1990s, the National government set up four regional purchasing authorities and 23 crown health enterprises (district health authorities) to function as commercial entities. The National/New Zealand First Coalition government in the late 1990s relieved the district health authorities of the requirement to make a profit and amalgamated purchasing into one central authority. The Labour/Alliance coalition elected in 1999 ended the purchaser/provider split by disestablishing the Health Funding Authority and creating 21 district health boards.

Reform trends

New Zealand governments in the 1990s went further than most countries in introducing market model practices into the health sector, including competition and a purchaser/provider split. However, at the end of the decade, the Labour/Alliance government decided that the "internal market" had not delivered significant improvements in effectiveness and efficiency. The government has returned responsibility to district boards for funding and partly providing health services, is improving equity of access to primary health care, and plans to strengthen its health partnership with Māori communities.

European Observatory on Health Care Systems
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 14 30
Telefax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

Fig. 1. Total health expenditure as % of GDP, New Zealand and selected OECD countries, 1976-1999



Source: OECD Health Data 2001

Health expenditure and GDP

New Zealand's total health care expenditure as a percentage of Gross Domestic Product (GDP) was only 5.2% in 1987, reflecting the depressed economy of the time, but rose steadily to 8.2% of GDP by 1998 (Fig. 1). New Zealand spends a similar amount on health care to an OECD country with a similar level of GDP.

Overview

More than other OECD countries, New Zealand implemented a series of radical health sector changes over the last decade, such that the population is said to be "weary and wary" of change. The Labour/Alliance government in recent reforms has reversed many market model practices of the last decade. New Zealand has preserved its largely tax-funded health care system and mixed model of service delivery and has increased the health budget. New Zealand health services generally are regarded as adequate in supply and of good quality, although the public are dissatisfied about waits for hospital elective surgery. Primary health care is being reorganized with the introduction of GP fund-holding groups.

Organizational structure of the health care system

The New Zealand health care system is funded mainly through general taxation supplemented by out-of-pocket payments and private health insurance. Patients meet some or all of the costs of primary health care and make co-payments for pharmaceuticals (with concession cards available for low-income patients), and receive free state hospital outpatient and inpatient services. The government retains overall responsibility for the health system but delivery is shared between the public, voluntary and for-profit sectors. Independent medical practitioners and specialists provide most ambulatory medical services, public hospitals provide most secondary and tertiary medical care, while the small private hospital sector specializes mainly in elective surgery and long-term care.

The Ministry of Health has national responsibility for policy formulation, monitoring, regulation and evaluation of the health system

(www.moh.govt.nz). After a reduced administrative role throughout the 1990s, the ministry is now responsible for funding district boards and monitoring health and disability service delivery.

The New Zealand Public Health and Disability Act 2000 created 21 district health boards covering geographically defined populations, which either deliver services themselves or fund other providers to do so. These autonomous authorities are allocated their own resources and are responsible to the Minister of Health for the health of their district populations, for setting their strategic direction, for appointing their chief executive, and for their own performance.

Community trusts provide or contract for health care for people in their local community, providing about 6% of primary care, including Māori health care groups, which number increased during the 1990s. Many iwi (tribe) and urban-based health organizations manage a range of health and disability services for enrolled populations, typically offering public health services, screening, primary care, well-child services and home support.

Planning, regulation and management

Consumers of health and disability support services are protected by legislation that regulates health professionals, therapeutic products, services and facilities, and consumer rights. The Ministry of Health exercises national policy and planning powers and lays out the government's goals and objectives on promoting the health of the population. The 2000 legislation requires the 21 district health boards to submit an annual plan to the Minister of Health detailing the services that will be funded in their area. Health care professionals are licensed by statutory boards, and the Ministry of Health licenses hospitals and other health-related and residential care facilities. Quality Health, established in 1993 as a non-profit organization, offers voluntary hospital accreditation. The New Zealand Health Strategy 2000 noted that while many quality initiatives are under way, a more coordinated approach is necessary.

Decentralization of the health care system

The New Zealand Public Health and Disability Act 2000 returned to a local system with the creation of 21 District Health Boards, which are responsible for both funding and providing health care in their districts. The independent sector has expanded over the last decade, via ventures with general practitioner associations, Māori groups and community trusts.

Health care financing and expenditure

The health care system is financed predominantly through general taxation (Pay as You Earn income tax and a Goods and Services Tax), and through the Accident Insurance Scheme (compulsory no-fault insurance) that accounts for about 4.5% of total health expenditure. In 1998/1999, 77.5% of health sector finance came from taxation, 15.9% from consumer out-of-pocket payments, and 6.2% from private insurance. The public share of healthcare funding has decreased over the last two decades from 88% in 1979/1980 to around 77% in 1994/1995 and thereafter, mainly because out-of-pocket consumer payments have increased.

Health care benefits and rationing

The National Health Committee in the early 1990s attempted to define what health services should be publicly funded, and although ultimately unsuccessful in determining exclusions, did define criteria for service priorities according to 'evidence-based' medicine.

Out-of-pocket expenditures account for 16% of health expenditures. Primary care is charged on a fee-for-service basis (with subsidies for low income earners) and treatment in public hospitals is free. Pharmaceuticals are free for inpatients

and people pay a maximum co-payment of NZ $15 per item on the Pharmaceutical Schedule from community-based pharmacies with children under six being exempt.

Government subsidies to patients for health care services and goods are flat rate (and thus not cost-indexed). General practitioners claim payment from the government on consultations with concession cardholders, which reduce the co-payment made by a patient. The government subsidies in 2001 were as follows: NZ $32.50 per visit for all children under six years (that originally covered the full cost but now has eroded); NZ $15 per visit for children aged 6–18 years (families without a concession card); NZ $20 per visit for children aged 6–18 years (family with a concession card); NZ $15 per visit for adults (over 18 years) with a concession card. In addition, maternity services largely are free. Over 40% of the New Zealand population hold concession cards, but perhaps another one quarter of eligible people do not, while people whose incomes are just above the eligibility threshold (another 5–10% of the population) face financial barriers in accessing primary care. Thus the government recently moved to change the funding basis for primary health care.

Complementary sources of financing

Private insurance is voluntary and largely unregulated. The schemes insure people against "gap" and "supplementary" costs but do not offer comprehensive health cover. About 33–37% of the population have private health insurance, down from an estimated 51% in 1990.

Health care expenditure

Total health care expenditure in constant prices increased steadily during the 1990s with a 3.8% annual average rise from a relatively low level. In the 1980s, New Zealand spent less on health for its population than many other OECD countries. Total health care expenditure as a percentage of GDP grew from 5.2% in 1970 to 7.1% in 1978 then fell steadily to 5.2% in 1987, then rose slowly but steadily between 1990 and 1997 despite efforts to contain costs, and by 1997/1998 was 8.2% of GDP.

Health as a share of the government budget rose from 10.1% in 1990 to 12.7% in 1997. In December 2001, a three-year cumulative funding package was announced that by 2004/2005 would be 21% above the 2001/2002 baseline.

About 60% of total health expenditure went on inpatient care in the early 1990s (the current share is unknown), which in OECD terms is a relatively high proportion, and in part may be due to the apparently large amount of ambulatory care provided through public hospitals.

Health delivery system

Health services in New Zealand are categorized in four groups, primary health care services, public health services, hospital and specialist medical and surgical services, and disability support services (since the latter come under the health portfolio).

Primary health care

Private general practitioners (GPs) provide most primary medical care and about two-thirds of GPs work in group practices. GPs act as gatekeepers since patients cannot access public secondary and tertiary services unless they are referred by their GP (except for accident and emergency services). Patients are free to choose their GP and are charged a fee for each visit although about 70% of consultations are subsidised in part or whole. Other primary care health professionals include independent midwife practitioners, practice nurses who work alongside general practitioners, and other community-based nurses.

General practice in New Zealand has undergone major changes since 1993, when GPs organized themselves into Independent Practitioner Associations to manage government budgets for pharmaceuticals and diagnostic tests and retained the savings. By 1999, over 80% of

GPs were members of these associations that ranged in size from several to over 300 physicians. From 2001, not-for-profit primary health organizations, based in large part on these associations, will manage patient capitation funds for enrolled patients with funds allocated by the district health boards.

Public health services

Public health services come under the district health boards, providing basic health protection services, such as water and food safety, and health promotion services such as anti-smoking programmes. Their employees include public health physicians and other health care professionals, as well as officers who monitor and enforce public health legislation. General practitioners and other primary care providers also provide prevention services for their patients, such as immunizations, as well as individual and group health education and promotion.

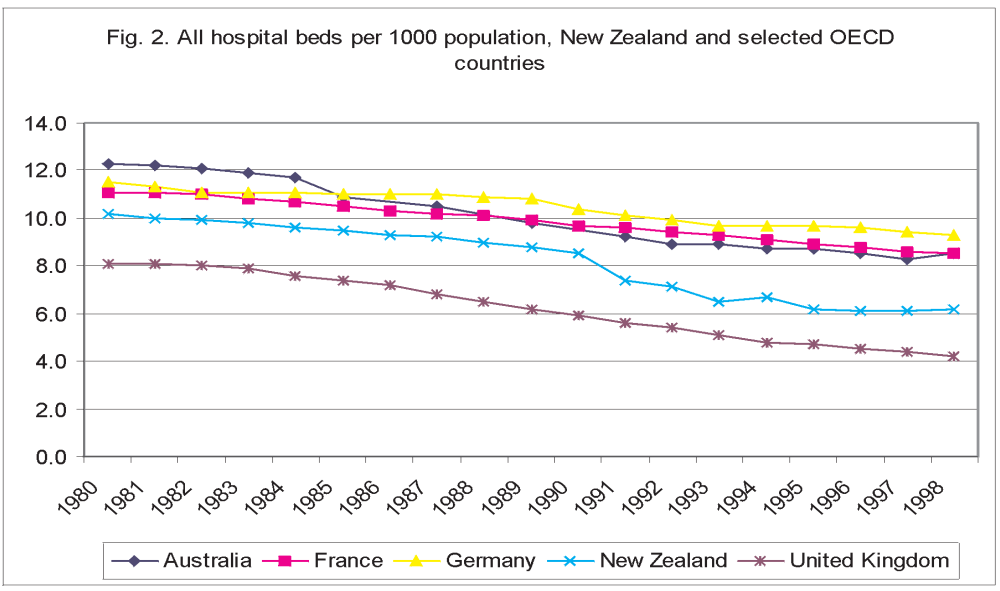
Secondary and tertiary care

Specialist physicians and surgeons provide ambulatory care either in community-based public or private clinics or in hospital outpatient departments. Most specialists are employed by public sector hospitals but many also maintain their own private practices.

New Zealand had 444 hospitals in 2001 with the 84 public sector hospitals containing 52% of the total bed stock. The numerous small private hospitals grew in bed capacity by 45% during the 1990s and concentrate mainly on elective surgery and long-term geriatric care. New Zealand has reduced its overall bed capacity by one quarter since 1980 (mainly public hospital beds). Time series statistics are not available for acute care beds in New Zealand, but in 1998 the country had 6.2 hospital beds per 1000 population; for example, fewer than Australia but more than the United Kingdom (Fig. 2).

One reason for the reduction in overall hospital beds was the shift of long-stay cases out of hospitals into either nursing homes or to treatment or care in the community. The reductions in acute care hospital beds are attributed to changes in patient management, more intensive treatment during shorter hospital stays, and more community-based treatment such

Fig. 2. All hospital beds per 1000 population, New Zealand and selected OECD countries



Source: OECD Health Data 2001

as day surgery. Clinical priorities have been introduced to manage waiting lists for elective surgery.

Discharges from acute care hospitals rose from 6.1 per 100 population in 1988/89 to 7.8 in 1999/2000 in line with upward trends in most OECD countries. The average length of stay in acute care hospitals in 1998 was 4.9 days, similar to the United Kingdom and Australia (Table 1). Data on the occupancy rate in New Zealand are only available around 1990 when the rate appeared low and hence inefficient.

Table 1. Inpatient utilization and performance in acute hospitals, New Zealand, EU and selected OECD countries, 1998

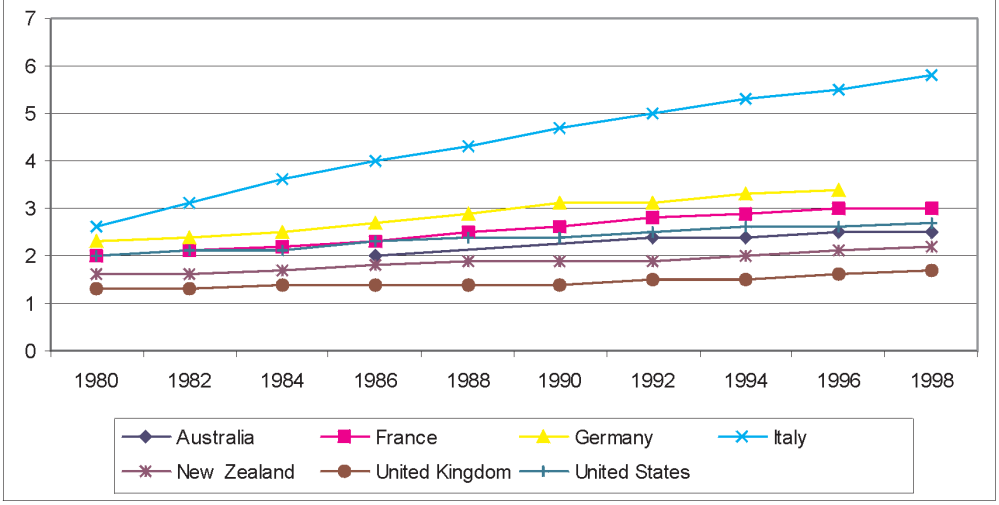
Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
New Zealand	–	–	4.9	–
Australia	3.9	15.8	6.2	68.5
EU average	4.2	17.1	8.2	77.0
Canada	3.1	9.9	7.0	–
United Kingdom	2.4	–	–	80.8
United States	3.1	11.8	5.9	63.4

Source: OECD Health Data 2001

Social and community care

Service providers include the government and the not-for-profit and for-profit private sectors. New Zealand overhauled its mental health services in the 1990s, closing large mental hospitals and moving care into the community, facilitated by new drugs and pushed by the movement to deinstitutionalize. In relation to disability services, funds and responsibilities were transferred from social welfare to the health portfolio from 1993, and most community-based services for younger people with disabilities are provided by not-for-profit agencies. Aged care is becoming more important with projected increases in the number and proportion of older people: thus the current policy aims to integrate health and social services in order to improve the delivery of care and to promote healthy ageing.

Fig. 3. Practising physicians per 1000 population, New Zealand and selected OECD countries



Source: OECD Health Data 2001

Human resources and training

New Zealand with 2.3 medical practitioners per 1000 population has fewer than Australia and some other OECD European countries (Fig. 3), and also has fewer general practitioners (0.83 per 1000 population in 2000) than some OECD countries. However, New Zealand has a relatively large supply of well-trained nurses, who undertake some work that in other countries is performed by physicians, having expanded their jurisdiction as midwives and as nurse practitioners with limited prescribing rights. Physicians are trained in six-year undergraduate courses and registered nurses in three-year tertiary-level courses. Training opportunities have been expanded for the mental health workforce and the Māori health care workforce.

Pharmaceuticals and health care technology assessment

Medsafe is the gatekeeper to the New Zealand market, charged with ensuring that medicines are safe and effective. The Pharmaceutical Management Agency, PHARMAC, decides what drugs should be listed on the Pharmaceutical Schedule, based on evidence of effectiveness, and decides the price that government is prepared to pay the supplier, thus wielding considerable bargaining power as a monopoly purchaser. PHARMAC is credited with achieving substantial cost containment, since pharmaceutical expenditure remained at around 12% of total health care expenditure during the 1990s. Demand side controls over prescribing have been less successful, although consumer co-payments are intended to curb consumer demand and contain expenditure.

Service providers (currently the district health boards) decide the purchase of new technology such as equipment, but given the many structural changes, there has been little overall planning or regulation of new technologies apart from drugs.

Financial resource allocation

The Ministry of Health negotiates the health budget with the Treasury, the final appropriation being determined in the Vote: Health budget line, with the non-departmental District Health Board block being ring-fenced. Ring fencing protects some other funds also, such as public health and disability support services, but this may change as funds are devolved to District Health Boards. The health budget proposal takes account of increased costs for existing services as well as the costs of any new initiatives using a "sustainable funding path" formula.

Funding structures and processes have changed several times over the last decade. State health funds now are allocated to the 21 district health boards in a three-year funding package, based on historical provider contracts. However, the intention is to move to population funding, based on the number of people living in each region, the ethnicity and age structure, and population characteristics that affect the need for health and disability services.

Payment of hospitals

Hospitals over the last two decades had a series of funders and were paid via different methods: historical budgets, capped price/volume contracts for procedures, and case weights for each patient. Currently, hospitals are given a fixed operating budget for the year, according to patient case weights (diagnosis related groups), which set a price/volume schedule based on the previous year's throughput. While overspending is not technically covered, deficit funding or short-term equity adjustments often are made.

Payment of physicians

Most public sector hospital specialists are paid a salary, while private doctors are paid primarily on a fee-for-service basis. General practitioners receive their income from several sources:

government subsidies for consultations (received as fee-for-service subsidies by 85% of GPs), capitation payments (received by 15% of GPs), and patient fees. The current strategy is to make patient capitation grants to GPs in Primary Health Organizations to look after an enrolled patient population. The advantages for GPs are a predictable cash flow and greater flexibility in delivering services, while the government gains greater overall budgetary control and hopes to improve patient access as well as the quality of care.

Health care reforms

Health sector reforms throughout the 1990s concentrated upon structural and microeconomic changes intended to improve allocative efficiency across regions and to produce more cost-efficient services, while the quasi-market model was seen as the answer to cost and demand pressures as well as offering greater consumer choice. The Labour/Alliance government elected in 1999, however, decided that the "internal market" had not delivered significant improvements in efficiency and quality of care, while the public had lost confidence.

Responsibility for health care funding and delivery has now been devolved to 21 district health boards, which each cover at least one large public sector hospital, and thus face the old problem of the continuing dominance of hospitals within the health care system. Many District Health Boards are in deficit and there is also a perception that hospitals are under-funded causing long waits for elective surgery. The largely elected District Health Boards are a more democratic method of decision-making, despite the danger they may be captured by special interest groups. The challenge will be to balance the needs of special interest groups against the population needs identified in assessment exercises.

The new strategy for primary health care has introduced patient capitation funding via the primary health organizations although the precise mechanism still are being sorted out. Primary health care appeared to be under-funded and under-used compared to hospital care, and the intention is to improve quality and reduce financial barriers for low-income people.

Quality of care is a current policy priority with initiatives planned to promote clinical excellence. There is no evidence as to whether quality of care improved or faltered during the 1990s and there are few outcome measures in place to evaluate hospital or physician performance. As in other countries, more emphasis is being placed upon the difficult tasks of evaluating policy changes and health outcomes.

Conclusions

New Zealand has reaffirmed a commitment to equity in health care through its mainly tax-funded health care system, has increased the health care budget, and has introduced capitation funding for primary health care, the intention being to reduce the burden of out-of-pocket payments upon patients. The emphasis now is upon collaboration not competition between health care providers. Gains made during the 1990s are being continued such as a fairer allocation between geographic regions and efforts to reduce social inequalities by increasing funds to Māori providers.

Māori health care remains a policy priority and Māori claims for more say over their own health care are linked to the political goals of indigenous people for greater power in their own land. Despite the continued disparities in health, there have been significant gains for Māori health over the last decade, in addition to a growth in the number of independent Māori providers. It is still too early to assess, however, whether Māori-provided health services provide better quality care and better health outcomes.

HiT summary

New Zealand

The New Zealand health care system has embarked upon a difficult phase of reform. The new policies have retained the impetus to greater cost-effectiveness and have returned to decentralized management structures. Health care providers are weary of change and the public is anxious about the future. The citizens of New Zealand, as well as policy-makers in other countries, will follow with interest the developments in establishing a twenty-first century health care system for New Zealand.

The Health Care Systems in Transition profile on New Zealand was written by Sian French and Andrew Old of the New Zealand Ministry of Health and by Judith Healy, European Observatory on Health Care Systems. Gillian Durham of the New Zealand Ministry of Health and Phillip Davies of the World Health Organization provided further assistance.

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The full text of the HiT can be found in *www.observatory.dk.*

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.