New Zealand Health System Review

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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with an international editor. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a HiT profile.

HiT profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems. They can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences between policy-makers and analysts in different countries implementing reform strategies; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are drawn from a number of different sources, including the World Health Organization (WHO) Western Pacific Country Health Information Profiles, national statistics offices, the International Monetary Fund (IMF), the World Bank, and other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.
A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions, so that these profiles can be used to inform comparative analysis of health systems. The HiT profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to the Asia Pacific Observatory on Health Systems and Policies [email: apobservatory@wpro.who.int]. HiT profiles and HiT summaries are available on the Asia Pacific Observatory’s web site. ¹

¹ Asia Pacific Observatory on Health Systems and Policies: www.wpro.who.int/asia_pacific_observatory
Acknowledgements

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This HiT draws upon the previous edition from 2001, written by Sian French and Andrew Old, and edited by Judith Healy.

This HiT is a collaborative activity of the Asia Pacific and European Observatories on Health Systems and Policies: the HiT was initiated by the European Observatory and finalized under the guidance of the Asia Pacific Observatory. Both observatories are grateful to Toni Ashton, Peter Davis, Judith Healy and the New Zealand Ministry of Health for reviewing the report.

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# List of abbreviations

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<td>ACART</td>
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<td>ACC</td>
<td>Accident Compensation Corporation</td>
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<td>ADD/ADHD</td>
<td>Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder</td>
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<td>AHB</td>
<td>Area Health Board</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ALOS</td>
<td>Average Length of Stay</td>
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<tr>
<td>APEC</td>
<td>Asia–Pacific Economic Cooperation</td>
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<td>APO</td>
<td>Asia Pacific Observatory on Health Systems and Policies</td>
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<td>AR</td>
<td>Active Review</td>
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<td>ARF</td>
<td>Acute Rheumatic Fever</td>
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<td>ASR</td>
<td>Age Standardized Rate (of diseases)</td>
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<td>aTT</td>
<td>Actual Treatment Threshold</td>
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<td>CAM</td>
<td>Complementary and Alternative Medicine</td>
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<td>CCMAU</td>
<td>Crown Company Monitoring Advisory Unit</td>
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<td>CDA</td>
<td>Combined Dental Agreement</td>
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<td>CHE</td>
<td>Crown Health Enterprise</td>
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<td>CIA</td>
<td>Central Intelligence Agency</td>
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<td>CIC</td>
<td>Capital Investment Committee</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CPAC</td>
<td>Clinical Priority Assessment Criteria</td>
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<td>CSC</td>
<td>Community Services Card</td>
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<td>CT</td>
<td>Computer Tomography (scanner)</td>
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<td>Child and Youth Mortality Review Committee</td>
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<td>DCNZ</td>
<td>Dental Council of New Zealand</td>
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<td>DHB</td>
<td>District Health Board</td>
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<td>DHBNZ</td>
<td>District Health Boards New Zealand</td>
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<td>DHBSS</td>
<td>DHB Shared Services</td>
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<td>ED</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>EECA</td>
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<td>ESPI</td>
<td>Elective Services Patient Flow Indicator</td>
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<td>ESR</td>
<td>Institute of Environmental Science and Research Limited</td>
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<td>EU</td>
<td>European Union</td>
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<td>FCTC</td>
<td>Framework Convention on Tobacco Control (WHO)</td>
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<td>FPC</td>
<td>Family Planning Clinic</td>
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<td>FPP</td>
<td>First-Past-the-Post (Electoral System)</td>
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<td>FSA</td>
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<td>FTE</td>
<td>Full-Time Equivalent</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GP</td>
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<td>General Practice New Zealand</td>
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<td>Hospital and Health Services</td>
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<td>Hib</td>
<td>Haemophilus influenzae type B</td>
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<td>HiT</td>
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<td>HIV</td>
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<td>HP</td>
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<td>Human papillomavirus</td>
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<td>High Use Health Card</td>
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<td>ICD-10</td>
<td>International Classification of Disease, 10th edition</td>
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<td>IDP</td>
<td>Indicator of DHB Performance</td>
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<td>IEP</td>
<td>Individual Education Programme</td>
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IMF  International Monetary Fund
IP  Individual Programme
IPA  Independent Practitioner Association
IPAC  Independent Practitioner Association Council
IRD  Inland Revenue Department
IT  Information Technology
ITU  International Telecommunication Union
LMC  Lead Maternity Carer
MACCAH  Ministerial Advisory Committee on Complementary and Alternative Health
MCOA  Multi-class Output Expense Appropriation
Medsafe  New Zealand Medicines and Medical Devices Safety Authority
MMP  Mixed Member Proportional (representation system)
MOH  Ministry of Health
MP  Member of Parliament
MPDS  Māori Provider Development Scheme
MRI  Magnetic Resonance Imaging
MSD  Ministry of Social Development
NA  Data Not Available (in tables)
NASC  Needs Assessment Service Co-ordination
NCSP  National Cervical Screening Programme
NEAC  National Ethics Advisory Committee
NGO  Nongovernmental Organization
NHB  National Health Board
NHC  National Health Committee
NHEP  National Health Emergency Plan
NHI  National Health Index
NHRMC  Australian National Health and Medical Research Council
NIR  National Immunization Register
NMDS  National Minimum Data Set
NRL  National Radiation Laboratory
NSU  National Screening Unit
NZALB  New Zealand Artificial Limb Board
NZBS  New Zealand Blood Service
NZDep  New Zealand Deprivation Index
NZPHDA  New Zealand Public Health and Disability Act 2000
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<td>NZPSHA</td>
<td>New Zealand Private Surgical Hospitals Association</td>
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<td>NZREX</td>
<td>New Zealand Registration Examination</td>
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<td>ODI</td>
<td>Office of Disability Issues (MSD)</td>
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<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OHSA</td>
<td>Service Agreement for Children and Adolescents</td>
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<td>PAYE</td>
<td>Pay as You Earn (income tax)</td>
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<td>PBFF</td>
<td>Population-Based Funding formula</td>
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<td>PHARMAC</td>
<td>Pharmaceutical Management Agency</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>PHCS</td>
<td>Primary Health Care Strategy</td>
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<td>PHO</td>
<td>Primary Health Organisation</td>
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<td>PHU</td>
<td>Public Health Unit</td>
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<td>PLT</td>
<td>Permanent and Long-Term</td>
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<td>PMMRC</td>
<td>Perinatal and Maternal Mortality Review Committee</td>
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<td>POMRC</td>
<td>Perioperative Mortality Review Committee</td>
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<td>PPP</td>
<td>Purchasing Power Parity</td>
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<td>RHA</td>
<td>Regional Health Authority</td>
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<td>SDSA</td>
<td>Special Dental Services for Children and Adolescents</td>
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<td>SIA</td>
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<td>Service Planning and New Health Intervention Assessment</td>
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<td>State Services Commission</td>
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<td>Transitional Health Authority</td>
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<td>Treatment Threshold</td>
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<td>TRIPS</td>
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<td>VAT</td>
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<td>Very Low Cost Access</td>
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<td>WAVE</td>
<td>Working to Add Value through E-information</td>
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<td>WFA</td>
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<td>WHO</td>
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<td>WIEE</td>
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Abstract

New Zealand has a predominantly tax-funded health system, providing universal coverage. The population enjoys high health status overall, but with significant inequalities in Māori and Pacific health.

Since the 1980s, there have been five major health system reforms. Currently, a central Ministry of Health (MOH) oversees the health system, while 20 District Health Boards are responsible for planning and funding health services for their geographical areas. There are no user charges for inpatient or outpatient services in publicly owned hospitals. Primary health care (PHC) is provided through Primary Health Organisations (presently 36) that receive capitation funding for their enrolled populations, and work with general practices and other providers to deliver comprehensive PHC in the community. Patients may pay user fees for PHC services, although most children under six years of age pay no fees.

The Pharmaceutical Management Agency (PHARMAC) manages the New Zealand Pharmaceutical Schedule and negotiates the purchase of drugs from suppliers, successfully controlling supply-side expenditure. A recently reformed National Health Committee is now responsible for strengthening assessment of new technologies and services to promote the delivery of a cost-effective mix of services in New Zealand.

The Accident Compensation Corporation (ACC) is a comprehensive, social insurance, no-fault, personal injury scheme which funds treatment, rehabilitation and compensation for people who are injured in New Zealand. It sits alongside the tax-funded health system, and can fund a wider range of services, raising concerns over equity of access between those whose health condition is due to illness and those receiving services because of accidents.

Current challenges for the health system include reducing inequalities in health, managing noncommunicable diseases and chronic conditions, reducing waiting times, improving productivity, and ensuring greater integration and coordination of services within and between primary and secondary care, and intersectorally with other social services.
Executive Summary

Introduction

New Zealand is a Pacific island nation of 4.49 million people, predominantly of New Zealand European ethnicity (68%), with significant Māori (15%), Pacific island (7%) and Asian (9%) populations. About 20% of the population is aged 0–14 years, while the proportion of the population aged over 65 years (13%) is growing slowly.

New Zealand is heavily reliant on foreign trade and, in common with the rest of the world, has been experiencing a period of economic downturn since 2008. In addition, the economy has been affected by two major earthquakes in 2010 and 2011 centred around the country’s second largest city, Christchurch.

New Zealand is a democracy with a parliament elected every three years under a Mixed Member Proportional (MMP) representation system. The National Party (centre-right) leads the current coalition government. Local government consists of a large number of regional and local territorial authorities.

New Zealanders generally enjoy a high health status by international comparisons. Current life expectancy is about 82 years for women and 78 years for men (2009 data). The primary causes of morbidity and mortality are noncommunicable diseases. Māori and Pacific island peoples’ health status is lower overall than that of New Zealanders of European ethnicity.

Organization and governance

New Zealand has a predominantly publicly funded, universal coverage health system with services provided by public, private and nongovernmental sectors. The Minister of Health has overall responsibility for the health and disability system, and the Ministry of Health (MOH) is the main advisory body to the government on policy issues. Other government agencies also contribute to health-related activities, including the Ministry of Social Development (through the
provision of some benefits), Te Puni Kōkiri (the Ministry of Māori Development), the Ministry of Pacific island Affairs, the Office for Disability Issues and the Accident Compensation Corporation (ACC).

Twenty District Health Boards (DHBs) are responsible for planning and funding health services for their geographical areas. They are governed by boards of elected and appointed members that are accountable to the Minister of Health. They are required to undertake formal strategic planning processes and, in doing so, to cooperate with neighbouring DHBs.

The National Health Board (NHB) was established in November 2009 as a business unit within the MOH with responsibilities for funding, monitoring and planning of DHBs; the planning and funding of designated national services (including DHB regional planning); stronger alignment of service, capital and capacity planning; strengthening and accelerating the linkages among information technology (IT), workforce and facilities capacity investment; and supporting the government’s initiative to reduce bureaucracy.

Since 2001, primary health care has been coordinated through primary health organisations (PHOs) (currently 31) which receive capitation funding for their enrolled populations. Patients are free to enrol with a general practitioner (GP) of their choice; the GP then chooses which PHO to join. Patients have a choice of accessing publicly funded or privately funded secondary care services, although this may be limited by availability in some areas. A range of Māori and Pacific health providers also offer primary health care and health promotion services.

Since 1996, New Zealand has had a Code of Health and Disability Services Consumers’ Rights, and the office of the Health and Disability Commissioner investigates complaints, along with health practitioners’ professional bodies.

Health and disability services (including medical, mental health, surgical and obstetric services, aged care facilities, and other health-related services) are regulated by the Health and Disability Services (Safety) Act 2001 and associated regulations. These set standards, provide for certification, and establish a framework for the monitoring of compliance. Health providers are required to demonstrate compliance with the relevant standards in order to gain and retain their accreditation.
The accreditation process for health professionals is governed by the Health Practitioners Competence Assurance Act 2003. The 16 authorities created under the Act are responsible for overseeing practitioners of a particular profession or professions, including their registration.

**Financing**

New Zealand finances health care primarily through government sources (83.2% in 2010, of which 8.4% comes from the ACC and almost all the remainder from general taxation), with the balance coming from direct payments by service users, private health insurance premiums and a small contribution from nonprofit organizations. In 2010, New Zealand ranked 12th in the Organisation for Economic Co-operation and Development (OECD) for health expenditure as a percentage of GDP at 10.1% (slightly above the OECD average of 9.5%). Health expenditure as a percentage of GDP rose from 6.8% in 1990 to 10.1% in 2010. However, New Zealand health expenditure per capita at USNZ$ 3022 PPP is lower than the OECD average (USNZ$ 3268).

Total appropriations for health spending in the 2013–2014 Crown (government) Budget are NZ$ 14 655 million, an increase of NZ$671 million or 4.8% over actual expenditure in 2012–2013. Most health services funding goes to DHBs (80%), with the remainder spent on national services purchased directly by the MOH.

The New Zealand health care system provides universal access to a broad set of health services; in addition, about 38% of adults hold some supplementary private health insurance (representing 4.9% of total health expenditure). The MOH funds 20 DHBs through a population-based funding formula and DHBs then fund a range of providers through service agreements as well as having their own hospital services. Outpatient and inpatient hospital services, including maternity services, are free. Following the introduction of The Primary Health Care Strategy in 2001, capitation funding has replaced fee-for-service funding of general practice, but patients continue to pay additional fees, though these have generally reduced. Most prescriptions have a co-payment of NZ$5 per item. Basic dental services are free for children; adult dental care and optometry are paid for privately. Long-term care is funded through both public and private mechanisms.
The state-run ACC provides injury compensation through a fully comprehensive, no-fault insurance scheme. ACC is funded through employer, employee, self-employed and car-licensing levies. It also provides funding to the MOH for accident-related care costs incurred by public hospitals and pays private providers for approved treatment for accident-related care.

**Physical and human resources**

The Health Capital Budget is a capped funding provision for new debt and equity from which DHBs and the MOH capital expenditure requirements can be funded. All DHBs need to maintain an asset management plan and to report annually on capital intentions through the District Annual Planning process. All the DHB asset management plans are consolidated centrally to inform a National Asset Management Plan. Prioritizing capital funding and investment in the health sector and advising the Ministers of Health and Finance on these matters is now the role of the Capital Investment Committee (CIC), a part of the NHB.

Medical equipment and devices are regulated for use in New Zealand. DHBs are responsible for purchasing the equipment they need. In 2010, New Zealand had 10.5 Magnetic Resonance Imaging (MRI) units per million population and 15.6 Computer Tomography (CT) scanners per million population (both lower than the average among OECD countries).

New Zealand hospitals have well-developed IT systems, and GP practices are also highly computerized. Electronic messaging is extensively used, including for sending referrals, payment claims, laboratory and pathology results, and hospital discharge summaries. Infrastructure planning of IT is now a role of the NHB. In 2010, the National Health IT Board (a sub-committee of the NHB) produced a National Health IT Plan, which aims to have electronic ‘virtual health’ records developed by 2014.

In 2010, there were 2.6 physicians per 1000 population (below the OECD average of 3.1) and 10 nurses per 1000 population (above the OECD average of 8.7). New Zealand has the highest proportion of migrant doctors among OECD countries and one of the highest for nurses: 52% of New Zealand’s doctors and 29% of its nurses are foreign-born; 36% of New Zealand’s doctors and 23% of its nurses are foreign-trained. New Zealand also has high expatriation rates (health professionals born in New Zealand and working overseas): the third highest expatriation
rate among OECD countries for doctors (28.5%) and the second highest expatriation rate for nurses (23%). Currently (2013), there are shortages of medical practitioners including some specialists such as psychiatrists, shortages of mental health workers, and there are long-standing problems in attracting professionals to rural areas and retaining them.

Gender representation in the health workforce varies significantly depending on the profession. Women make up 93% of nurses, 80% of physiotherapists, and 71% of psychologists, but only 40% of the medical practitioner workforce, 45% of GPs and 29% of dentists. Māori and Pacific people are markedly under-represented among health professionals.

There are two universities that train doctors (a six-year undergraduate course). Registered nurses are trained in three-year tertiary-level courses that are offered in both universities and polytechnics. Nurse practitioners undertake advanced training and may have prescribing rights within their specialist field. New Zealand also has Enrolled Nurses who undergo an 18-month training programme and must practise under the direction and delegation of a registered nurse or nurse practitioner.

**Provision of services**

Public health services in New Zealand are largely provided by DHBs through 12 DHB-owned Public Health Units, including environmental and communicable disease control, health promotion and preventive services.

Since 2001, primary health care (PHC) has been coordinated through Primary Health Organisations (PHOs) which receive capitation funding for their enrolled populations, and which contract GP practices and other providers to deliver PHC services. GPs can also charge patient co-payments.

New Zealand has a lower average ratio of medical practitioners and a higher average ratio of nurses for its population compared to other OECD countries. However, the 2011–2012 New Zealand Health Survey found 27% of adults and 20% of children had had an unmet need for PHC in the previous year.

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. Hospital outpatient
and inpatient services are mainly provided by public hospitals that are
owned and administered, or funded by, the DHBs. There are no charges
for inpatient or outpatient treatment in public hospitals. Patients are
prioritized for access to publicly funded elective services.

Mental health care is largely community- and outpatient-based. Maternity
services are provided through a Lead Maternity Carer, 75% of whom
are midwives. Basic dental care is free for children under 18 years, but
there is limited publicly funded dental treatment for adults, other than
for emergencies. There are two main providers of ambulance services,
staffed with paramedics and volunteers. Many forms of complementary
and alternative care are available in New Zealand.

The Pharmaceutical Management Agency (PHARMAC) manages the
Pharmaceutical Schedule and negotiates the purchase of drugs from
suppliers. The Medicines and Medical Devices Safety Authority (Medsafe)
administers legislation and regulations about medicines and therapeutic
products.

The ACC is a comprehensive, government-funded no-fault personal injury
scheme that funds treatment, rehabilitation and compensation for people
who are injured in New Zealand.

New Zealand’s health system is now also responsible for services to
people with disabilities. The Ministry of Health funds services for those
aged under 65 years, while DHBs fund services for those 65 years and
over. Many private for-profit and not-for-profit providers deliver these
services.

**Principal health reforms**

During the 20th century, the New Zealand Government gradually
picked up the overall financing of hospitals which were progressively
amalgamated into larger units as hospital care became more
technologically driven and birth rates fell. The first Labour government’s
(1935–1938) aim of a comprehensive and integrated public health care
system was never fully achieved, with compromises including fee-for-
service funding for independent GPs; user charges, which rose over time
as subsidies did not keep pace with costs (raising concerns about equity
of access); and hospital specialists able to practise privately. Health
funding and service delivery continued to be fragmented.
Since the 1980s, the New Zealand health system has undergone a series of reforms. From 1984, fourteen Area Health Boards (AHBs) were established, funded on a population basis and responsible for funding and providing secondary and tertiary health care and public health services (PHC funding remaining with the Department of Health). AHBs became increasingly accountable to central government, for example, through ministerial appointments to governing boards, contractual requirements and performance targets.

In the early 1990s, a National Party government introduced separation of funding and provision of services with four Regional Health Authorities responsible for purchasing all personal health and disability services for their regional populations from both public and private providers. Twenty-three public Crown Health Enterprises (CHEs) ran hospitals, community and public health services as commercial entities. Other developments included the establishment of the government’s community drug-buying agency, PHARMAC, the formation of Independent Practitioner Associations of GPs to facilitate collective contracting, growth of Māori health providers and services, and deinstitutionalization (particularly of mental health and disabled service users), with growth in the role of the private sector in delivering community-based services. However, implementation of these reforms was costly and aspects were unpopular with both the public and clinicians.

In 1998, a single Health Funding Authority was formed to purchase services. CHEs became Hospital and Health Services (HHSs) which were no longer required to make a profit. These changes were short-lived as a Labour–Alliance coalition government elected in 1999 introduced further reforms, returning to a model similar to that of the 1980s with AHBs.

The New Zealand Public Health and Disability Act 2000 introduced 21 (now 20) majority locally elected DHBs, responsible for planning and purchasing or providing services for their region. Since 2002, PHOs (currently 31) have been established to coordinate PHC services for an enrolled population, funded on a capitation basis. Significant new funding has reduced user charges and improved patient access in PHC.

Recent reforms have concentrated on increasing care coordination and integration in the health system. The National Party-led government elected in 2008 has focused on increased ‘frontline’ services and reduced bureaucracy. It has implemented a new National Health Board
(advising the Minister of Health) to plan and fund national health services, and a Shared Services Agency to undertake administrative and support services on behalf of DHBs to reduce duplication. It has sought improved collaboration between DHBs and reductions in the numbers of PHOs (down from over 80 to 31), and is seeking ‘better, sooner, more convenient’ services, in particular focusing on new arrangements for delivering PHC services and shorter waiting times for assessment and treatment in elective services.

**Assessment of the health system**

The New Zealand Public Health and Disability Act (2000) sets the strategic direction and goals for the health and disability sector in New Zealand. The Act requires the responsible ministers to develop overall health and disability strategies for the country, which currently include The New Zealand Health Strategy (2000), The New Zealand Disability Strategy (2001), The Primary Health Care Strategy (2001), and He Korowai Oranga: Māori Health Strategy (2002). The current government (elected in 2011 for the 2011–2014 period) is focusing on six specific health targets, along with better public services, clinical integration, financial management and sustainability, and ensuring quality.

The MOH reports annually on the state of public health in New Zealand. The 2012 report showed continuing improvement in life expectancy and health expectancy; decreases in the rates of death from cancer and cardiovascular disease; relatively stable levels of obesity in children, but a continuing rise in adult rates; increasing immunization rates; and a continuing reduction in smoking rates. However, in all cases, Māori (and, where reported, Pacific) health outcomes were poorer than non-Māori. This inequality has been decreasing at least in life expectancy, but remains a focus for improvement throughout the New Zealand health system.

Overall, New Zealanders have very good coverage of their health care needs through public health services. User co-payments for PHC and pharmaceuticals have been regularly identified as a barrier to access in the past. These charges have been reduced by additional government funding made available since the introduction of The Primary Health Care Strategy, although cost is still a barrier to accessing PHC for some people.
New Zealand has a range of measures of people’s experiences with the health system. Available data (such as the Commonwealth Fund surveys) show that the New Zealand public is somewhat satisfied with the public health system overall. The New Zealand Health Survey shows high levels of satisfaction with aspects of PHC services; however, Asian, Pacific and Māori adults and those in the most deprived areas were less likely to report positively about their treatment. More work is needed to systematize the available measures, however, and to better understand the basis for New Zealanders’ views on their health services.

New Zealand has been paying particular attention to better managing waiting lists and reducing waiting times since 1995. The focus for elective surgery is on balancing treatment with available resources and ensuring that those who can be treated are treated within six months of assessment (reducing to four months by the end of 2014), using priority-setting tools. However, there are major gaps in our understanding of access to elective services, including a lack of information about the number of people who are returned to their GP for ongoing care as they do not reach the agreed thresholds for treatment; changes over time in the actual thresholds; and the actual times that people wait.

The Health and Disability Services (Safety) Act 2001 aims to promote the safe provision of health and disability services to the public. The Health Quality and Safety Commission New Zealand, established in December 2010, is responsible for assisting both public and private providers across the whole health and disability sector to improve service safety and quality, and therefore improve outcomes for all service users. Performance indicators are used in both primary and secondary care to assess PHO and DHB performance against set targets. The results of DHB performance targets and PHO Performance Programme targets are publicly available on the MOH web site. Generally, performance is improving over time, but significant differences in performance between DHBs are evident.

**Conclusion**

Overall, New Zealanders have a high health status, but significant inequalities, particularly in Māori and Pacific island peoples’ health, must continue to be addressed. Managing the growing burden of noncommunicable diseases and chronic health conditions is the current challenge for the health system, along with greater integration and coordination of services.
Chapter 1: Introduction

Chapter summary

New Zealand is a Pacific island nation of 4.49 million people, predominantly of New Zealand European ethnicity (68%), with significant Māori (15%), Pacific island (7%) and Asian (9%) populations. About 20% of the population is aged 0–14 years, while the proportion of the population aged over 65 years (13%) is growing slowly.

New Zealand is heavily reliant on foreign trade and, in common with the rest of the world, has been experiencing a period of economic downturn since 2008. In addition, the economy has been affected by two major earthquakes in 2010 and 2011 centred around the country’s second largest city, Christchurch.

New Zealand is a democracy with a parliament elected every three years under a Mixed Member Proportional (MMP) representation system. The National Party (centre-right) leads the current coalition government. Local government consists of a large number of regional and local territorial authorities.

New Zealanders generally enjoy a high health status by international comparisons. Current life expectancy is about 82 years for women and 78 years for men (2009 data). The primary causes of morbidity and mortality are noncommunicable diseases. Māori and Pacific island peoples’ health status is lower overall than that of New Zealanders of European ethnicity.
1.1 Geography and sociodemography

Figure 1.1 Map of New Zealand

New Zealand is situated in the South Pacific Ocean, south-east of Australia. The three main islands (North Island, South Island and Stewart Island) cover an area of 270 000 km², comparable to the size of Japan or the British Isles. New Zealand or Aotearoa (in Māori – ‘land of the long white cloud’) is more than 1600 km long with a temperate climate, although regional differences exist. New Zealand has 4.49 million inhabitants (2012 estimate). The capital city is Wellington (population about 180 000), but Auckland is the largest city with around one third of the country’s population [http://www.stats.govt.nz]. There are three official languages: Te Reo Māori, English and New Zealand Sign Language.

Māori people are of Polynesian ancestry and are believed to have descended from a small group who arrived in the 10th century. Their descendants were scattered in settlements around the coastline by the 12th century and diversified into different tribes (Iwi) controlling their own lands and fishing grounds, although they continued to speak one language (Te reo).
In 1769, modern New Zealand was claimed for Great Britain by Captain James Cook, who outlined a map of the country. European settlement gradually followed, initially with whalers in the 1790s. New Zealand’s founding document, the Treaty of Waitangi, was signed in 1840 by numerous Māori chiefs and the British Crown. Briefly, the treaty sought to control increasing lawlessness, address Māori rights and ownership of land, and establish a British Governor. Since the signing of the Treaty in 1840, New Zealand has shifted from a predominantly Māori population and cultural heritage to one that is dominated by European cultural traditions. There was widespread failure by the Crown to uphold the treaty over the following century and consequently significant loss of Māori land and other economic and cultural resources. From early on, but increasingly since the 1970s, Māori have sought to have their claims about breaches of the treaty addressed. In 1975, the Waitangi Tribunal was established for this purpose, and successive governments have continued to work to settle historical claims with Māori.

The total resident population in New Zealand (as at December 2012) is 4,490,000 (Statistics New Zealand, 2012a). Cultural identity (self-identified in the latest, 2006 census) has continued to change, with 67.6% of the population identifying as European, 14.6% as Māori, followed by Asian (9.2%) and Pacific island people (6.9%). From being the dominant population in 1840, Māori numbers fell dramatically after European colonization due to wars, epidemics and the effects of cultural disintegration. Population numbers then recovered, and have grown steadily since the 1950s, and are projected to increase to 22% of the population by 2051 (Statistics New Zealand, 2004). The population defined by European descent came predominantly from Great Britain and Ireland. Additionally, migration from Asia and the Pacific islands has contributed to the cultural diversity of New Zealand. Asia, Australia and the United Kingdom provide the most common source of immigrants (Statistics New Zealand, Undated-a). Asia represents the fastest-growing immigrant population, with the proportion of immigrants increasing 4.9% in the period 2001–2006. New Zealand also has high levels of emigration, particularly to Australia. There were 53,700 permanent and long-term departures from New Zealand by New Zealand citizens in the year ended June 2011, about three quarters moving to Australia (Statistics New Zealand, Undated-c). In the same period, there were 84,000 permanent and long-term arrivals (PLT; people intending to stay for a period of 12 months or more, and including New Zealand residents returning after an absence of 12 months or more) (Statistics New Zealand, Undated-c). Of
these, 23 800 were New Zealand citizens and 60 200 non-New Zealand citizens. The largest group of PLT arrivals was from Australia (15 000 arrivals, of whom 63% were New Zealand citizens) followed by the United Kingdom of Great Britain and Northern Ireland (14 400 arrivals, of whom 40% were New Zealand citizens) (Statistics New Zealand, Undated-c).

The 2006 census recorded the Pacific population as 6.9% of the total population, an increase of 15% in the period 2001 to 2006 and 59% in the period 1991 to 2006 (Statistics New Zealand, Undated-c). The Pacific population was initially predominantly composed of migrants (particularly from the 1960s onwards), but the majority (60%) is now New Zealand-born (Statistics New Zealand and Ministry of Pacific island Affairs, 2010). The Pacific population is projected to increase 2.4% a year from 2006 to 2026 (Statistics New Zealand, 2010b).

The Pacific population consists of at least 13 distinct languages and cultural groups, with the Samoan community the largest (49%), followed by Cook Islanders (22%), Tongans (19%), Niueans (8%), Fijians (4%), Tokelaueans (3%) and Tuvaluans and others (3%) (totals add to more than 100 because multiple ethnic identities can be given). Pacific peoples have a youthful population structure, with a median age of only 21 years, in contrast to the general population where the median age is 35 years (Statistics New Zealand, 2007c). The largest proportion of Pacific people live in the Auckland region (67%), making Auckland the largest Polynesian city in the world. These Pacific peoples share a common migrant history but many have retained the unique language and cultural characteristics of their islands of origin. The three largest Asian ethnic groups consist of Chinese (147 570), Indian (104 583) and Korean (30 792) (2006 census data).

Table 1.1 shows selected demographic trends in New Zealand. Since 1980, there has been slow population growth. Changing levels of immigration and fertility have influenced a change in demographic structure of New Zealand. About 20% of the population is aged 0–14 (down from 27% in 1980) and about 13% aged 65 and above (up from 10% in 1980). Both the crude birth and death rates have declined slowly since 1980. The fertility rate (births per woman) for the total population (11–50+) decreased from 2.03 in 1980 to 1.96 in 2005 (Table 1.1). However, since 2005 a steady rise in birth rates has been observed, and in 2009 a rate of 2.14 was recorded. Fertility rates are higher among Māori and Pacific women – 2.8 for Māori women in 2009 and 2.95 for Pacific women in 2005–2007 (MSD, 2010). The
crude birth rate per 1000 population for New Zealand decreased from 16.20 in 1980 to 13.97 in 2005, then increased to 14.67 in 2009 (Table 1.1).

Most New Zealanders are urban dwellers (87%) and about half are tertiary graduates. The growing proportion of older New Zealanders, together with the increasing incidence of chronic conditions with age, poses challenges for the future provision of health services.

### Table 1.1 Trends in population/demographic indicators, selected years

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<tr>
<td>Total population (million)³</td>
<td>3.11</td>
<td>3.45</td>
<td>3.67</td>
<td>3.86</td>
<td>4.13</td>
<td>4.32</td>
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<tr>
<td>Population, female (% of total)³</td>
<td>50.27</td>
<td>50.64</td>
<td>50.64</td>
<td>50.82</td>
<td>50.70</td>
<td>50.61</td>
</tr>
<tr>
<td>Population ages 0–14 (% of total)³</td>
<td>27.20</td>
<td>23.08</td>
<td>22.96</td>
<td>22.71</td>
<td>21.51</td>
<td>20.44</td>
</tr>
<tr>
<td>Population ages 65 and above (% of total)³</td>
<td>9.75</td>
<td>11.11</td>
<td>11.63</td>
<td>11.82</td>
<td>12.13</td>
<td>12.74</td>
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<tr>
<td>Population ages 80 and above (% of total)³</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>3.38</td>
</tr>
<tr>
<td>Population growth (average annual growth rate)³</td>
<td>0.13</td>
<td>1.46</td>
<td>1.46</td>
<td>0.59</td>
<td>1.13</td>
<td>1.09</td>
</tr>
<tr>
<td>Population density (people per sq. km)²</td>
<td>11.82</td>
<td>13.09</td>
<td>13.95</td>
<td>14.65</td>
<td>15.70</td>
<td>16.39</td>
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<tr>
<td>Fertility rate, total (births per woman)²</td>
<td>2.03</td>
<td>2.18</td>
<td>1.99</td>
<td>2.00</td>
<td>1.96</td>
<td>2.14</td>
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<tr>
<td>Birth rate, crude (per 1000 people)²</td>
<td>16.20</td>
<td>17.50</td>
<td>15.77</td>
<td>14.91</td>
<td>13.97</td>
<td>14.67</td>
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<tr>
<td>Death rate, crude (per 1000 people)²</td>
<td>8.50</td>
<td>8.10</td>
<td>7.49</td>
<td>6.91</td>
<td>6.72</td>
<td>6.66</td>
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<tr>
<td>Age dependency ratio (population 0–14 &amp; 65+: population 15–64 years)²</td>
<td>58.60</td>
<td>51.95</td>
<td>52.87</td>
<td>52.74</td>
<td>50.69</td>
<td>49.64</td>
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<tr>
<td>Distribution of population (% urban population)³</td>
<td>NA</td>
<td>80</td>
<td>NA</td>
<td>86</td>
<td>NA</td>
<td>87</td>
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<tr>
<td>Educational level³</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>50.31</td>
<td>51.26</td>
<td>NA</td>
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NA, not available.

³ Data from http://data.worldbank.org/

¹ Data from http://www.stats.govt.org.nz/

² Tertiary education graduation rates, percentage of graduates to the population at the typical age of graduation: http://stats.oecd.org/Index.aspx

### 1.2 Economic context

New Zealand, due in part to geographic isolation, is heavily reliant on foreign trade as a driver of the economy and is therefore susceptible to fluctuations in international economic growth. New Zealand’s largest trade partners, by exports, include Australia (22%), the United States of America (11.5%), Japan (9.2%), China (5.3%) and the United Kingdom (4.3%) (CIA, 2009). In 2007–2008, New Zealand had a current account trade deficit of NZ$ 5.3 billion. This deficit is represented by total goods exports of NZ$ 36.6 billion (USNZ$ 26.9 billion) leveraged with total goods imports of NZ$ 41.9 billion. The current account deficit increased from
3.4% of gross domestic product (GDP) in 2003 to 8.9% of GDP in 2008. This expanding deficit, together with high net foreign liabilities (94.5% GDP), exposes the vulnerabilities of the New Zealand economy to global economic trends (OECD, 2009).

Up to the 1980s, New Zealand had a highly regulated economy. The direction of economic policy turned dramatically with the election of the fourth Labour government in 1984. While in power, the Labour government introduced policies that aimed to liberalize the New Zealand economy. Economic reform included the deregulation of the financial system and a decrease in government assistance programmes. Macroeconomic policies aimed to achieve low inflation and a sound fiscal position, while macroeconomic reforms were intended to open the economy to competitive pressures. These reforms included floating the New Zealand Dollar (NZ$), reducing trade protection, cross-sector deregulation, privatization and commercialization of state enterprises, and the introduction of the Goods and Services Tax (GST) in 1987. During this transitional period, the economy stagnated and then entered recession in the early 1990s. Economic reform continued after the election of the fourth National Party-led government in 1991, particularly in the labour market and welfare sector. For most of the remainder of the 1990s, New Zealand enjoyed economic growth, apart from a brief recession in 1998.

The new millennium brought with it a change in the economic fortunes of New Zealand. In the period 2000–2007, GDP growth surpassed that of most member countries of the Organisation for Economic Co-operation and Development (OECD) with average annual growth of 3.54% (New Zealand Government, 2012a). During this period, New Zealand was a beneficiary of rapid global growth, particularly that of China, which stimulated the price of commodities (OECD, 2009). Accompanying high commodity prices were record low unemployment, high foreign investment and a house price boom.

New Zealand has moved away from its traditional dependence on dairy, meat and wool exports, as forestry, tourism, horticulture, fisheries and manufacturing have become more significant, while also developing its agriculture and manufacturing industries to suit niche markets. As a proportion of GDP, the services sector accounts for 69.6% of economic output, followed by the industry sector (26%) and agriculture (4.4%) (CIA, 2009).
Consistent with OECD trends, New Zealand has experienced a period of economic downturn as a result of the global financial crisis. The economy entered recession in 2008, but began to recover from mid-2009. However, the recovery lost momentum from the second half of 2010 as a result of the slowing global economy and the effect of two major earthquakes affecting New Zealand’s second largest city (Christchurch) in September 2010 and February 2011, causing 181 deaths and widespread damage. Earthquake reconstruction is expected to provide an economic boost for the next 5–10 years (New Zealand Government, 2012a).

Table 1.2 sets out selected macroeconomic indicators for New Zealand.

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<tbody>
<tr>
<td>GDP (USNZ$ million)</td>
<td>22,870</td>
<td>44,503</td>
<td>62,795</td>
<td>51,599</td>
<td>110,977</td>
<td>126,679</td>
</tr>
<tr>
<td>GDP, PPP (current international USNZ$ million)³</td>
<td>27,066</td>
<td>48,893</td>
<td>64,675</td>
<td>81,378</td>
<td>104,608</td>
<td>126,271</td>
</tr>
<tr>
<td>GDP per capita (current USNZ$)³</td>
<td>7,346</td>
<td>12,907</td>
<td>17,094</td>
<td>13,375</td>
<td>26,845</td>
<td>29,352</td>
</tr>
<tr>
<td>GDP per capita, PPP (current international USNZ$)³</td>
<td>8,694</td>
<td>14,180</td>
<td>17,606</td>
<td>21,094</td>
<td>25,304</td>
<td>29,258</td>
</tr>
<tr>
<td>GDP average annual growth rate for the previous 10 years (%)³</td>
<td>0.90</td>
<td>0.04</td>
<td>4.24</td>
<td>2.66</td>
<td>3.25</td>
<td>0.79</td>
</tr>
<tr>
<td>Public expenditure (% of GDP)³</td>
<td>38.03</td>
<td>35.49</td>
<td>34.92</td>
<td>33.32</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Cash surplus/deficit (% of GDP)³</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>4.40</td>
<td>NA</td>
</tr>
<tr>
<td>Tax burden (% of GDP)³</td>
<td>30.81</td>
<td>36.92</td>
<td>36.19</td>
<td>33.24</td>
<td>36.74</td>
<td>31.02</td>
</tr>
<tr>
<td>Public debt (% of GDP)³</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>22.10</td>
<td>27.50</td>
</tr>
<tr>
<td>Value added in industry (% of GDP)³</td>
<td>30.79</td>
<td>27.66</td>
<td>26.70</td>
<td>25.06</td>
<td>25.31</td>
<td>NA</td>
</tr>
<tr>
<td>Value added in agriculture (% of GDP)³</td>
<td>10.35</td>
<td>6.88</td>
<td>7.37</td>
<td>8.81</td>
<td>5.40</td>
<td>NA</td>
</tr>
<tr>
<td>Value added in services (% of GDP)³</td>
<td>58.86</td>
<td>65.46</td>
<td>65.93</td>
<td>66.12</td>
<td>69.29</td>
<td>NA</td>
</tr>
<tr>
<td>Labour force (total) (million)³</td>
<td>1.51</td>
<td>1.69</td>
<td>1.82</td>
<td>1.94</td>
<td>2.19</td>
<td>2.36</td>
</tr>
<tr>
<td>Unemployment, total (% of labour force)³</td>
<td>NA</td>
<td>7.78</td>
<td>6.45</td>
<td>6.15</td>
<td>3.80</td>
<td>6.13</td>
</tr>
<tr>
<td>Income or wealth inequality (Ratio of high-income households to low-income households)³</td>
<td>NA</td>
<td>2.42</td>
<td>2.57</td>
<td>NA</td>
<td>NA</td>
<td>2.52</td>
</tr>
<tr>
<td>Real interest rate³</td>
<td>2.28</td>
<td>12.48</td>
<td>9.08</td>
<td>5.85</td>
<td>7.91</td>
<td>8.59</td>
</tr>
<tr>
<td>Official exchange rate (NZ$ per USNZ$)³</td>
<td>1.03</td>
<td>1.68</td>
<td>1.52</td>
<td>2.20</td>
<td>1.42</td>
<td>1.60</td>
</tr>
</tbody>
</table>

a Data from http://data.worldbank.org/  
b Data from http://www.stats.govt.nz/  
c Data from http://stats.oecd.org/Index.aspx  
NA, data not available
1.3 Political context

New Zealand is a liberal democracy with a parliamentary system of government, consisting of an elected body known as the House of Representatives. Three branches of government – Parliament, the Executive and the Judiciary – create, administer and interpret the law. New Zealand is one of only three liberal democracies without a formal written constitution, instead drawing upon various documents passed under the authority of the Queen and assorted Acts of parliament from the United Kingdom (New Zealand Parliament, 2006).

In July 1993, New Zealand adopted the Mixed Member Proportional (MMP) system of government, transforming the electoral system from one previously based on the British first-past-the-post (FPP) system. Upon adoption of the MMP system, the total number of members of parliament (MPs) increased from 99 to about 120. Under MMP, an elector can vote for both an individual standing member and a political party, hence the use of the term ‘mixed member’. The party vote determines the number of seats in the House (Parliament) a party will hold, with Parliament made up of electorate MPs (representing geographic populations) plus list MPs as required to make up their party’s proportional entitlement. To gain seats in parliament, a party must gain at least one electorate seat or 5% of the total party vote (Electional Commission, 2013). Elections are generally held every three years.

By law, all people aged 18 years and over who are eligible to enrol as a voter must do so, although voting itself is not compulsory. New Zealand was the first country in the world to give women the vote in 1893. New Zealand has two electoral rolls: the General Roll and the Māori Roll. Following each Census (held every five years), Māori in New Zealand are given the option of whether they want to register on the General Roll and thereby cast votes for candidates in their local general electorate, or on the Māori Roll, enabling them to cast votes in their local Māori electorate. The proportion of Māori voters choosing to enrol on the Māori roll has been increasing, from about 50% in 1996 to 57% in 2008 (New Zealand Parliament, 2009).

There are two main political parties in New Zealand: the National Party (centre-right) and the Labour Party (democratic socialist). With the introduction of MMP in 1993, minor parties such as the Greens and the Māori Party have had an increased influence over policy direction. Since
1996, all governments have been coalition governments, led by either the National or Labour parties, with smaller parties in coalition, managed through a series of coalition agreements.

Following nine years of Labour Party-led coalition governments between 1999 and 2008, the National Party gained control of Parliament in the 2008 General Election with 44.93% of the vote. Under the MMP system, confidence and supply agreements were negotiated by the National Party with ACT (a libertarian party), United Future (a centrist party) and the Māori Party (established in 2004 to promote Māori views). In the November 2011 election, the National Party won 59 seats with 47.31% of the vote; the Labour Party won 34 seats with 27.48%; the Greens had a significant increase in their votes, winning 14 seats with 11.06%; the New Zealand First Party had a resurgence having been removed from Parliament in 2008, winning 8 seats (6.59% of the vote) in 2011; the Māori Party won 3 seats with 1.43% of the vote; and the new Mana Party, ACT and United Future parties won 1 seat each (each having won electorate seats). The National Party has formed a coalition government with the support of the ACT, United Future and Māori parties, with the coalition holding 64 of the 121 seats in Parliament.

The local government sector of New Zealand is composed of 11 regional councils and 67 territorial authorities. Both regional councils and territorial authorities have legislative and regulatory roles; however, their powers are set by parliament. Regional councils are primarily concerned with regional and environmental management, biosecurity, transportation planning and civil defence. Meanwhile, territorial councils are responsible for infrastructure maintenance and planning; resource management (including land utilization and sub-division) and advocating community views (Department of Internal Affairs, 2011a).

New Zealand is party to many international contracts and conventions relating to health care policy. For example, New Zealand is an active participant of the World Health Organization (WHO) Regional Office for the Western Pacific. Additionally, through affiliation with the OECD and the Commonwealth Fund, New Zealand maintains strong correspondence with international health ministries and assemblies. Two treaties, the Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR) directly concern health. The FCTC came into effect in 2005 and seeks to regulate certain facets of the tobacco industry, including advertising and taxation (WHO Framework Convention on
Tobacco Control, 2010), while the IHR is a global agreement binding 194 WHO Member States that provides measures to reduce health risks that cross borders, including procedures in the event of an international health crisis (WHO, 2013). The current 2005 version of the IHR has been in force since 2007 (replacing the IHR 1969).

1.4 Health status

New Zealanders enjoy a high standard of living by international standards. The Human Development Index (HDI), a measure of education, life expectancy and GDP per capita, placed New Zealand fifth in the ‘very high human development’ category in 2011 with an HDI of 0.908, below Norway (0.943), Australia (0.929), the Netherlands (0.910) and the United States (0.910) (UNDP, 2011).

New Zealanders of European descent experience low mortality and fertility rates, common to most Western developed democracies. Reductions in mortality mean that New Zealanders can now expect to live, on average, over 20 years longer than they did a century ago. The most recent data (2009) show overall life expectancy for females is 82.35 years and 78.35 years for males (World Bank, Undated) (see Table 1.3). Demographic change has been accompanied by an epidemiological transition, with a shift from communicable to noncommunicable disease and those associated with an ageing population. The main causes of death are noncommunicable disease, particularly circulatory diseases, malignancies, ischaemic heart disease, cerebrovascular disease and chronic respiratory disease (see Table 1.4).

Table 1.3 Mortality and health indicators, selected years

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth, total</td>
<td>72.83</td>
<td>75.38</td>
<td>76.73</td>
<td>78.64</td>
<td>79.85</td>
<td>80.30</td>
</tr>
<tr>
<td>Life expectancy at birth, male</td>
<td>70.00</td>
<td>72.50</td>
<td>74.10</td>
<td>76.10</td>
<td>77.90</td>
<td>78.35</td>
</tr>
<tr>
<td>Life expectancy at birth, female</td>
<td>75.80</td>
<td>78.40</td>
<td>79.50</td>
<td>81.30</td>
<td>81.90</td>
<td>82.35</td>
</tr>
<tr>
<td>Total mortality rate, adult, male</td>
<td>167.27</td>
<td>142.87</td>
<td>125.98</td>
<td>104.26</td>
<td>94.33</td>
<td>NA</td>
</tr>
<tr>
<td>Total mortality rate, adult, female</td>
<td>108.07</td>
<td>93.14</td>
<td>80.84</td>
<td>67.08</td>
<td>59.58</td>
<td>NA</td>
</tr>
</tbody>
</table>

Data from http://data.worldbank.org/ (accessed 11 November 2013),
NA, data not available
## Table 1.4 Main causes of death, selected years

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable diseases</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>All infectious and parasitic diseases (A00–B99)</td>
<td>173</td>
<td>215</td>
<td>208</td>
<td>173</td>
<td>147</td>
<td>214</td>
</tr>
<tr>
<td>Tuberculosis (A15–A19)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sexually transmitted infections (A50–A64)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HIV/AIDS (B20–B24)</td>
<td>-</td>
<td>52</td>
<td>57</td>
<td>22</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Circulatory diseases (I00–I99)</td>
<td>13 000</td>
<td>11 611</td>
<td>11 755</td>
<td>10 920</td>
<td>10 505</td>
<td>10 482</td>
</tr>
<tr>
<td>Malignant neoplasms (C00–C97)</td>
<td>5 465</td>
<td>6 746</td>
<td>7 416</td>
<td>7 620</td>
<td>7 864</td>
<td>8 417</td>
</tr>
<tr>
<td>Colon cancer (C18)</td>
<td>890</td>
<td>1 024</td>
<td>1 119</td>
<td>1 134</td>
<td>1 221</td>
<td>1 253</td>
</tr>
<tr>
<td>Cancer of larynx, trachea, bronchus and lung (C32–C34)</td>
<td>1 133</td>
<td>1 336</td>
<td>1 404</td>
<td>1 406</td>
<td>1 451</td>
<td>1 528</td>
</tr>
<tr>
<td>Breast cancer (C50)</td>
<td>509</td>
<td>635</td>
<td>639</td>
<td>622</td>
<td>648</td>
<td>643</td>
</tr>
<tr>
<td>Cervical cancer (C53)</td>
<td>94</td>
<td>101</td>
<td>96</td>
<td>66</td>
<td>54</td>
<td>55</td>
</tr>
<tr>
<td>Diabetes (E10–E14)</td>
<td>446</td>
<td>414</td>
<td>509</td>
<td>802</td>
<td>839</td>
<td>847</td>
</tr>
<tr>
<td>Mental and behavioural disorders (F00–F99)</td>
<td>166</td>
<td>295</td>
<td>471</td>
<td>541</td>
<td>728</td>
<td>821</td>
</tr>
<tr>
<td>Ischaemic heart diseases (I20–I25)</td>
<td>7 459</td>
<td>6 807</td>
<td>6 697</td>
<td>5 973</td>
<td>5 807</td>
<td>5 634</td>
</tr>
<tr>
<td>Cerebrovascular diseases (I60–I69)</td>
<td>3 158</td>
<td>2 600</td>
<td>2 716</td>
<td>2 668</td>
<td>2 587</td>
<td>2 624</td>
</tr>
<tr>
<td>Chronic respiratory diseases (J00–J99)</td>
<td>3 024</td>
<td>2 580</td>
<td>3 023</td>
<td>2 053</td>
<td>2 151</td>
<td>2 341</td>
</tr>
<tr>
<td>Digestive diseases (K00–K93)</td>
<td>668</td>
<td>804</td>
<td>765</td>
<td>721</td>
<td>685</td>
<td>803</td>
</tr>
<tr>
<td>Transport accidents (V01–V99)</td>
<td>623</td>
<td>758</td>
<td>604</td>
<td>508</td>
<td>455</td>
<td>465</td>
</tr>
<tr>
<td>Suicide (X60–X84)</td>
<td>337</td>
<td>455</td>
<td>545</td>
<td>458</td>
<td>514</td>
<td>493</td>
</tr>
<tr>
<td>Ill-defined and unknown causes of mortality (R95–R99)</td>
<td>221</td>
<td>242</td>
<td>183</td>
<td>118</td>
<td>90</td>
<td>90</td>
</tr>
</tbody>
</table>

Data from [http://stats.oecd.org/Index.aspx](http://stats.oecd.org/Index.aspx)

a ICD-10 = International Classification of Disease, 10th edition.
b Lung only.
c Land transport only.

Average life expectancy differs not only with gender, but also ethnicity as discussed in the following sub-sections.

New Zealand has a younger population structure than the European Union (EU), with 21.0% aged under 15 years (compared to the 2006 estimate of 16.03% for the EU) and 12.5% of the population aged 65 years and over in 2007 (compared with 16.81% for the EU). However, in line with most developed countries, New Zealand has experienced an increase in
median age from 31.4 years in 1991 to 36.1 years in 2007 (Statistics New Zealand, 2008). Also, given the increased fertility rates among Māori and Pacific ethnicities, the average age of the population of European descent will increase faster than that of Māori and Pacific populations.

New Zealand has high adolescent (15–19 year olds) pregnancy rates (59.1 per 1000 in 2009) and adolescent birth rates (32.8 per 1000) (Table 1.5). The overall rate of termination of pregnancy has increased from 14 per 1000 in 1990 to 19.2 in 2009 (Table 1.5). Perinatal, neonatal, post-neonatal and infant mortality rates are all low and have continued to decline since 1990, while the maternal mortality rate has fluctuated (Table 1.5).

### Table 1.5 Maternal, child and adolescent health indicators, selected years

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent pregnancy rate (15–19 years), per 1000&lt;sup&gt;a&lt;/sup&gt;</td>
<td>NA</td>
<td>-</td>
<td>53.2</td>
<td>51.5</td>
<td>52</td>
<td>59.1</td>
</tr>
<tr>
<td>Adolescent birth rate&lt;sup&gt;b&lt;/sup&gt;</td>
<td>38.2</td>
<td>35</td>
<td>33.4</td>
<td>28.2</td>
<td>27.2</td>
<td>32.8</td>
</tr>
<tr>
<td>Termination of pregnancy (abortion) rate, per 1000&lt;sup&gt;c&lt;/sup&gt;</td>
<td>8.5</td>
<td>14</td>
<td>16.1</td>
<td>18.7</td>
<td>19.3</td>
<td>19.2</td>
</tr>
<tr>
<td>Perinatal mortality rate, per 1000 live births&lt;sup&gt;d&lt;/sup&gt;</td>
<td>12.2</td>
<td>7.4</td>
<td>6.1</td>
<td>6.4</td>
<td>5.7</td>
<td>NA</td>
</tr>
<tr>
<td>Neonatal mortality rate, per 1000 live births&lt;sup&gt;d&lt;/sup&gt;</td>
<td>6</td>
<td>4.2</td>
<td>3.2</td>
<td>3.8</td>
<td>3.1</td>
<td>NA</td>
</tr>
<tr>
<td>Postneonatal mortality rate&lt;sup&gt;e&lt;/sup&gt;</td>
<td>356</td>
<td>255</td>
<td>205</td>
<td>144</td>
<td>113</td>
<td>134</td>
</tr>
<tr>
<td>Infant mortality rate, per 1000&lt;sup&gt;f&lt;/sup&gt;</td>
<td>13</td>
<td>8.4</td>
<td>6.7</td>
<td>6.3</td>
<td>5</td>
<td>4.7</td>
</tr>
<tr>
<td>Under-five mortality rate, per 1000&lt;sup&gt;'&lt;/sup&gt;</td>
<td>15.6</td>
<td>11.1</td>
<td>8.7</td>
<td>7.4</td>
<td>6.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Maternal mortality rate, per 1000&lt;sup&gt;g&lt;/sup&gt;</td>
<td>13.8</td>
<td>6.6</td>
<td>3.5</td>
<td>8.8</td>
<td>8.5</td>
<td>NA</td>
</tr>
<tr>
<td>Syphilis incidence rate&lt;sup&gt;h&lt;/sup&gt;</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>122</td>
</tr>
<tr>
<td>Gonococcal infection incidence rate&lt;sup&gt;i&lt;/sup&gt;</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>967</td>
</tr>
</tbody>
</table>

<sup>a</sup> Source: Statistics New Zealand (2003, 2010a).
<sup>b</sup> Data from http://mdgs.un.org/unsd/mdg/Data.aspx
<sup>c</sup> Data from http://www.stats.govt.nz/
<sup>d</sup> Data from http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT
<sup>e</sup> Source: Statistics New Zealand (2010a).
<sup>f</sup> Data from http://data.worldbank.org/
<sup>g</sup> Data from http://www.surv.esr.cri.nz/
<sup>h</sup> Data not available.
1.4.1 The health of Māori

Māori health status has seen significant gains over the past four decades; however, it continues to lag behind that of New Zealanders of European descent and Māori experience an excess burden of mortality and morbidity across the age spectrum. Identifying and removing inequalities is a key focus of the New Zealand Health Strategy, Māori Health Strategy and Primary Health Care Strategy (King, 2000, 2001c; King & Turia, 2002).

Inequalities stem from a range of factors, most notably lower socioeconomic status, reduced access to health services and professionals, and health risk factors. Māori females have a life expectancy of 75.1 years (2006) compared to 82.2 years for non-Māori females. A similar ethnic gap is also observed for males, with Māori males having a life expectancy of 70.4 years compared to 78.1 years for non-Māori males (MOH, 2009a). Lower Māori life expectancy is of particular concern to the Ministry of Health (MOH), but the gap has recently been reducing – significantly so for Māori females. The gap between non-Māori and Māori life expectancy has reduced by approximately 1.2 years for males and 2 years for females over the past decade (MOH, 2009a).

Mortality figures for 2005 (Table 1.6) display increased incidence of a range of diseases in the Māori population compared the non-Māori population. The Age Standardized Rate (ASR) measured per 100 000 population for lung cancer is 3.5 times that for the non-Māori population; ASR for ischemic heart disease is double; COPD (chronic obstructive pulmonary disease) rates are 2–3 times; and the prevalence of diabetes mellitus is 5 times that for the non-Māori population. Māori also have significantly higher rates of hypertensive disease (Table 1.6).

Infant mortality rate has decreased substantially in New Zealand over the last 40 years, and has remained relatively static since 2002. Māori infant mortality is higher than non-Māori (7.1 per 1000 live births in 2004–2006 compared with 4.6 for non-Māori) and Māori sudden infant death mortality is also higher (1.8 per 1000 live births in 2004–2006 compared with 0.3 for non-Māori) (MOH, 2012h).

Māori also constitute the largest portion of mental health clients, with an ASR of 2739.5 per 100 000 (MOH, 2008j). The Māori suicide rate (16.0 per 100 000 population in 2010) is significantly higher than that of non-Māori (10.4 per 100 000 population in 2010), and while the non-Māori rates have
been trending downwards since 1996, the non-Māori rates have been very variable (MOH, 2012p).

Māori smoking rates are 46% overall, compared with 31% for Pacific, 23% for European/other and 13% for Asian peoples (MSD, 2010). Māori have higher age-standardized obesity rates (43%) than European (23%) and Asian (12%) ethnic groups (MSD, 2010).

**Table 1.6  New Zealand mortality data (selected causes) 2005**

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Total</th>
<th>Māori</th>
<th>Non-Māori</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ASR</td>
<td>No.</td>
<td>ASR</td>
</tr>
<tr>
<td>All causes of death</td>
<td>361.1</td>
<td>27 141</td>
<td>643.7</td>
</tr>
<tr>
<td>Total cancer</td>
<td>114.2</td>
<td>7 970</td>
<td>188.7</td>
</tr>
<tr>
<td>Lung cancer&lt;sup&gt;a&lt;/sup&gt;</td>
<td>21.8</td>
<td>1 451</td>
<td>65.2</td>
</tr>
<tr>
<td>Colorectal cancer&lt;sup&gt;b&lt;/sup&gt;</td>
<td>16.9</td>
<td>1 222</td>
<td>13.5</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>10.2</td>
<td>652</td>
<td>14.0</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>6.4</td>
<td>564</td>
<td>10.3</td>
</tr>
<tr>
<td>Stomach cancer</td>
<td>3.7</td>
<td>256</td>
<td>8.5</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>66.7</td>
<td>5 806</td>
<td>127.7</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>27.5</td>
<td>2 587</td>
<td>37.0</td>
</tr>
<tr>
<td>COPD&lt;sup&gt;c&lt;/sup&gt;</td>
<td>16.5</td>
<td>1 404</td>
<td>41.5</td>
</tr>
<tr>
<td>Other heart disease&lt;sup&gt;d&lt;/sup&gt;</td>
<td>13.2</td>
<td>1 148</td>
<td>29.5</td>
</tr>
<tr>
<td>Transport accidents</td>
<td>11.6</td>
<td>486</td>
<td>20.5</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>11.2</td>
<td>840</td>
<td>43.8</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>11.3</td>
<td>505</td>
<td>15.6</td>
</tr>
<tr>
<td>Organic mental disorders</td>
<td>6.0</td>
<td>662</td>
<td>3.4</td>
</tr>
<tr>
<td>Pneumonia and influenza</td>
<td>3.9</td>
<td>381</td>
<td>5.3</td>
</tr>
<tr>
<td>Hypertensive disease</td>
<td>2.9</td>
<td>258</td>
<td>8.3</td>
</tr>
</tbody>
</table>


<sup>a</sup> Includes cancer of the trachea, bronchus and lungs.

<sup>b</sup> Includes cancer of the colon, rectosigmoid junction, rectum, anus, anal canal.

<sup>c</sup> Chronic obstructive pulmonary disease.

<sup>d</sup> Includes pericardial diseases, valve disorders, myocarditis, cardiomyopathy, conduction disorders, cardiac arrest, and heart failure.

**1.4.2 The health of Pacific island peoples living in New Zealand**

Pacific peoples also experience lower standards of health compared with other groups in New Zealand, and improving Pacific people’s health is one of the priority areas of the MOH (MOH, 2008d). Pacific life expectancy in 2006 was 73.9 years for males and 78.9 years for females, compared with 82.2 and 78.1 years, respectively, for all New Zealanders (MOH, 2008d, 2009a).
In 2006, the infant mortality rate for Pacific children was 6.4 per 100 births, compared with 7.2 for Māori and 3.8 for ‘other’ ethnicities (MOH, 2009f). Pacific children have the highest rates of hospitalization for acute and chronic respiratory and infectious diseases (MOH, 2007a). Acute rheumatic fever (ARF) in Pacific peoples is exceedingly high (67 cases per 100 000) compared to New Zealanders of European decent (3 cases per 100 000). Achieving a substantial reduction in ARF cases among children is a priority for the current government. Its goal is to reduce the incidence by two thirds to 1.4 cases per 100 000 people by June 2017 (MOH, 2013a).

Similarly, the ASR of meningococcal disease is 2.4 times higher in Pacific peoples (4.8 per 100 000 in 2007) than that of other ethnicities. However, this rate represents a sizable drop in incidence of the disease from 2001, when the ASR was 53.1 per 100 000 in Pacific peoples; this drop is largely attributable to an aggressive national meningococcal B vaccination programme run between 2002 and 2008 (Lopez, Sexton & Carter, 2011). Pacific peoples have the highest rates of obesity in New Zealand (65% in 2006–2007) (MSD, 2010).
Chapter 2: Organization and governance

Chapter summary

New Zealand has a predominantly publicly funded, universal coverage health system with services provided by public, private and nongovernmental sectors. The Minister of Health has overall responsibility for the health and disability system, and the Ministry of Health (MOH) is the main advisory body to the government on policy issues. Other government agencies also contribute to health-related activities, including the Ministry of Social Development (through the provision of some benefits), Te Puni Kōkiri (the Ministry of Māori Development), the Ministry of Pacific Island Affairs and the Office for Disability Issues and the Accident Compensation Corporation (ACC).

Twenty District Health Boards (DHBs) are responsible for planning and funding health services for their geographical areas. They are governed by boards of elected and appointed members that are accountable to the Minister of Health. They are required to undertake formal strategic planning processes and, in doing so, to cooperate with neighbouring DHBs.

The National Health Board (NHB) was established in November 2009 as a business unit within the MOH with responsibilities for funding, monitoring and planning of DHBs; the planning and funding of designated national services (including DHB regional planning); stronger alignment of service, capital and capacity planning; strengthening and accelerating the linkages among information technology (IT), workforce and facilities capacity investment; and supporting the government’s initiative to reduce bureaucracy.

Since 2001, primary health care has been coordinated through primary health organisations (PHOs) (currently 31) which receive capitation funding for their enrolled populations. Patients are free to enrol with
a general practitioner (GP) of their choice; the GP then chooses which PHO to join. Patients have a choice of accessing publicly funded or privately funded secondary care services, although this may be limited by availability in some areas. A range of Māori and Pacific health providers also offer primary health care and health promotion services.

Since 1996, New Zealand has had a Code of Health and Disability Services Consumers’ Rights, and the office of the Health and Disability Commissioner investigates complaints, along with health practitioners’ professional bodies.

Health and disability services (including medical, mental health, surgical, obstetric services, aged care facilities, and other health-related services) are regulated by the Health and Disability Services (Safety) Act 2001 and associated regulations. These set standards, provide for certification, and establish a framework for the monitoring of compliance. Health providers are required to demonstrate compliance with the relevant standards in order to gain and retain their accreditation.

The accreditation process for health professionals is governed by the Health Practitioners Competence Assurance Act 2003. The 16 authorities created under the Act are responsible for overseeing practitioners of a particular profession or professions, including their registration.

2.1 Overview of the health system

Central government in New Zealand has overall responsibility for health policy. The health system provides universal coverage, and is predominantly publicly funded, with provision of services shared between a variety of public, private and voluntary sector agencies.

Using Organisation for Economic Co-operation and Development (OECD) definitions, total expenditure on health was NZ$19,870 million in 2009–2010 (MOH, 2012e). The main source of funding for health care in New Zealand is public funding, largely through taxation, with 83.2% of expenditures funded through public sources in 2009–2010 (MOH, 2012e). Most public funding comes through the health budget. The Accident Compensation Corporation (ACC, a social insurance scheme covering New Zealanders for accident-related care) contributes 8.4% of total health expenditure, and other central and local government sources contribute 2.1% (MOH, 2012e). Private out-of-pocket payments make
up 16.8% of expenditure. New Zealanders can also purchase private health insurance to supplement the services they can receive through the publicly financed system, but private health insurance contributed only 4.9% of expenditures in 2009–2010.

Publicly owned hospitals provide most secondary and tertiary medical care, while the small private hospital sector specializes mainly in elective surgery and long-term care. Independent medical, nursing and allied practitioners provide most primary health care (ambulatory) services. A key player in health services delivery is the ‘third sector’, which refers to nonprofit, nongovernmental organizations (NGOs), a sector which has expanded rapidly since the mid-1980s (Crampton, Dowell & Woodward, 2001). These providers offer primary health care (PHC), community-based health services and disability support services, many of which are fully or partially publicly funded. The third sector includes union-based health services, and Māori and Pacific providers.

The main components of the New Zealand health system are shown in Figure 2.1. The historical development of the New Zealand health system is explained in the following section, and then the roles and functions of the main health organizations are given in detail.

2.2 Historical background

From the early days of European settlement in New Zealand, there has been mixed provision of health care services by the government, voluntary and private sectors. The first state hospitals were commissioned in 1846. Their services were free only to the indigenous Māori population and to ‘indigents’ (i.e. poor or needy people), but government health services became increasingly accessible to the general population and, by the 1880s, the government funded about three quarters of hospital care, including all mental health services (Gauld, 2009). There were also private primary and secondary health care services provided by medical practitioners who worked independently and were paid directly by their patients. Voluntary provision included charitable work and ‘friendly societies’, and nonprofit insurance schemes which provided care for their contributing members (Gauld, 2009).

The Hospital and Charitable Institutions Act 1885 divided the country into 28 hospital districts (Hay, 1989), with local hospital boards responsible for raising half of the finance they needed (via patient
Figure 2.1  Organization of the health system in New Zealand

Source: Ministry of Health (MOH, 2011n).

charges, contributions from local authorities levied from rate-payers, and voluntary contributions) and the government contributing the remainder (Department of Health, 1969).
The Public Health Act 1900 created a Department of Public Health headed by a Chief Health Officer, and stipulated that those appointed as local district health officers were to be medical practitioners with “special knowledge of sanitary and bacteriological science” (Royal Commission on Social Policy, 1988, p. 44). New Zealand thus set up a national department of health to oversee the health of the population earlier than other countries. The Department of Public Health gradually took on broader functions, merging with the Department of Hospitals and Charitable Aid in 1909 and eventually being renamed the Department of Health in 1920 (Dow, 1995).

By the mid-20th century, hospitals had become the key component in the health care system. Advances in medical knowledge and technology meant that hospitals were able to offer effective treatment rather than just care, while caring for seriously ill people at home ceased to be the norm. Government funding of medical care gradually increased while patient fees made up a smaller share of revenue (Royal Commission on Social Policy, 1988).

2.1.1 A national health care system

The first Labour government of New Zealand (1935–1949) substantially shaped the health care system of today, setting up a welfare state in the years following the depression of the 1930s. The Social Security Act 1938 marked the introduction of universal entitlement to tax-financed and comprehensive health care. Free hospital treatment was provided for all (including inpatient and outpatient care in general hospitals, mental hospitals, maternity hospitals and sanatoria); medicines were made free; and benefits were introduced for X-ray and laboratory services and dental services for children aged under 16 (McLintock, 1966). The government originally also envisaged free primary health care services, but general practitioners (GPs) insisted on remaining independent and, after lengthy negotiations, were subsidized by the government on a fee-for-service basis, rather than through capitation payments or salaries. The GPs’ view was that the subsidy attaches to the patient and is not a payment by the government to the practitioner. In addition to the government subsidy, GPs were also given the right to charge their own fees to patients. Some services, such as adult dental care and optometry, were still paid for privately (Department of Health, 1974). By 1947, however, New Zealand had set up a predominantly tax-funded health care system that made most services available free to the user at the point of delivery with a mix
of public and private provision. However, the initial intention to develop an integrated national health service was not achieved (Gauld, 2009), and New Zealand’s health care system continues to face problems with fragmentation of services to this day as a result.

### 2.1.2 Developments from the 1940s to the 1980s

Incremental, pragmatic adjustments to the health care system continued over the next 40 years or so, with a series of reviews (Gauld, 2009). The 1953 Consultative Committee on Health Reform (‘the Barrowclough Committee’) supported the establishment of additional private hospital beds (in line with the view of the National Party government of the time), recommended that the Minister of Health (rather than individual hospital boards) have ultimate responsibility for hospital and health service organization (enacted in The Hospitals Act 1957), and recommended reducing the number of hospital boards (although this recommendation was not implemented due to a change of government) (Gauld, 2009). A Review of Hospital and Related Services in New Zealand (Department of Health, 1969) also emphasized the need for more integrated health services and suggested amalgamations of the then 31 hospital boards, though again these did not occur. With the 1972 election of a Labour government, a further review was undertaken by the Department of Health, resulting in the White Paper, A Health Service for New Zealand (Department of Health, 1974). This outlined principles for change, including the need for integration of health services, more emphasis on health promotion (in addition to the treatment of illness), and the equitable provision of health care services on the basis of need rather than ability to pay (Department of Health, 1974). The White Paper proposed that 14 regional health authorities be established to coordinate all services in their geographic areas, and also suggested a split between the funding and the provision of services. Before any reforms could be enacted, however, there was a change of government, with the National Party government taking office in 1975 and remaining there until 1984.

The National Party government set up a Special Advisory Committee on Health Services Organisation, which proposed the establishment of 14 regional ‘Area Health Boards’ (Gauld, 2009). The government chose to pilot these in two areas and consult further with stakeholders rather than introduce them nationally all at once, before finally passing the Area Health Boards Act 1983, which allowed for the voluntary establishment of 14 AHBs (Gauld, 2009). These were formed between 1984 and 1989,
during the period of the Labour government which was elected in 1984. This government undertook significant economic and public sector reforms, including the introduction of the State-Owned Enterprises Act 1986 (which restructured some government departments, separating trading activities into more business-like enterprises in order to promote improved performance); the State Sector Act 1988 (which introduced managerialism and performance objectives to state services), and the Public Finance Act 1989 (which reformed public financial management systems to incentivize the effective and efficient use of financial resources by government departments). The principles underpinning these major economic reforms were later reflected in changes in New Zealand’s health care system during the 1990s.

During this period, the Labour government also commissioned two health policy reviews: the 1986 Health Benefits Review (Scott, Fougere & Marwick, 1986) and the 1988 Hospital and Related Services Taskforce (Gibbs, Fraser & Scott, 1988). The former presented five options for the state’s funding role in health care, while the latter recommended separating the purchasing and provision of health care. At the time, these reforms were not enacted, but they provided the bases for later reforms.

2.1.3 Reforms since the 1990s

Not long after the last of the AHBs had been established, a National Party government was elected in 1990 and set up a task force that recommended a split between the purchase and provision of health services (Upton, 1991). This was enacted through the 1993 Health and Disability Services Act. Four regional health authorities (RHAs) were established and given a budget to purchase all personal health and disability services for their regional populations from both public and private providers; many disability services were previously the responsibility of the social welfare sector rather than the health sector. The provider arms of the 14 AHBs were converted into 23 Crown Health Enterprises (CHEs) which were to function as commercial entities; run hospitals, community and public health services; and return a surplus for reinvestment in health.

These reforms represented a major restructuring of the New Zealand health system. As such, they proved complex and expensive to implement, with one estimate that the reform process itself cost at least NZ$ 800 million (Gauld, 2009). The reforms were highly contentious, with many
health professionals not in favour of the business or competitive focus of the model. The reforms would later be seen to have led to some gains – most notably, a clear focus for providers, improvements in information (including about the cost of services), the development of the Pharmaceutical Management Agency (PHARMAC) to manage the national pharmaceutical budget, the increased development of by-Māori for-Māori and by-Pacific-for-Pacific providers, the development of new meso-level primary health care organizations, and some acknowledged savings in pharmaceutical and laboratory spending. The National Health Committee (NHC) was also formed, originally to determine ‘core’ health services that would be publicly funded. However, there were also major concerns over the cost of the reforms, poor purchasing practice, inconsistencies arising from having four RHAs, and the lack of competition in key areas of service provision (Gauld, 2009). There were also concerns that the major promised efficiency gains did not materialize with the most obvious being a major increase in the numbers of New Zealanders waiting for elective surgery when reductions in waiting lists and times were originally promised. The reforms were so contentious that health was barely out of the news for a number of years, with a number of changes in the Minister of Health as the government tried to put the health sector onto a surer footing.

New Zealand’s first Mixed Member Proportional (MMP) representation election in 1996 resulted in a coalition government of the National Party and the smaller New Zealand First party. Difficulties with the purchaser–provider system and the influence of New Zealand First saw a shift away from the quasi-market model approach to a national approach and a less competitive and more collaborative arrangement. The four RHAs were abolished on 30 June 1997. Their functions were transferred to a single health funding body, the Transitional Health Authority, which was renamed the Health Funding Authority (HFA) on 1 January 1998. As a single, national purchasing authority, the HFA continued the split between purchase and provision. It contracted with a range of providers for the provision of medical, hospital, public health, disability and other health services, and was also responsible for purchasing postgraduate clinical training. Its other functions were to monitor the need for health services and to monitor the performance of providers.

At the same time the CHEs were converted into 23 companies called Hospital and Health Services (HHSs), which were relieved of the requirement to make a surplus but were still expected to cover their costs and not to run deficits. They continued to run hospitals and related
services, community and public health services, and were contracted to deliver these services by the HFA. These companies had independent legal and financial status and operated in a commercial legal framework.

At the end of 1999, a Labour–Alliance coalition government was elected and swiftly enacted the New Zealand Public Health and Disability Act 2000, which ushered in another major reorganization of the health sector. Local governance was re-established by way of 21 District Health Boards (DHBs) to replace the HHSs, and the HFA was disestablished, its purchasing role being split between the new DHBs and an expanded Ministry of Health (MOH). DHBs became responsible for planning and funding of all health services for their region. They provide hospital and some community-based services (removing the purchaser–provider split for such services), but continue to contract for PHC and a wide range of community-based services from private providers. While DHBs are responsible for PHC services in their area, these are now largely provided through primary health organisations (PHOs) which were established from 2002 on. (See section 2.3 for more information on DHBs and PHOs.)

In November 2008, the National Party won the national election and led a coalition government with confidence and supply agreements with the ACT Party, the Māori Party and United Future. The National Party-led coalition did not seek to ‘restructure’ the health system, but it has sought various changes – establishing a National Health Board (NHB) as a business unit of the MOH to oversee DHBs, fund and plan specialist national services, and oversee infrastructure planning of information technology (IT), workforce and capital management; reorganizing the functions of the rest of the Ministry; changing the functions of the NHC to focus on priority setting; establishing a separate national Health Quality and Safety Commission to oversee quality of care; establishing a shared services agency to undertake DHB back-office functions across DHBs (Health Benefits Ltd); encouraging Southland and Otago DHBs to merge; and seeking mergers between PHOs, with a view to reducing the number of PHOs from the 80 in place in 2008.

Following its re-election in November 2011, the National Party-led government has shifted the focus of the public sector from outputs to results that benefit families and communities. In 2012, the Prime Minister announced 10 high-level results across the public sector. The MOH is leading the delivery of those in the areas of increasing immunization and reducing rheumatic fever cases among children (MOH, 2013a).
Chapter 6 provides more detail about health care reforms in New Zealand since the 1990s.

2.3 Organization

2.3.1 Ministry of Health

The Minister of Health has overall responsibility for the health and disability system, with the MOH being the main advisor to the government on health and disability policy issues. Other core functions of the MOH are to advise, fund, monitor and improve the performance of health-sector Crown entities (statutory bodies) and DHBs; purchase health support services on behalf of the Crown (government); administer, implement and enforce legislation and regulations on behalf of the Crown; provide leadership and coordination in managing emergencies; provide key infrastructural support to the health and disability system (including national information systems and a payments service), and service Ministers’ offices and ministerial advisory committees (MOH, 2012s).

The structure and funding of public health and disability services are set out in the New Zealand Public Health and Disability Act 2000. Under this Act, the objectives of these services are to improve, promote and protect the health of New Zealanders; promote the inclusion and participation in society and independence of people with disabilities; achieve the best care or support for those in need of services; reduce health disparities by improving the health outcomes of Māori and other population groups; provide a community voice in matters relating to personal health services, public health services and disability support services; facilitate access to, and the dissemination of, information to deliver appropriate, effective and timely health and disability services.

Two overarching strategies, The New Zealand Health Strategy (King, 2000) and The New Zealand Disability Strategy (MOH, 2001b), set the direction for the health and disability sector, with a number of other strategies providing guidance in specific areas, for example, PHC and Māori health (King, 2001c; King & Turia, 2002).

The MOH has a number of business units and groups within these. HealthCERT (http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services) is the group within the Ministry responsible for ensuring that hospitals, rest homes and residential disability care facilities provide safe and reasonable levels
of service for consumers, as required under the Health and Disability Services (Safety) Act 2001. The New Zealand Medicines and Medical Devices Safety Authority (Medsafe; http://www.medsafe.govt.nz) is the group within the Ministry responsible for administering the Medicines Act 1981 and Regulations 1984, which regulate therapeutic products in New Zealand. It applies a framework of controls, including pre-marketing approval of products and post-marketing surveillance, to ensure that the therapeutic products available can be expected to have greater benefits than risks if used appropriately. The National Radiation Laboratory (NRL; http://www.nrl.moh.govt.nz) provides expert advice, service provision and research capability on matters concerning public, occupational and medical exposure to radiation, the performance of radiation equipment and the measure of radiation and radioactivity.

2.3.2 National Health Board (NHB) – http://www.nationalhealthboard.govt.nz

The NHB was established in November 2009 with a board that advises the Minister of Health and is supported by a business unit within the MOH. The NHB business unit has responsibilities for funding the monitoring and planning of the DHBs; the planning and funding of designated national services (including DHB regional planning); stronger alignment of service, capital and capacity planning; strengthening and accelerating the linkages among IT, workforce and facilities capacity investment; and supporting the government’s initiative to reduce bureaucracy (MOH, 2011l).

The NHB has two sub-committees: The Capital Investment Committee is responsible for planning and prioritization for capital investment in the health sector, while the IT Health Board provides strategic leadership on information systems across the health and disability sector and ensures IT strategy is reflected in capital allocation and capacity planning (MOH, 2011l).

Also part of the NHB are Health Workforce New Zealand (HWNZ) and the National Screening Unit (NSU). HWNZ has overall responsibility for planning and development of the health and disability workforce. NSU is responsible for the development, management and monitoring of nationally organized, population-based screening in New Zealand. The NSU is currently responsible for five screening programmes: Antenatal HIV Screening, BreastScreen Aotearoa, National Cervical Screening, Newborn Metabolic Screening and Universal Newborn Hearing Screening, in addition to introducing quality improvement measures for antenatal screening for
Down syndrome. A four-year pilot bowel-cancer screening programme began in Waitemata DHB in December 2011. After this pilot is completed and has been evaluated, consideration will be given to implementing a national bowel-cancer screening programme.

2.3.3 Health Crown Entities and agents
The Crown Entities Act 2004 established five categories of Crown Entity. The first of these statutory entities has three types, each of which includes health-related organizations.

- Crown agents (which must implement government policy when directed by the responsible minister) include the Health Research Council of New Zealand, New Zealand Blood Service, the Pharmaceutical Management Agency, the Health Promotion Agency and the Health Quality and Safety Commission New Zealand.
- Autonomous Crown entities (which must have regard to government policy when directed by the responsible minister) include the New Zealand Artificial Limb Board.
- Independent Crown entities (which are generally independent of government policy) include the Health and Disability Commissioner.

Each of these health-related organizations is described briefly below.

Health Research Council of New Zealand
http://www.hrc.govt.nz
The Health Research Council of New Zealand (HRCNZ) is responsible for managing the government’s investment in health research. It is responsible to the Minister of Health and has its major funding agreement through the Ministry of Business, Innovation and Employment. HRC’s functions include initiating and supporting health research; undertaking consultation to establish priorities in health research; advising the minister and administering funds in relation to national health-research policy; fostering the recruitment, education, training and retention of those engaged in health research in New Zealand; promoting and disseminating the results of health research and ensuring the development and application of appropriate assessment standards by committees that assess health research proposals. The HRCNZ received NZ$ 83 583 million in government revenue for the year ended June 2012 (HRCNZ, 2011). In 2010, the annual health and medical research spending per head of population by the HRC was about NZ$ 18.60. In comparison,
the Australian National Health and Medical Research Council (NHRMC) spent more than double this amount (NZ$ 43.00 per capita) in the same year (authors’ own calculation).

**New Zealand Blood Service (NZBS)**
http://www.nzblood.co.nz

NZBS ensures the supply of safe blood products through an integrated national blood transfusion process. All blood donations within New Zealand are voluntary.

**Pharmaceutical Management Agency (PHARMAC)**
http://www.pharmac.govt.nz

PHARMAC aims to ensure the best health care value from the government’s expenditure on pharmaceuticals. It manages the Pharmaceutical Schedule of subsidized community medicines, working on behalf of DHBs to decide which medicines to fund, negotiating prices with pharmaceutical companies, setting subsidy levels and conditions, and ensuring spending remains within budget. PHARMAC also plays a role in helping New Zealanders understand how to use their medicines optimally.

**The Health Promotion Agency (HPA)**
http://www.healthpromotion.org.nz

The HPA was established in June 2012 under the New Zealand Public Health and Disability Amendment Act 2012. The HPA subsumes the functions of the former Alcohol Advisory Council and Health Sponsorship Council. Its purposes, direct by the Act, are:

- promoting health and well-being and encouraging healthy lifestyles
- preventing disease, illness and injury
- enabling environments that support health and well-being and healthy lifestyles
- reducing personal, social and economic harm.

**Health Quality and Safety Commission New Zealand**
http://www.hqsc.govt.nz

The Health Quality and Safety Commission was established in December 2010 under the New Zealand Public Health and Disability Amendment Act 2010. It is responsible for assisting both public and private providers
across the whole health and disability sector to improve service safety and quality and therefore improve outcomes for all service users.

**New Zealand Artificial Limb Board (NZALB)**
http://www.nzalb.govt.nz
NZALB is the sole national provider of prosthetic limb services to New Zealand amputees, through five regional Limb Centres.

**Health and Disability Commissioner (HDC)**
http://www.hdc.org.nz
The office of the HDC was established to protect the rights of health consumers and disability services consumers and resolve complaints arising from the infringement of those rights. (See further under section 2.9.3.) Since June 2012, the HDC has incorporated the functions of the former Mental Health Commission (set up in 1996 to monitor mental health services), and includes a specific Mental Health Commissioner.

**Ministerial advisory committees and councils**
The MOH provides secretariat support for a number of ministerial health advisory committees and councils, which are described in brief below.

**Advisory Committee on Assisted Reproductive Technology (ACART)**
http://www.acart.health.govt.nz/
ACART was established under the Human Assisted Reproductive Technology Act 2004. It formulates policy and advice specific to New Zealand for the regulation of assisted human reproduction. It is required to undertake extensive public consultation before issuing advice or finalizing guidelines.

**Ethics Committee on Assisted Reproductive Technology (ECART)**
http://www.ecart.health.govt.nz/
ECART is required to consider and determine applications for assisted reproductive procedures or human reproductive research, and keep under review approvals previously given. It liaises with ACART and other relevant ethics committees on matters relating to assisted reproductive procedures and human reproductive research.
Cancer Control New Zealand
http://www.cancercontrol.govt.nz/
Cancer Control New Zealand is responsible for ensuring that New Zealand’s Cancer Control Strategy (Minister of Health, 2003) is implemented. In addition, it seeks to foster collaboration and cooperation among everyone involved in cancer control to ensure that the incidence, impact and inequalities of cancer are reduced.

National Ethics Advisory Committee (NEAC)
http://www.neac.health.govt.nz/
NEAC’s statutory functions are to provide advice to the Minister of Health on ethical issues of national significance regarding health and disability research and services, to determine nationally consistent ethical standards, and to provide scrutiny for such research and services.

National Health Committee
http://www.nhc.health.govt.nz/
The National Health Committee (NHC) was established under sections 11 and 13 of the New Zealand Public Health and Disability Act 2000. It was previously charged with advising the Minister of Health on health and disability services and public health (through its Public Health Advisory Committee). Following the 2009 Ministerial Review of the health care system (see section 6.1), the NHC’s terms of reference were revised in 2011 to focus its role on establishing evaluation systems to ensure greater value for the money invested in health (NHC, 2011a). In particular, its work includes assessing [non-pharmaceutical] technologies, services, models of care and programmes.

New Zealand health and disability ethics committees
http://www.ethicscommittees.health.govt.nz/
New Zealand has four ethics committees whose primary role is to provide independent ethical review of health and disability research and innovative practice to safeguard the rights, health and well-being of consumers and research participants, particularly those with diminished autonomy.

Radiation Protection Advisory Council
Under the Radiation Protection Act 1965, the Radiation Protection Advisory Council advises the Minister about matters relating to the
Radiation Protection Act and the Director-General of Health in respect of applications for licences under the Act.

**Mortality review committees**

New Zealand has four mortality review committees that report to the Health Quality and Safety Commission. The Child and Youth Mortality Review Committee (CYMRC; http://www.cymrc.health.govt.nz) reviews the deaths of children and young people aged 28 days up to 25 years; the Family Violence Death Review Committee (FVDRC; http://www.fvdrc.health.govt.nz) reviews all deaths related to family violence; the Perinatal and Maternal Mortality Review Committee (PMMRC; http://www.pmmrc.health.govt.nz) reviews the deaths of babies and mothers in New Zealand, and the Perioperative Mortality Review Committee (POMRC; http://www.pomrc.health.govt.nz) reviews deaths following any invasive procedure or any form of anaesthesia.

### 2.3.4 Other government ministries

The health system depends upon a number of other ministries, whose health-related activities are identified below.

The Treasury monitors and manages the financial affairs of the government and provides economic and fiscal policy advice. It provides support for ministers in balancing priorities through the Budget process and also plays a role in assessing the efficiency and effectiveness of government agencies and their actions.

The Ministry of Social Development (MSD) carries out social sector policy, research and evaluation for the government. Within MSD, the Office for Disability Issues provides policy advice on disability issues; promotes, monitors and reports on the progress of the New Zealand Disability Strategy; and ensures the disability sector has a voice within government. Another MSD service, Work and Income, provides financial assistance and employment services for New Zealanders. This includes Invalid’s and Sickness Benefits, war veteran’s pensions, some disability support allowances, and a Community Services Card, which helps with some health care costs for low- to middle-income New Zealanders (Work and Income, 2009).

The Accident Compensation Corporation (ACC) came into operation in 1974 and provides comprehensive no-fault personal injury cover for all
New Zealand residents and for visitors injured in New Zealand. Cover can include medical costs, compensation of up to 80% of weekly income, vocational and social rehabilitation, an independence allowance (for people permanently impaired as a result of an injury that occurred before 1 April 2002), and death and funeral benefits. Under the Accident Insurance Act 1998, the National–New Zealand First government set up a competitive insurance market for work-related injuries from registered private insurance companies or from a new state-owned enterprise, Work Insurance, which came into force on 1 July 1999. The following Labour Party-led coalition government re-nationalized cover for work-related injuries from 1 July 2000. Further details on ACC are provided in sections 3.3.1 and 5.7.

Te Puni Kōkiri (Māori Development) is the government’s principal adviser on Crown–Māori relationships; it also advises on policy issues affecting Māori well-being and development. Three main areas of policy advice contribute to the government’s objective of reducing inequalities between Māori and non-Māori people in the delivery of health and disability support services: how to make progress towards reducing inequalities in health status between Māori and non-Māori; how to improve Māori health outcomes by increasing Māori participation in the purchase and provision of health services; and the development of new Māori health initiatives for the well-being of Māori (MOH, 2008e, pp. 33–34).

Ministry of Education health-related activities include tertiary training and education for doctors, nurses, dentists and other allied health professionals.

The Department of Corrections provides health care services to prison inmates and those held in judicial custody. In 2007–2008, it was estimated that NZ$ 27.1 million was spent on general medical treatment and NZ$ 13.8 million on psychiatric treatment (MOH, 2010a).

The Department of Internal Affairs administers the Lottery Grants Board, which made grants of NZ$ 19.8 million in 2007–2008 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 (MOH, 2008e, p. 33). Additional grants of NZ$ 6.2 million funded health research (MOH, 2010a).
The Ministry of Business, Innovation and Employment provides information and guidance to workplaces about occupational health and safety issues, and managing hazardous substances; enforces workplace health and safety legislation; and works to reduce work-related death and injury rates. It is also responsible for the policy and investment functions for research, science and innovation, including health research. In 2007–2008, expenditure on health research was NZ$ 83.8 million, compared with NZ$ 74.5 million in 2006–2007 (Ministry of Science and Innovation, 2012).

The Ministry of Defence includes the provision of health care services to Army, Navy and Air Force personnel. The estimated total health-related expenditure for 2007–2008 was NZ$ 34.9 million (MOH, 2010a). These estimates include the cost of medical and dental treatments carried out within the defence services, as well as payments for services acquired from external professionals and organizations, but exclude expenditure related to medical examinations.

The Ministry for Primary Industries was formed from a 2011 merger of the Ministry of Agriculture and Forestry and the Ministry of Fisheries. Its responsibilities cover regulatory processes related to a wide range of statutes. Those relevant to health include biosecurity regulations (encompassing pest and disease surveillance) and food policy and regulations.

The Ministry of Pacific island Affairs, the Ministry of Women’s Affairs and the Ministry of Youth Development (which is administered by the MSD) may provide advice on health issues specific to these groups.

2.3.5 District health boards

The New Zealand Public Health and Disability Act 2000 created 21 DHBs replacing the previous single HFA and the 23 hospital and health services companies. Southland and Otago DHBs merged into the Southern DHB in May 2010, leaving 20 DHBs. The DHBs cover geographically defined populations and are responsible for planning and funding services for their district, including PHC, secondary and tertiary health care, and aged care services. In order not to split smaller funding pools over many DHBs, and because of concerns that funding would be diverted to personal health services, funding for public health services remains the responsibility of the MOH. Similarly, funding for disability support
services for those aged less than 65 years also remains the responsibility of the MOH, as a result of major concerns from the disability community that disability services would become ‘medicalized’ if they were overseen by DHBs. DHBs directly provide many secondary and tertiary health care services, including community services related to secondary and tertiary care and community mental health services. They contract provision for primary health care services and other community services, including aged care and mental health, from private for-profit and not-for-profit providers.

DHBs are crown agents as defined by the Crown Entities Act 2004 (section 7(1)[a]), meaning they are bodies established under an Act and must implement government policy when directed by the responsible minister. DHBs are responsible to the Minister of Health for setting their strategic direction, for appointing their chief executive, and for their own performance. The DHBs are allocated resources to improve, promote and protect the health of the population within their district, and to promote the independence of people with disabilities.

DHBs (as organizations) are governed by DHB Boards, of which membership is intended to balance the need for community participation, skill mix, and the Crown’s partnership with Māori. Each DHB Board has up to 11 members, who serve three-year terms. The local community elects seven members (at the same time as local government elections), the Minister of Health appoints up to four members, and each board is expected to have at least two Māori members, in proportion to the local Māori resident population. Each board must establish three advisory committees: Community and Public Health, Hospitals, and Disability Support.

DHBs are expected to cooperate with adjoining districts in delivering services, particularly where there are cross-DHB border issues, and where specialist services draw patients from a region larger than a single district. In addition, four ‘shared services agencies’ undertake some collaborative work between specific DHBs (rather than replicating some functions within each DHB), including health service and funding planning, a range of information and analysis planning, and provider audits (MOH, 2008e). Further amalgamation of back-office services and IT systems also occurred in July 2010 with the establishment of Health Benefits Limited (HBL), a company established to share services across
DHBs, including finance and accounting, human-resource management, procurement, corporate and executive services and information services (HBL, Undated).

DHBs are expected to ensure that their communities can participate in board deliberations, are involved in planning, have access to information, are consulted on policies, funding and performance outcomes, and have access to a full range of health services. DHB plans must reflect the health policies of the government and prudently manage assets owned by the crown. DHBs were initially required to produce an annual plan and a 5–10 year strategic plan to provide services to meet the needs of their communities, but under the New Zealand Public Health and Disability Amendment Act 2010, they are now required to consider not only their own community but also “the most effective and efficient delivery of health services in order to meet local, regional, and national needs” (section 8(1)). They must produce an annual plan and contribute to one or more regional plans with other DHBs (section 38).

The accountability framework is intended, in particular, to ensure that a DHB does not unduly favour its own hospital and other services above those of other providers. A DHB must also produce a business case for the approval of the Ministers of Health and Finance if it wishes to undertake capital investment. DHBs are subject to a range of other legislation including the Public Finance Act 1989, the Official Information Act 1982, and the Ombudsman Act 1975.

Crown funding agreements govern the relationship between the government and DHBs, and funding agreements are also in place between DHBs and other service providers. Providers must be given notice on the terms and conditions under which payments will be made. The Act requires these notices to be nationally consistent where possible in order to keep transaction costs down.

Sanctions can be applied against individual DHB board members or the whole board. The Act empowers the Minister of Health as follows: to direct DHBs; to appoint a Crown Monitor to report to the minister on the performance of the board; to replace the board with a Commissioner; to dismiss board members and to replace the Chair or the Deputy Chair of the board.
2.3.6 Primary health organisations

Prior to 2001, most primary medical care services were provided by GPs working in private practices, and by a small number of community-governed providers. In February 2001, the Labour Party-led coalition government’s Minister of Health published The Primary Health Care Strategy (King, 2001c), which outlined a new vision for PHC, including moving to a system where services are organized around the needs of an enrolled population with a greater emphasis on population health, health promotion and preventive care. Funding is based on population needs rather than the fee-for-service model. The strategy aims for improved coordination of care across service areas and the involvement of a wider range of professionals in service delivery. There is also a strong emphasis on reducing health inequalities between different groups.

Primary health organisations (PHOs) were the local structures designed to implement this new model of PHC by establishing networks of GPs and other primary health providers. PHOs are required to be not-for-profit organizations, and are expected to involve their communities in their governing processes, with all providers and practitioners involved in the organization’s decision-making. PHOs are funded by DHBs to coordinate primary health care services (including services to improve, maintain and restore health) for their enrolled population.

The first two PHOs were established in July 2002, increasing to 45 by July 2003 (covering about half the population), 68 by June 2004 (covering about three quarters of the population) and 80 by 2009 (covering 95.7% of the population) (MOH, 2005c, 2009a). Subsequent mergers have resulted in 36 PHOs by 2013 with almost all general practices participating and most New Zealanders enrolled in a PHO. Those not enrolled with a PHO can still access GP services, but pay higher user fees than those enrolled.

Further detail about PHOs is provided in sections 3.7.1 and 6.1.5.

2.3.7 Māori health services

Between 1900 and 1930, Māori were actively involved in shaping local health policies and delivering health services, with some tension between an approach based on Māori autonomy and self-determination, compared to an essentially monocultural medical model. Control was increasingly exerted by the state, however, so that the Department of Health eventually assumed full responsibility and health professionals (medical officers and district nurses) displaced Māori community leaders (Durie, 1994, p. 42).
Whereas in earlier decades Māori men had led the drive for better public health, from 1931 to 1974 Māori women became more active with the establishment of the Women’s Health League (Te Rōpu o Te Ora) and the Māori Women’s Welfare League. These women liaised between a largely rural and conservative Māori society and a health sector dominated by institutions and health professionals. Māori women essentially were regarded as a support for professionals and as a community link for the mainstream health institutions (Durie, 1994, p. 47). One indication of changing attitudes, however, was the repeal in 1964 of the 1907 Tohunga Suppression Act which had forbidden traditional healers to practise.

Although slow to appreciate the links between culture and health, New Zealand began to face this issue from the late 1970s. A resurgence of interest in Māori language (te reo) and culture, combined with a reinterpretation of the Treaty of Waitangi, led to a reassessment of the value assumptions underlying health and social services. Different models for describing Māori health were debated that took more account of cultural, social and economic factors (Pomare et al., 1995). In 1984, the Department of Health hosted a national conference with Māori (Hui Whakaoranga) to identify ways to address health inequalities and to develop culturally relevant programmes. A Ministerial Committee was set up as a result of the hui (meeting) to provide advice on Māori issues to the Department of Health, to be implemented through its Māori health resources unit (Te Wahanga Hauora Māori). The Department of Health began to incorporate Treaty principles into its management philosophy and to train its staff to respond in more culturally sensitive ways to the needs of Māori patients and their whānau (family). Although Māori health initiatives were under way in many Māori communities by the early 1990s, these depended on the goodwill of AHBs and were vulnerable to the sudden withdrawal of funds (Durie, 1994, p. 55).

The government strategy for Māori health in the early 1990s, Whaia te Ora mo te Iwi (Department of Health & Ministry of Maori Development, 1993), outlined the general policy directions:

- greater participation by Māori people at all levels of the health and disability sector
- priorities for resource allocation that take account of Māori needs and perspectives
- the development of culturally appropriate practices and procedures.
The restructuring of the New Zealand health system and the new purchasing arrangements in 1993 opened up more opportunities to Māori health care providers (Ashton, 1996). Māori community trusts were encouraged to provide services, to contract with other providers, and to develop alliances with local health and social service providers (MOH, 1996, p. 43). The number of independent Māori health service providers increased tenfold from approximately 23 in 1993 to over 240 in 1998 (de Raad, 2003). Many iwi (tribe) and urban-based health organizations now 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.

The New Zealand Public Health and Disability Act 2000, which established DHBs, requires that DHBs:

- reduce disparities by improving the health outcomes of Māori and other population groups (section 3(1)b);
- involve Māori in decision-making and in the delivery of health and disability services (section 4);
- have Māori representation on the boards and their committees (section 29(4), 34–36);
- build the capacity of Māori to participate in the health and disability sector and to ensure that it responds to the needs of Māori (section 23(1)e).

The Māori Health Strategy He Korowai Oranga was published in 2002 and continues to provide a framework for Māori health policy and provision (King & Turia, 2002). The overall aim is whānau ora (broadly translated as ‘family health’): “Māori families supported to achieve their maximum health and wellbeing” (King & Turia, 2002, p. 1). To achieve this, four pathways are identified: Pathway One, the development of whānau, hapū, iwi (families, clans and tribes) and Māori communities; Pathway Two, Māori participation in the health and disability sector; Pathway Three, effective health and disability services; and Pathway Four, working across sectors. An action plan (subsequently updated and extended) was produced to guide the implementation of He Korowai Oranga (Minister of Health & Associate Minister of Health, 2006a; MOH, 2002e), and the Whānau Ora Health Impact Assessment tool was developed to assess the impact of government and sector activities on whānau ora, and identify how policies can support and Māori health and well-being and reduce inequalities (MOH, 2007f).
MOH Māori workforce development initiatives include the Hauora Māori Scholarships to assist students to undertake accredited courses in health and disability studies, and the Māori Provider Development Scheme (MPDS) to provide financial assistance to enable Māori health providers to develop more effective health service provision and accelerate the development of the Māori health and disability workforce (MOH, 2012i; MOH & Minister of Health, 2008).

An important new development for Māori health is the Whānau Ora initiative. A whānau ora taskforce was established by the government in June 2009 to develop a whānau-centred approach to well-being and development. Following the Taskforce’s report (Taskforce for Whānau-Centred Initiatives, 2010), the 2010 Budget allocated NZ$134 million of new funding for whānau ora over four years. Te Puni Kōkiri has the lead responsibility for the policy, supported by the Ministries of Health and Social Development. The approach focuses on empowering whānau (families) as a whole (rather than individuals) to achieve their aspirations with the intended outcomes that whānau become self-managing, living healthy lifestyles, participating fully in society, confidently participating in te ao Māori (the Māori world), economically secure and successfully involved in wealth creation, and cohesive, resilient and nurturing (MOH, 2011g, p. 3). In 2010, twenty-five Whānau Ora collectives were established, covering 150 service providers, to provide comprehensive services with less duplication (MOH, 2011g). A Whānau Integration, Innovation and Engagement Fund (WIIE) has also been established to help whānau strengthen their connections, skills and leadership in order to be more self-reliant (Te Puni Kōkiri, 2011). With the Māori Party part of the National Party-led coalition government elected to power at the end of 2011, further developments with whānau ora are expected over the next few years.

2.3.8 Pacific peoples’ health services

Pacific peoples experience significant health inequalities in New Zealand. The 2002 Pacific Health and Disability Action Plan set out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities (King, 2002b). It has now been replaced by ʻAla Moʻui, which sets out the government’s priority foci for Pacific people’s health in the period 2010–2014 (Minister of Health & Minister of Pacific island Affairs, 2010). ʻAla Moʻui seeks to achieve the following six priority outcomes:
• Pacific workforce supply meets service demand
• Systems and services meet the needs of Pacific people
• Every dollar is spent in the best way to improve health outcomes
• More services delivered locally in the community and in primary care
• Pacific people are better supported to be healthy
• Pacific people experience improved broader determinants of health
  [Minister of Health & Minister of Pacific island Affairs, 2010, p. 5].

In addition to mainstream health services, there are about 37 Pacific-owned health providers and some Pacific churches are contracted to provide health education and health promotion programmes. Churches play a key role in the community since a high proportion of Pacific peoples affiliate with a church. Since 1998, the MOH has provided a Pacific Provider Development Fund to assist the development of Pacific health providers and health workforce [MOH, 2008e].

2.3.9 Health insurance

Private health insurance companies in New Zealand insure people against ‘gap’ and ‘supplementary’ costs rather than providing comprehensive health cover. People can insure against some or all of the gaps between the government subsidy and the charges levied by providers on a range of health services (including GP and prescription costs). Insurers also provide supplementary insurance to reimburse consumers for specialist visits and elective surgery and other treatment by private hospitals and private specialists [MOH, 1996], in this way avoiding waits for elective surgery through the publicly funded health care system, and having access to enhanced facilities, such as private rooms and choice of specialist. Although a number of private health insurers provide cover in New Zealand, Southern Cross (a not-for-profit organization that owns its own private hospitals) is the largest, with around two thirds of the market share [Ashton, 2005; Southern Cross Medical Care Society, 2008]. In 2007, it was estimated that private insurance was held by 38.4% of adults and 31.3% of children in 2006–2007 [MOH, 2008a], but as noted above, it accounted for only 4.9% of total expenditure in 2009–2010. It is likely that the percentages of people covered has fallen in recent years, with reported private health insurance coverage falling from 1.395 million people in September 2008 to 1.36 million in September 2011) [HFANZ, 2011].
2.3.10 Other

The Health Practitioners Competence Assurance Act 2003 covers 15 health profession authorities (Chiropractic Board, Dental Council, Dietitians Board, Medical Radiation Technologists Board, Medical Council of New Zealand, Medical Laboratory Science Board, Midwifery Council, Nursing Council of New Zealand, Occupational Therapy Board, Optometrists and Dispensing Opticians Board, Osteopathic Council, Pharmacy Council, Physiotherapy Board, Podiatrists Board and Psychologists Board). In addition to these statutory bodies, there are also professional bodies that advocate on behalf of their members. The main medical and nursing organizations are noted below.

Medical Council of New Zealand
http://www.mcnz.org.nz

The Medical Council of New Zealand’s roles under the Health Practitioners Competence Assurance Act 2003 include registering doctors to practise in New Zealand, setting standards for doctors’ conduct and competence, giving guidance on medical practice issues, and promoting the education and training of doctors.

New Zealand Medical Association
http://www.nzma.org.nz

The New Zealand Medical Association is the country’s largest medical association and represents all disciplines within medicine, including specialists, GPs, doctors in training, and medical students. The association is active in political and media issues concerning medical practitioners, and maintains close relationships with related health associations, New Zealand Medical Students Association and the Medical Assurance Society. It publishes The New Zealand Medical Journal.

General Practice New Zealand
http://www.ipac.org.nz

Independent Practitioner Associations (IPAs) were formed in New Zealand in the 1990s in response to health reforms and the introduction of contracting for GPs [Barnett, 2003]. The Independent Practitioner Association Council (IPAC) was established in 2000 as a national body to support the role of organized general practice. From February 2010, IPAC and the General Practice Nursing Alliance were merged to establish General Practice New Zealand (GPNZ) as a new entity which aims to
“provide national strategic leadership, advocacy and support for general practice networks and teams who deliver co-ordinated health care through ‘organised general practice’” (GPNZ, Undated).

**Nursing Council of New Zealand**  

The Nursing Council of New Zealand is the statutory authority that governs the practice of nurses. The council is responsible for setting and monitoring the standards of nurses to ensure public safety under the Health Practitioners Competence Assurance Act 2003.

**College of Nurses, Aotearoa (NZ) Inc.**  

The College of Nurses is a professional body representing New Zealand nurses of all specialities. The college provides commentary on policy issues that affect the nursing profession and publishes the journal Nursing Praxis in New Zealand.

**New Zealand Nurses Organisation**  

The New Zealand Nurses Organisation is a professional and industrial organization representing nurses, midwives, students, kaimahi hauora, health workers and allied health professionals. Services provided by the organization include education development, scholarships and grants, legal services, indemnity insurance, and other professional services.

### 2.4 Decentralization and centralization

Under the New Zealand Public Health and Disability Act 2000 (NZPHDA), the Minister of Health is responsible for determining national health and disability strategies, and negotiating Crown Funding Agreements to fund agreed services. The MOH plans nationwide service frameworks, but since the health reforms brought about by the Act, the responsibility for purchasing and providing most health and disability services, guided by the national health and disability strategies, has been devolved to the 20 DHBs (apart from planning and funding disability support services for people aged under 65 and public health services, which remain under the control of the MOH).
An evaluation of the 2001 health reforms found overall support for the NZPHDA model, with key strengths identified as its local focus, the ability to involve the community in decision-making and the ability to be locally responsive (Cumming, 2007, p. ix). However, key informants for the research also identified a number of weaknesses with the model, including perceived dual accountabilities to both local communities and central government (albeit board members were learning to manage these), the large number of DHBs covering the country’s small population (though forced amalgamations would not be supported), and a perceived lack of devolution of decision-making to DHBs. Issues with devolution included concern about too much control and ‘interference’ in boards’ decision-making by the Ministry and Minister of Health, and the failure to devolve public health funding and funding for disability support services for those aged under 65 to DHBs (these budgets continue to be centrally administered by the MOH). The researchers concluded that many informants believed the DHBs have insufficient autonomy and would like greater devolution of decision-making, although some of those working at central government level considered some centralized decision-making is necessary to promote national consistency and ensure accountability for central government funding (Cumming, 2007).

Similar matters now arise in relation to New Zealand’s PHOs. A key issue is the respective roles of DHBs and PHOs, which are often unclear, and whether PHOs are expected to be purchasers or providers of primary health care services (Smith & Cumming, 2009a, 2009b). The number of PHOs has also been raised as an issue, given the small size of the New Zealand population (around 4 million); however, from a high of 80 in 2009, many PHOs have amalgamated to reduce the current (2013) number to 31.

The establishment of the NHB has given greater focus to regional and national planning, and there is a trend towards more centralization, such as the establishment of a shared services agency, HBL, to deliver administrative, support and procurement services to all DHBs in an effort to reduce costs (MOH, 2012r).

### 2.5 Planning

See sections 2.3.2 National Health Board and 2.3.5 District Health Boards.
2.6 Intersectorality – health initiatives outside the health care sector

There are many examples of initiatives in other sectors that impact on health, and of intersectoral collaboration. For example, the government’s target of reducing the incidence of rheumatic fever by two thirds by June 2017 requires the health sector to work closely with other social agencies, including housing and education. The government has committed NZ$24 million to this Rheumatic Fever Prevention Programme.

Sport New Zealand is a government organization whose roles include encouraging children and adults to participate in sport and recreation (see http://www.sportnz.org.nz/en-nz/).

Walking school bus resources have been developed by the NZ Transport Agency. The resources provide schools and parents with information to develop a walking school bus in their community, whereby an adult walks children to school on a set route and timetable. Children can join or leave the ‘bus’ at designated stops (NZ Transport Agency, 2009). Walking buses are one way to encourage healthy physical activity for children.

Housing New Zealand Corporation (a Crown agent) provides social housing and housing support for people who have no other housing options. The Corporation owns or manages more than 69,000 properties throughout the country, providing housing for over 200,000 people (Housing New Zealand Corporation, 2011). Local councils provide over 14,000 housing units, primarily for older people (Saville-Smith et al., 2007). Many older New Zealand homes are poorly insulated and heated. Warm Up New Zealand: Heat Smart is a government-funded programme that began in 2009 to retrofit insulation and/or provide additional heating for houses built before 2000 (EECA, 2011, 2012). All homeowners (including landlords) are eligible for insulation and heating grants, with higher levels of funding for Community Services Card holders (see section 3.3.1).

Health Promoting Schools is an initiative to help schools and their communities assess and address their health and social needs (see http://hps.tki.org.nz/).

The new Whānau ora policy (see section 2.3.7) is another initiative involving a number of different sectors and stakeholders.

Churches are an important locus of health promotion for the Pacific community, as are marae for Māori.
2.7 Health information management

2.7.1 Information systems
See section 4.1.4 Information technology.

2.7.2 Health technology assessment
New Zealand has had a number of arrangements in place since the 1990s to assist in setting priorities across the health sector. In the early 1990s, the government established the Core Services Committee (CSC) (the NHC) to determine an explicit ‘core’ of services that would be publicly funded (see under section 2.3.3). However, the CSC rejected the approach of establishing an explicit list of such services and instead focused on identifying key principles for allocating resources, improving priority-setting processes for elective surgery and management of waiting times, and developing guidelines to support decision-making and improve effectiveness. PHARMAC was also established during this time to prioritize and manage New Zealand’s pharmaceutical budget (see section 5.6).

In the late 1990s, the HFA also worked on an improved priority-setting process, based around programme budgeting and marginal analysis, incorporating cost-effectiveness analyses, and taking into account equity, Māori health and acceptability principles.

Following on from the establishment of the DHBs in 2000, joint work by the MOH, DHBs and the NHC resulted in guidance for DHBs around decision-making and later a 2006 Service Planning and New Health Intervention Assessment (SPNIA) framework for collaborative decision-making (DHBNZ & MOH, 2006). The framework was intended to help DHBs and the MOH assess and make service changes that required a collective decision (covering new health interventions and service reconfigurations), and to ensure that individual DHB decisions did not compromise other DHBs (DHBNZ & MOH, 2006).

The 2009 Ministerial Review Group report found that the SPNIA framework had been difficult to implement due to its governance structure (split between the Ministry and DHBs) and lack of influence over funding decisions (Ministerial Review Group, 2009). The review group therefore recommended that a single national agency, removed from both the ministry and DHBs, be responsible for prioritizing eligibility
for funding of all significant new diagnostic procedures and treatment interventions, and proposed reconfiguring the NHC to take on this role (Ministerial Review Group, 2009). The government accepted this recommendation and the NHC was refocused in 2011 with a mandate to assess non-pharmaceutical technologies, services, models of care and programmes, applying consistent standards of assessment across the country and avoiding duplication (NHC, 2011b). Assessing and prioritizing pharmaceuticals continues to be PHARMAC’s responsibility. The review group also recommended that PHARMAC become responsible for medical devices (see section 2.8.4).

The NHC is now developing programme budgets to identify areas of high and fast-growing expenditures; using ‘mega-analyses’ to focus on assessing interventions across a disease state; developing a number of levels of evidence-based analyses to suit particular decisions; establishing key criteria for decision-making; developing a specialist team to undertake analyses; and establishing international linkages to make the best use of resources in its work. The NHC is aiming to provide advice that results in savings of NZ$30 million (2012–2013), NZ$45 million (2013–2014) and NZ$60 million (2014–2015) (NHC, 2012).

2.8 Regulation

In New Zealand, central government is responsible for the overall direction and policy-setting for health care services and in particular for publicly funded services. The government has introduced four-year plans across all government agencies to get a tighter alignment between strategic direction and fiscal planning, and to provide confidence that services can be delivered and the government’s health objectives met within the fiscal allocation. The overall level of health funding is now forecast for the next four years and reviewed annually. The Four-year Budget Plan establishes the funding required for key national programmes and for DHBs. Final decisions are made annually through the government budget process, where priorities and allocations are confirmed.

Governments can exert regulatory leverage over the health system in four ways: funding, legislation, administrative authority, and professional authority (Healy & Braithwaite, 2006). Regulation, narrowly defined, is the promulgation of rules, often by a specialist public agency, accompanied by mechanisms for monitoring and enforcing compliance. A broader
definition uses the term to mean ‘governance’ in the more general sense of steering the flow of events (Healy & Braithwaite, 2006). Here, we focus on a range of governance arrangements within the New Zealand health sector, which set the rules for the way in which key health-sector activities are undertaken in New Zealand.

2.8.1 Regulation and governance of third-party payers

Under the New Zealand Public Health and Disability Act 2000, the Minister of Health is responsible for setting out a health strategy to provide a framework for the government’s overall direction for the health sector. The New Zealand Health Strategy (King, 2000) is a national policy statement that sets the agenda for government action on health. It specifies seven fundamental principles, which should be reflected across the health sector. These principles are:

• acknowledge the special relationship between Māori and the Crown under the Treaty of Waitangi;
• good health and well-being for all New Zealanders throughout their lives;
• an improvement in health status of those currently disadvantaged;
• collaborative health promotion and disease and injury prevention by all sectors;
• timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay;
• a high-performing system in which people have confidence;
• active involvement of consumers and communities at all levels.

Any new strategies or developments that are carried out are expected to conform to these seven principals. The strategy goes on to identify 61 objectives, from which 13 specific priority objectives were chosen as the short- to medium-term focus for the MOH and DHBs (King, 2000). These priority population health objectives are:

• reduce smoking
• improve nutrition
• reduce obesity
• increase the level of physical activity
• reduce the rate of suicides and suicide attempts
• minimize harm caused by alcohol and illicit and other drug use to both individuals and the community
• reduce the incidence and impact of cancer
reduce the incidence and impact of cardiovascular disease
reduce the incidence and impact of diabetes
improve oral health
reduce violence in interpersonal relationships, families, schools and communities
improve the health status of people with severe mental illness
ensure access to appropriate child health care services including well-child and family health care and immunization.

The current government has had a strong emphasis on setting a small number of specific health targets and monitoring performance against them. The targets are reviewed annually to ensure they align with government health priorities (MOH, 2011i). There are six current targets: shorter stays in hospital emergency departments; improved access to elective surgery; shorter waits for cancer treatment; increased immunization; better diabetes and cardiovascular services/more heart and diabetes checks; and better help for smokers to quit. Information about each target is available on the MOH web site, along with quarterly DHB performance data (MOH, 2012g, 2013j).

Ensuring compliance with health legislation and regulations is a responsibility of the MOH. The ministry is also responsible for funding and purchasing health and disability support services on behalf of the government, and monitoring the performance of health-sector Crown Entities and DHBs. The ministry is required, under the New Zealand Public Health and Disability Act 2000, to report annually on the implementation of the New Zealand Health Strategy (Minister of Health, 2010).

A Crown Funding Agreement is negotiated annually between the Minister of Health and DHBs, setting out the funding that will be provided by the government in return for the provision of services by the DHB. DHBs report quarterly to the MOH against Indicators of DHB Performance (IDPs), which measure nonfinancial DHB performance in the government’s priority areas as identified in the New Zealand Health Strategy and the Minister’s stated annual expectations (MOH, 2008a).

DHB funding is determined by a population-based funding formula that tries to recognize relative need fairly (see section 3.3.3).

DHBs are required to undertake formal strategic planning processes, including Health Needs Assessment, to determine the services they
will provide for their district, set out in five-year District Strategic Plans and in one-year District Annual Plans. In addition to the New Zealand Health Strategy, a number of other government strategies also give direction to DHBs. At the same time, DHBs have a statutory requirement for community consultation, although research has found significant variation in the degree to which this is undertaken, and community and stakeholder input seemed to have more influence on decision-making related to specific service issues than in the broader planning processes (Tenbensel, 2007). The same research reported that DHB board members and managers considered they had little flexibility to respond to the needs and priorities of their communities, but were highly constrained in their decision-making by government opposition and community resistance to any disinvestment they might contemplate (Mays, Cumming & Tenbensel, 2007, p. 21). Instead, generally, each DHB agreed its priorities for services based on the New Zealand Health Strategy and other national strategies, the MOH’s strategic priority service areas, the Minister of Health’s priorities (outlined in an annual ‘Letter of Expectations’), an Operational Policy Framework from the MOH, and lastly the DHB’s own preferences (Mays, Cumming & Tenbensel, 2007, p. 21).

PHOs are the local structures for coordinating primary health care services. PHOs bring together doctors, nurses and other health professionals (such as Māori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives) in the community to serve the needs of their enrolled populations.

The first PHOs were established in July 2002, and by the end of 2008 there were 80 PHOs around the country. DHBs worked with local communities and provider organizations to establish PHOs in their regions. PHOs have varied widely in size and structure and are not-for-profit (Smith & Cumming, 2009a). The Minister of Health released a set of minimum requirements that guided the establishment of PHOs, and set out standards that PHOs must meet. This includes a requirement that PHOs will give communities, iwi (Māori tribal groups) and enrolled people the opportunity to have their say about the services PHOs provide (King, 2001b).

Funding for PHOs is determined by a capitation-based funding formula, with additional funding for services to improve access, health promotion, ‘Care Plus’ services (for people with high health needs) and management services. Since January 2006, PHOs participating in the
PHO Performance Management Programme have been eligible to receive payments for improvements in performance against clinical, process/capacity and financial indicators (DHBSS, Undated-c). In addition to their capitation funding, GPs are free to charge patients a fee for the services provided. However, PHOs must notify DHBs of their providers’ standard consultation fees and, where the DHB considers these unreasonable, they may refer them to a fee review committee to consider.

PHOs are “required to provide a defined set of services including population services to improve health, screening and preventive services; support for people with chronic health problems; and information, assessment and treatment for any episodes of ill health” (King, 2001c, p. 13). Service specifications are included in the DHB–PHO agreements. PHOs are also expected to involve their communities in their governing processes, and “be able to show they are responsive to communities’ priorities and needs” (King, 2001c, p. 5).

New Zealand has a strong non-profit sector, with rich historical traditions, which is increasing in importance in New Zealand society (Sanders et al., 2008). Nongovernmental organizations (NGOs) are independent community organizations that operate on a not-for-profit basis. They perform a wide array of functions, from the provision of health, education and social services to the promotion of culture and civic action. Any financial gain or profit generated by NGOs must be reinvested in the objectives of the organization. NGOs are self-governing through mechanisms for internal governance, are able to cease operations on their own authority and are fundamentally in control of their own affairs. Where NGOs are funded by government agencies to deliver services, this work is governed by formal contracts between government agencies and NGOs.

2.8.2 Regulation and governance of providers

In New Zealand, health and disability services (including medical, mental health, surgical and obstetric services, aged care facilities, and other health-related services, whether public or private) are regulated by the Health and Disability Services (Safety) Act 2001 and associated regulations. These set standards, provide for certification, and establish a framework for the monitoring of compliance. Health providers are required to demonstrate compliance with the relevant standards in order to gain and retain their accreditation.
2.8.3 Regulation and planning of human resources

Health Workforce New Zealand was established in 2009 (replacing the former Clinical Training Agency) as a business unit of the NHB with responsibility for planning and developing the country’s health and disability workforce (see http://www.healthworkforce.govt.nz/).

The accreditation process for health professionals is governed by the Health Practitioners Competence Assurance Act 2003. Prior to 2003, health professionals were mostly self-regulated by certification. That is, only those practitioners who met certain requirements were certified to use certain titles, and generally to ‘hold themselves out’ to be practitioners of a particular kind (MOH, 2009h). Following concerns about the governance, ethics and accountability of the medical profession, a framework was developed for reduced professional self-regulation, with the New Zealand Medical Council, for example, having an increased lay membership and a majority of appointed members (MOH, 2009h).

A range of responsible authorities was established under the Act to be responsible for overseeing practitioners of a particular profession or professions (see Table 2.1). The 16 authorities responsible for 21 health professions compares with 9 registration boards in Australia. A 2009 MOH review of the Act recommended the it “be amended to give the Minister the power by Order in Council to join and restructure two or more existing authorities and/or add other practitioner groups to an existing authority in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and the authorities and their professions are generally in agreement” (MOH, 2009h, p. 29). No legislative change has yet occurred.

Each responsible authority must describe its profession(s) in terms of one or more scopes of practice, and prescribe qualifications for every scope of practice. Health practitioners must work within their scope of practice when performing a health service that is part of their profession, although scopes of practice may overlap between different professions. Authorities also register practitioners and issue annual practising certificates. Registered practitioners must have the prescribed qualifications, be competent to practise within their scope and meet certain requirements to be fit for registration. An authority must not issue an annual practising certificate unless it is satisfied the practitioner is competent (MOH, 2009h). (See section 2.9.3 regarding complaints procedures.)
Table 2.1  Responsible authorities currently established under the Health Practitioners Competence Assurance Act 2003

<table>
<thead>
<tr>
<th>Profession</th>
<th>Responsible authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic</td>
<td>Chiropractic Board</td>
</tr>
<tr>
<td>Dentistry, dental hygiene, clinical dental technology, dental technology and dental therapy</td>
<td>Dental Council</td>
</tr>
<tr>
<td>Dietetics</td>
<td>Dietitians Board</td>
</tr>
<tr>
<td>Medical laboratory science &amp; Anaesthetic technology</td>
<td>Medical Sciences Council</td>
</tr>
<tr>
<td>Medical radiation technology</td>
<td>Medical Radiation Technologists Board</td>
</tr>
<tr>
<td>Medicine</td>
<td>Medical Council</td>
</tr>
<tr>
<td>Midwifery</td>
<td>Midwifery Council</td>
</tr>
<tr>
<td>Nursing</td>
<td>Nursing Council</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Occupational Therapy Board</td>
</tr>
<tr>
<td>Optometry and optical dispensing</td>
<td>Optometrists and Dispensing Opticians Board</td>
</tr>
<tr>
<td>Osteopathy</td>
<td>Osteopathic Council</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Pharmacy Council</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Physiotherapy Board</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Podiatrists Board</td>
</tr>
<tr>
<td>Psychology</td>
<td>Psychologists Board</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Psychotherapists Board</td>
</tr>
</tbody>
</table>

2.8.4 Regulation and governance of pharmaceuticals

The New Zealand Medicines and Medical Devices Safety Authority (Medsafe) is the Ministry of Health’s business unit responsible for the regulation of therapeutic products. Medsafe administers the Medicines Act 1981 and Medicines Regulations 1984. Included in its remit is the regulation of medicines, related products, herbal remedies and controlled drugs used as medicines. Medsafe also administers a post-market system for regulating medical devices supplied in New Zealand (see section 2.8.5).

The objective of the medicines legislation is to manage the risk of avoidable harm associated with the use of medicines. The legislation is designed to ensure that:

- medicines meet acceptable standards of safety, quality and efficacy;
- personnel, premises and practices used to manufacture, store and distribute medicines comply with requirements designed to ensure that products meet acceptable standards right up until they are delivered to the end-user;
- information about the selection and safe use of medicines is provided to health professionals and consumers.
Medsafe is responsible for applying a framework of controls designed to ensure that the therapeutic products available in New Zealand are those that can be expected to maximize therapeutic benefits and minimize risks. This is achieved through the pre-marketing approval of products and post-marketing surveillance. In New Zealand, new medicines cannot be marketed without the approval of the Minister of Health (or delegate). Data that satisfactorily establish the quality, safety and efficacy of the product, for the purposes for which it is to be used, must be submitted to Medsafe for evaluation before marketing consent can be granted. Once Medsafe approval has been granted for the marketing of a pharmaceutical, the sponsor (usually the manufacturer) may apply to PHARMAC to have it assessed for listing on the Pharmaceuticals Schedule (i.e. to receive a subsidy). While PHARMAC is not strictly a regulatory body, it is a powerful player in the health sector as it provides advice to government on which pharmaceuticals should be subsidized, and negotiates with suppliers to obtain supplies on favourable terms.

(See section 5.6 for further information about Medsafe and PHARMAC.)

2.8.5 Regulation of medical devices and aids

New Zealand has a post-market system for regulating medical devices supplied in New Zealand. Medical device manufacturers are required to notify details of their medical device to a database operated by Medsafe. The Director-General of Health has the right to request information about the safety of devices and to remove products from the market for up to one year should safety concerns arise. There is no pre-market approval process for medical devices supplied in New Zealand.

From 1 July 2012, Medsafe began publishing information about all medicine and medical-device recall actions occurring in New Zealand on its web site. This information is publicly available via the Medsafe Online Recalls Database (http://www.medsafe.govt.nz/hot/Recalls/RecallSearch.asp).

2.8.6 Regulation of capital investment

See section 4.1.1 Capital stock and investments.
2.9 Patient empowerment

2.9.1 Patient information

The MOH provides information about various aspects of New Zealand health services on its web site (http://www.health.govt.nz) along with links to other information sites. For example, there is information about a range of health conditions and their treatment, choosing a GP or finding a PHO (MOH, 2007b). Information pamphlets are also produced, for example, Enrolling with a Primary Health Organisation was published in 2002 as PHOs were being established; Childhood Immunisation (last revised 2011) provides information for families’ decision-making about immunization; and there are pamphlets about breast and cervical screening programmes. Many other brochures are available about health conditions and health services.

Two free, 24-hour telephone services (Healthline and the Well Child Telephone Advice Service) are contracted by the MOH to provide health advice (MOH, 2012a). The services are staffed by registered nurses.

Disability information is available through over 20 regional Disability Information Centres (part-funded by the MOH) and a national web site (http://www.weka.net.nz).

A large number of not-for-profit groups, usually grouped around health conditions, also exist to provide support and information to patients, and in some cases act as advocates for patient services. Examples include the Cancer Society of New Zealand, the National Health Foundation, New Zealand AIDS Foundation, Alzheimers New Zealand, IHC (which provides services to people with intellectual disabilities and their families), CCS Disability Action (a partnership organization working with disabled people) and the Disabled Persons Assembly (an umbrella organization representing people with disabilities, the organizations involved in advocacy on their behalf and service providers). Consumer New Zealand (along with other media) also has a role to play in providing information for patients.

2.9.2 Patient choice

Patients are free to enrol with a GP (and other primary health care providers) of their choice, although this can be limited in some geographical areas where there is a shortage of key providers. Patients
can, however, be enrolled with only one PHO at a time; they will be asked to enrol when they choose to register with a particular GP, though it is the GP who will have decided which PHO they affiliate with. Patients can still use other doctors or health providers, but will be charged as a ‘casual patient’ for such visits (at a higher rate than care received from the GP they are registered with) (MOH, 2007b). This can be as much as NZ$75 for an adult without a Community Services Card (see sections 3.3.1 and 3.7.1). A high proportion of New Zealanders have a regular primary health care provider. Results from the 2006–2007 New Zealand Health Survey showed 97% of children and 93% of adults had a primary health care provider they go to first when unwell or injured, and 92% of adults who had seen their provider in the previous 12 months reported they had not changed provider in that time (MOH, 2008a). Eighty per cent of adults who saw a GP at their primary health care provider in the previous year said they usually saw the same GP every time, and 82% reported there was no time in this period that they were unable to see their PHC provider within 24 hours (MOH, 2008a).

A person may choose to dis-enrol from a GP practice, and hence a PHO, at any time. A PHO can terminate an individual’s enrolment only if there is genuine concern that the relationship between the patient and the practitioner is severely compromised, and having given appropriate notice and a reason for termination (MOH, 2002b). Enrolment cannot be terminated or refused on the basis of health status, anticipated need for health care or any other form of discrimination as defined in the Human Rights Act 1993. If a PHO terminates or refuses enrolment, it must also offer to help the person find another suitable provider (MOH, 2002b).

Patients have a choice of public or private secondary care. However, within the public system they do not usually have a choice of either specialist or hospital but will be referred by their GP to the nearest service, which will allocate appointments with the available specialists. Those who can afford to pay for private secondary care or who have health insurance will have the choice to receive services from the private sector if they wish; however, patient choice of private providers may be limited as private providers are largely located in the main centres and may not be available in provincial and rural areas.

### 2.9.3 Patient rights

The office of the Health and Disability Commissioner (HDC) was established under the Health and Disability Commissioner Act 1994,
with the purpose “to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights” (section 6). This is achieved through the implementation of a Code of Health and Disability Services Consumers’ Rights, which applies to all health and disability services in New Zealand and which carries legal force (Health and Disability Commissioner, 1996). The Code includes 10 rights of consumers and duties of providers, as follows:

1. Right to be treated with respect
2. Right to freedom from discrimination, coercion, harassment and exploitation
3. Right to dignity and independence
4. Right to services of an appropriate standard
5. Right to effective communication
6. Right to be fully informed
7. Right to make an informed choice and give informed consent
8. Right to support
9. Right in respect of teaching or research
10. Right to complain.

Providers must have complaints procedures and must “facilitate the fair, simple, speedy, and efficient resolution of complaints” (Health and Disability Commissioner, 1996). Consumers may complain directly to a provider, or use the services of the Health and Disability Commissioner, including their independent advocates (Paterson, 2002).

Consumers may also complain to health practitioners’ professional bodies. Under the Health Practitioners Competence Assurance Act 2003, where such complaints affect a consumer, they must be referred to the Health and Disability Commissioner (section 64). In addition, Professional Conduct Committees can consider complaints to determine whether they are related to competence or discipline issues, and recommend appropriate action, which can be to review the practitioner’s competence, fitness to practise, and/or scope of practice; refer the matter to the police; or counsel the practitioner (section 80).

The 1993 Privacy Act exists to promote and protect individual privacy. The Act includes 12 information privacy principles to guide the way personal information can be collected, used, stored and disclosed. The Health Information Privacy Code sets out the specific applications of the Privacy
Act to the health sector (Privacy Commissioner, 1994). Organizations are required to have procedures to deal with complaints about breaches of privacy, and failure to comply with the Code can result in penalties for both organizations and individuals.

2.9.4 Complaints procedures (mediation, claims)
See section 2.9.3 above.

2.9.5 Public participation
Consumer participation in the health system occurs at a number of levels in New Zealand, including representation on MOH advisory committees and the Disability Support Services Consumer Consortium, which provides input and advice to Disability Support Services on its planning, policy and service development (MOH, 2011f). At DHB level, consumers may become elected or appointed board members, and may be appointed by the board to serve on its mandated advisory committees (the community and public health advisory committee, disability support advisory committee and hospital advisory committee). Public voting for DHB members takes place every three years alongside local body elections. In 2010, forty-nine per cent of electors on the roll voted for DHB board members (Department of Internal Affairs, 2011b). PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community (King, 2001b). There are also many NGOs representing consumers in the health and disability sectors.

2.9.6 Patients and cross-border health care
There is no information available on the numbers of New Zealanders who might travel abroad for medical treatment, although reports surface from time-to-time about individuals who have sought care elsewhere (e.g. Blundell, 2009). Some DHBs have made occasional and temporary use of specific services, such as radiotherapy during a period of staff shortages. At times, New Zealanders have had to travel in order to receive some new services such as liver transplants, which could be carried out in Australia before they became available in New Zealand for adults from 1998 and children from 2002 (Hoby, 2002). DHB specialists can also apply to the MOH Special High Cost Treatment Pool for funding of one-off treatments not otherwise funded by the public health system (MOH, 2008f). This can include treatment which is only available outside New Zealand (as well as treatment offered only by private hospitals).
All residents in New Zealand, including visitors, are eligible for ACC services if they receive an injury within New Zealand. Other publicly funded health services are restricted to New Zealand citizens, permanent residents who have lived in New Zealand for two years or more, people on work permits and eligible to be in New Zealand for two years or more, and some other categories. New Zealand citizens living in the Cook Islands, Niue and Tokelau who visit New Zealand are eligible for publicly funded services (MOH, 2011b). The government’s international aid and development programme funds health assistance for citizens living in the Cook Islands, Niue and Tokelau which may be delivered within those countries, or assistance may be given to transport people to New Zealand for services.

The government’s aid programme also funds two schemes for citizens of Fiji, Kiribati, Samoa, Tonga, Tuvalu and Vanuatu (MOH, 2011b). The Visiting Medical Specialists Scheme funds specialists to travel to these countries to provide services, assist in Pacific staff professional development and to strengthen local services. The Medical Treatment Scheme funds residents of these Pacific countries who meet certain criteria to travel to New Zealand for treatment.
Chapter 3: Financing

Chapter summary

New Zealand finances health care primarily through government sources (83.2% in 2010, of which 8.4% comes from the Accident Compensation Corporation (ACC) and almost all the remainder from general taxation), with the balance coming from direct payments by service users, private health insurance premiums and a small contribution from nonprofit organizations. In 2010, New Zealand ranked 12th in the Organisation for Economic Co-operation and Development (OECD) for health expenditure as a percentage of GDP at 10.1% (slightly above the OECD average of 9.5%). Health expenditure as a percentage of GDP rose from 6.8% in 1990 to 10.1% in 2010. However, New Zealand health expenditure per capita at USNZ$ 3022 PPP is lower than the OECD average (USNZ$ 3268).

Total appropriations for health spending in the 2013–2014 Crown (government) Budget are NZ$ 14 655 million, an increase of NZ$671 million or 4.8% over actual expenditure in 2012–2013. Most health services funding goes to District Health Boards (DHBs) (80%), with the remainder spent on national services purchased directly by the Ministry of Health (MOH).

The New Zealand health care system provides universal access to a broad set of health services; in addition, about 38% of adults hold some supplementary private health insurance (representing 4.9% of total health expenditure). The MOH funds 20 DHBs through a population-based funding formula and DHBs then fund a range of providers through service agreements as well as having their own hospital services. Outpatient and inpatient hospital services, including maternity services, are free. Following the introduction of The Primary Health Care Strategy in 2001, capitation funding has replaced fee-for-service funding of general practice, but patients continue to pay additional fees, though these have generally reduced. Most prescriptions have a co-payment of NZ$5 per item. Basic dental services are free for children; adult dental care and optometry are paid for privately. Long-term care is funded through both public and private mechanisms.
The state-run ACC provides injury compensation through a fully comprehensive, no-fault insurance scheme. ACC is funded through employer, employee, self-employed and car-licensing levies. It also provides funding to the MOH for accident-related care costs incurred by public hospitals and pays private providers for approved treatment for accident-related care.

3.1 Health expenditure

New Zealand finances health care primarily through government sources, with the remainder coming from direct payments by service users, private health insurance premiums and a small contribution from non-profit organizations. Figure 3.1 shows that 83.2% of New Zealand’s total health expenditure in 2010 was from public sector spending, well above the Organisation for Economic Co-operation and Development (OECD) average of 72.2% and placing it in the top quarter of OECD countries.

Figure 3.1 Public-sector health expenditure as a share (%) of total health expenditure in the OECD, 2010

Source: OECD Health data 2012
In 2010, New Zealand ranked 12th in the OECD for health expenditure as a percentage of GDP at 10.1% (slightly above the OECD average of 9.5%) (Figure 3.2). As with other OECD countries, New Zealand’s health expenditure as a percentage of GDP has been increasing since 1990 (Figure 3.3), rising from 6.8% in 1990 to 10.1% in 2010. However, New Zealand health expenditure per capita at USNZ$ 3022 in purchasing power parity (PPP) in 2010 was lower than the OECD average (USNZ$ 3268) (Figure 3.4).

Figure 3.2  Health expenditure as a share (%) of GDP in the OECD, 2010

Source: OECD Health data 2012
**Figure 3.3** Trends in health expenditure as a share (%) of GDP in New Zealand and selected other countries, 1990–2010

Source: OECD Health data 2012

**Figure 3.4** Health expenditure in NZ$ PPP per capita in the OECD, 2010

Source: OECD Health data 2012
Between 1999–2000 and 2009–2010, total (nominal) public expenditure on health rose from NZ$ 9.633 billion to NZ$ 16.536 billion, with a real annual average growth rate of 5.6% [Table 3.1]. Private expenditure rose from NZ$ 2.547 billion to NZ$ 3.334 billion, a real annual average growth rate of 2.7%. Thus, total expenditure rose from NZ$ 12.181 billion to NZ$ 19.870 billion, a real annual average growth rate of 5.0%. Nominal public expenditure per capita grew by 4.2%; private expenditure per capita by 1.4%; and total expenditure per capita by 3.7%. Overall, health expenditure grew by more than the real growth in GDP, which grew over the period by 2.4% in total and 1.1% per capita (MOH, 2012e; OECD & ILIS, 2009). This came after a period of robust growth in private-sector financing, where, between 1980 and 1995, private expenditure grew from 12.0% to 23.3% of total health expenditure (MOH, 1999a, p. 26). Increases in private expenditure reflected both government budget pressures and a shift from the welfare state to a free market economic philosophy, common to many industrialized countries of the time.

Table 3.1  Real current expenditure trends, 1999–2000 to 2009–2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Total current health expenditure (NZ$ million June 2010)</th>
<th>Expenditure per capita (NZ$ June 2010)</th>
<th>Real GDP (NZ$ million June 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public Private Totala Public Private Totala Total</td>
<td></td>
<td>Total Per capita</td>
</tr>
<tr>
<td>1999–2000</td>
<td>9 633 2 547 12 181 2 502 662 3 164</td>
<td>150 081 38 987</td>
<td></td>
</tr>
<tr>
<td>2000–2001</td>
<td>10 144 2 885 13 030 2 620 745 3 365 156 664 40 459</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001–2002</td>
<td>10 787 2 882 13 670 2 758 737 3 495 159 790 40 856</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003–2004</td>
<td>11 430 2 923 14 353 2 814 720 3 533 176 234 43 381</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004–2005</td>
<td>12 270 3 130 15 400 2 994 764 3 757 179 599 43 816</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005–2006</td>
<td>13 075 3 255 16 329 3 159 786 3 945 181 692 43 892</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006–2007</td>
<td>13 803 3 496 17 652 3 264 698 3 962 191 369 45 259</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007–2008</td>
<td>14 740 3 053 17 793 3 453 715 4 168 188 382 44 129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008–2009</td>
<td>15 809 3 232 19 041 3 663 749 4 412 187 619 43 473</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009–2010</td>
<td>16 536 3 334 19 870 3 786 763 4 549 189 295 43 340</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAAGRb</td>
<td>5.6% 2.7% 5.0% 4.2% 1.4% 3.7% 2.4% 1.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: MOH (2012e, p. 18).

a Totals may be affected by rounding.
Figure 3.5  Aggregate real (2009–2010) per capita health expenditure, 1980–2010

Source: MOH (2012e, p. 16).

Total appropriations for health spending in the 2013–2014 Crown (government) Budget are NZ$14,655 million, an increase of NZ$671 million or 4.8% from actual expenditure in 2012–2013 (Treasury, 2013). Of this, 95% is spent on purchasing health services, 3.6% on capital expenditure, 1.3% on the Ministry of Health (MOH) and 0.2% on other government expenses (such as funding provider development, legal expenses and international obligations including WHO membership) (Treasury, 2013). Of the health services funding, most goes to District Health Boards (DHBs) (almost 80%), with the remainder spent on national services purchased directly by the MOH (see Figure 3.7).

Expenditure on ancillary services is dominated by public financing, accounting for 88% of total expenditure, or NZ$ 672 million, with the remaining 12% (NZ$ 91 million) financed by the private sector. The preponderance of ancillary expenditure is appropriated for laboratory services, totalling NZ$ 328 million in 2007 (OECD & ILIS, 2009).

Over half (53.8%) of health expenditure is spent on services of curative and rehabilitative care, 16% on long-term nursing care, 13% on medical goods dispensed to outpatients and 7% on ancillary services. About 6% is spent on prevention and public health services and 4% on health administration (Table 3.2).
Table 3.2  Health care expenditure by source (percentage of total expenditure on health care, 2006)

<table>
<thead>
<tr>
<th></th>
<th>Government</th>
<th>Private insurance</th>
<th>Out-of-pocket expenditure</th>
<th>Not-for-profit institutions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services of curative and rehabilitative care</td>
<td>40.13</td>
<td>3.96</td>
<td>9.49</td>
<td>0.22</td>
<td>53.80</td>
</tr>
<tr>
<td>Long-term nursing care</td>
<td>14.77</td>
<td>0.15</td>
<td>0.80</td>
<td>0.28</td>
<td>16.00</td>
</tr>
<tr>
<td>Ancillary services to health care</td>
<td>4.31</td>
<td>0.34</td>
<td>2.07</td>
<td>0.06</td>
<td>6.77</td>
</tr>
<tr>
<td>Medical goods dispensed to outpatients</td>
<td>8.70</td>
<td>0.25</td>
<td>4.18</td>
<td>NA</td>
<td>13.12</td>
</tr>
<tr>
<td>Prevention and public health services</td>
<td>6.00</td>
<td>NA</td>
<td>NA</td>
<td>0.37</td>
<td>6.37</td>
</tr>
<tr>
<td>Health administration and health insurance</td>
<td>3.94</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>3.94</td>
</tr>
<tr>
<td>Total current expenditure</td>
<td>77.85</td>
<td>4.69</td>
<td>16.54</td>
<td>0.93</td>
<td>100.00</td>
</tr>
</tbody>
</table>

NA, data not available.

3.2  Sources of revenue and financial flows

Figure 3.6 shows the sources of New Zealand’s health funding as percentage shares, comparing 2000 and 2010. Most health services are publicly funded, the majority by the MOH, followed by ACC, whose share increased from 5% to 9% over the 10-year period. Other government agencies and local authorities make only small contributions. Private funding is largely comes from individual payments, with about 5% from private health insurance.

Figure 3.6  Percentage shares of New Zealand’s total health funding, 1999–2000 and 2009–2010

Source: MOH (2012e).
Figure 2.1 (p. 19) shows the financial flows within the New Zealand health system. Key points are:

- most funding flows from the population through general taxation into central government, through to the MOH (Vote Health);
- about 20% of funding is used by the Ministry to directly fund national services such as disability support, public health, specific screening programmes, mental health, elective services, Well Child and primary maternity services, Maori health and postgraduate clinical education/training (MOH, 2013d);
- most of the remaining Vote Health funding is allocated to DHBs – the MOH funds the (now 20) DHBs through a population-based funding formula;
- DHBs then fund a range of providers through service agreements;
- patients pay some fees for primary health care services; most New Zealanders would pay NZ$5 per prescription item as a co-payment, while co-payments for GP services are set by the GPs themselves and vary according to the funding arrangements the GP’s PHO has with their DHB and according to how GPs wish to set fees;
- patients may also purchase private health insurance; usually, patients directly pay providers for private care and apply to the insurer for reimbursement, but in some cases the insurer will have an arrangement with a specialist or private hospital where the insurer pays the provider of the service directly; patients may also pay for private care out of their own pockets;
- ACC is funded through employer, employee, self-employed and car-licensing levies;
- ACC provides funding for accident-related care delivered by publicly owned hospitals and pays private providers for approved treatment for accident-related care.

The state-owned ACC accounts for a significant portion of public funding, 8.4% (NZ$1.7 billion) of total health expenditure in 2009–2010 [MOH, 2012e]. Apart from the MOH and ACC, a number of other government agencies contribute to public health financing, including bio-security departments such as the Ministry for Primary Industries and Department of Conservation; Education; Research, Science and Technology; Corrections and Social Development (MOH, 2008e). In 2007–2008 bio-security departments and agencies accounted for NZ$ 181 million, and are responsible for services including border inspection and disease surveillance. Health funding through the Ministry of Education includes
training professionals such as doctors, nurses and clinical psychologists, which accounted for approximately NZ$484.8 million in 2007–2008. Moreover, NZ$118.5 million of health funding through the Ministry of Education was devoted to clinical research undertaken by tertiary institutions. Finally, other major government agencies including the Department of Corrections (health care for those in custody), the Ministry of Defence (health care for defence force personnel) and the Ministry of Social Development (health care for veterans and for administering the Community Services Card programme) contributed, respectively, NZ$40.8 million, NZ$34.9 million and NZ$27.7 million (2007–2008) in health-related expenditure. Health research investment expenditure reached NZ$83.8 million in 2007–2008 (MOH, 2010a).

### 3.3 Overview of the statutory financing system

#### 3.3.1 Coverage

The New Zealand health care system provides universal access to a broad set of health services. Entitlement to free health care was originally defined through the Social Security Act 1938. However, it was not until 1947 that a tax-funded health system, delivered through both public and private systems, was made universally available to New Zealand citizens. Currently, under substantial public financing, all New Zealanders have access to extended health care services including primary health care (PHC) services, public health services, inpatient/outpatient medical and surgical hospital care, maternity services, mental health services, listed-prescription drugs, dental care for children, and disability support services (including home care, residential rest home and hospital care).

Many health services are provided free of charge to patients in New Zealand. Ambulatory care in hospital (day patient and outpatient) is free to all people with New Zealand citizenship or permanent resident status. In 2007, public expenditure on ambulatory services reached 25% of total expenditure on health, consistent with most OECD member countries (OECD & ILIS, 2009). Co-payments were introduced for both inpatient and outpatient hospital treatment in the early 1990s, but proved to be extremely unpopular. Inpatient charges were quickly dropped and outpatient charges were removed in 1997.

Medical aids and prostheses are free of charge for children under 16 years. For adults over 16 years, the government fully subsidizes medical items required for employment or educational training purposes. If the
medical aid or prosthesis is required as a result of injury, and is deemed necessary after assessment by one of the limb centres of the New Zealand Limb Board, ACC will usually cover the cost of the item (ACC, Undated-a).

Traditionally, governments have only partially subsidized PHC services in New Zealand, leaving patients to pay co-payments for each visit. In the early 1940s, government subsidies covered around two thirds of total general practice fees (Department of Health, 1974); this fell to around 50% by the mid-1960s (Sutch, 1966), and the subsidy was virtually worth nothing by the early 1990s for many adults (including beneficiaries, those with chronic conditions and pensioners), with a higher rate for children and young people (Scott, Fougere & Marwick, 1986). Subsidy arrangements were changed in the early 1990s, with government funding then targeted towards those with lower incomes and/or higher needs.

The Community Services Card (CSC) was introduced in February 1992 to provide health care subsidies for individuals on low to middle incomes. Additionally, a person may be eligible for the CSC if they receive income support such as sickness benefit or unemployment benefit, or if the family income is below a certain threshold. Current CSC thresholds are set out in Table 3.3. The average annual household income threshold for the year ended June 2012 was NZ$81 067 (Statistics New Zealand, 2012b).

**Table 3.3 Eligibility for Community Services Card, as at 1 April 2012**

<table>
<thead>
<tr>
<th>You may be able to get a card if you are</th>
<th>And your yearly income (before tax) is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single – living with others</td>
<td>NZ$24,894.00 or less</td>
</tr>
<tr>
<td>Single – living alone</td>
<td>NZ$26,393.00 or less</td>
</tr>
<tr>
<td>Married, civil union or de-facto couple – no children</td>
<td>NZ$39,423.00 or less</td>
</tr>
<tr>
<td>Family of 2</td>
<td>NZ$47,597.00 or less</td>
</tr>
<tr>
<td>Family of 3</td>
<td>NZ$57,640.00 or less</td>
</tr>
<tr>
<td>Family of 4</td>
<td>NZ$65,627.00 or less</td>
</tr>
<tr>
<td>Family of 5</td>
<td>NZ$73,450.00 or less</td>
</tr>
<tr>
<td>Family of 6</td>
<td>NZ$82,193.00 or less</td>
</tr>
<tr>
<td>For families of more than 6, the limit goes up another NZ$7,703.00 for each extra person</td>
<td></td>
</tr>
</tbody>
</table>


The High Use Health Card (HUHC) was originally introduced to assist people who were not eligible for a CSC, but had ongoing health problems requiring frequent doctor’s visits (12 or more in the previous year).
Following new funding for PHC which has reduced the cost of GP visits and prescription charges for people enrolled in PHOs, the HUHC subsidy now applies only when the cardholder is seen on a casual basis at a practice where they are not enrolled or at an after-hours medical service.

In the early 1990s, about half of the population was entitled to a subsidy card, with the subsidy for adults (then NZ$15) covering about one third to two fifths of the average charge (NZ$37.50–45.00; MOH, personal communication); at that time, the majority of adults paid the full costs of general practice services themselves (or from private insurance) (Cumming & Mays, 2011; Cumming, Mays & Gribben, 2008). Those without a CSC paid the full cost of their general practice services. Higher subsidies were introduced in 1997 for children, with a view to enabling free PHC (for standard visits) for children aged less than six years, although GPs continued to be free to set their own fees.

The system was changed again in 2002, when New Zealand adopted a largely capitation-based system of financing (see section 3.7.1), with the extent of financing dependent upon factors including age, health status and deprivation. GPs then set the co-payment levels they charge patients for each visit. Accordingly, standard primary health services may be delivered free of charge (for many children under the age of six) or partially subsidized by the government. The CSC does not reduce co-payments for visits to a patient’s usual PHO, but may provide a discount for visits to another PHO or after-hours visits.

Injury compensation is provided by the state-run ACC, established in 1974 under the Accident Compensation Act 1972. Through a fully comprehensive insurance compensation scheme, ACC provides no-fault insurance for accident-related injuries and disabilities. The ACC has the responsibility for establishing and operating an insurance-based scheme to rehabilitate and compensate people who suffer personal injury. In order to meet this responsibility, ACC directly purchases primary care, emergency transport, community and referred services, and nonurgent (‘elective’) treatment for patients directly from public and private hospitals, and ancillary services for people with injuries from accidents. Under the Accident Insurance Act 1998, ACC was briefly exposed to competition and employers were required to purchase health insurance for employees from competing insurers to cover work-related and non-work-related injuries. A change in government in 1999 quickly reversed those legislative changes, reintroducing most of the provisions.
of the Accident Compensation Act. The National Party-led coalition government elected at the end of 2011 has, however, been planning to reintroduce competition for Work Account (covering injuries incurred in the workplace), although proposals have yet to be finalized.

In 2009–2010, total ACC expenditure on health was NZ$1669.8 million, which was 8.4% of total health expenditure (MOH, 2012e).

ACC receives income from five sources:

- employers pay a premium based on their total payroll and on the relative safety/risk involved in the type of work performed – the employer’s work record also influences the premium level;
- earners, who pay a premium based on their total earnings which is collected as PAYE (pay as you earn) income tax;
- motor vehicle owners and drivers, where the premium is included in the annual vehicle registration fee and an excise duty component on petrol sales;
- an annual government payment, using money collected through general taxation, to cover people who are not earning an income;
- investment earnings from respective account reserves (ACC, 2012b).

In addition to covering medical and rehabilitation expenses, depending on the type of injury sustained, ACC will provide an income of 80% of the patients’ pre-injury income, as well as any specialized equipment required for daily activities (ACC, 2008b).

Less than half of New Zealanders hold private health insurance, which supplements rather than competes with the publicly funded system and accounts for only about 4.9% of total health care expenditure (see section 3.5 for further details).

The New Zealand Government subsidizes medicines through the state-owned PHARMAC. Pharmaceuticals are free for inpatients and, from the mid-2000s, other people paid a maximum of NZ$ 3 per item on the pharmaceutical schedule from pharmacies; this charge rose to NZ$5 in January 2013 (no charge for children under six years). However, prescriptions for a non-schedule or partially subsidized medicine incur an additional charge. Once an individual or family has collected 20 new prescription items in a year, they are eligible for a pharmaceutical subsidy card and do not have to pay any more prescription charges until 1 February the following year (MOH, 2013i). Some evidence suggests,
however, that not all those eligible for free prescriptions get their medicines free, as pharmacies do not work with a national information system and family members’ information is also not linked together well (University of Otago, 2012).


Under reciprocal health agreements signed with Australia and the United Kingdom, citizens are entitled to certain health services of the country they are visiting as defined in the terms and conditions of the respective Health Benefits Act (MOH, 2011o). For example, the Health Benefits (Reciprocity with Australia) Act 1999 allows Australian temporary visitors the same medical treatment as a New Zealand citizen if deemed necessary by a registered medical professional. New Zealand citizens are entitled to reciprocal health benefits in both Australia and the United Kingdom.

3.3.2 Collection

New Zealand’s health care system is financed predominantly through general taxation. In 2009–2010, public-sector financing accounted for 83.2% of total health expenditure. All other funding was from private sources, including out-of-pocket payments and voluntary health insurance, which collectively contributed an additional 16.8% of financing (MOH, 2012e; OECD & ILIS, 2009).

New Zealand citizens contribute to health care revenue through general taxation based mainly upon PAYE income tax and Goods and Services Tax (GST, a form of value-added tax on goods and services). A portion of general taxation is allocated to the government health system budget each year (Government of New Zealand, 2008). The second compulsory contribution is through the ACC, paid through a mix of taxation and levies (section 3.3.1; see also section 5.7).

Taxation in New Zealand is collected at both the central level, through the Inland Revenue Department (IRD), and at the local and regional levels by local governments. New Zealand has a progressive form of income taxation, based on a four-tier system, with PAYE rates ranging from 10.5% to 33%. In addition, an ACC levy of 2.04% is charged with a maximum of NZ$ 2244.36 per year (IRD, 2011). Local taxes are collected in the form of
property taxes, known as ‘Rates’, at the discretion of local governments. Rates are based on land valuation and capital improvements to the land, and can only be collected by local or regional bodies – not central government. Corporate taxation is now set at 28%. Additionally, New Zealand has GST, introduced in 1986, which was originally 12.5% but increased to 15% in October 2010. New Zealand Government tax revenue as a percentage of GDP was 36.7% in 2006, close to the OECD average of 35.9%.

Table 3.4 sets out health expenditure in New Zealand by source of funds and their percentage contribution from 1999–2000 to 2009–2010. The majority comes from public funding, the percentage contribution of which has risen slightly from 80% in 1999–2000 to 83% in 2009–2010, with a concomitant drop in private funding.

**Table 3.4 Health expenditure by source of funds (%), 1999–2000 to 2009–2010**

<table>
<thead>
<tr>
<th>Year</th>
<th>MOH</th>
<th>Deficit funding a</th>
<th>ACC – social security</th>
<th>Other government agencies</th>
<th>Local authority</th>
<th>Total public funding</th>
<th>Private household</th>
<th>Health insurance</th>
<th>Not-for-profit organizations</th>
<th>Total private funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999–2000</td>
<td>69.5</td>
<td>0.1</td>
<td>6.2</td>
<td>2.7</td>
<td>0.6</td>
<td>79.1</td>
<td>14.6</td>
<td>6.0</td>
<td>0.3</td>
<td>20.9</td>
</tr>
<tr>
<td>2000–2001</td>
<td>66.9</td>
<td>0.7</td>
<td>6.8</td>
<td>2.7</td>
<td>0.6</td>
<td>77.9</td>
<td>16.0</td>
<td>5.9</td>
<td>0.3</td>
<td>22.1</td>
</tr>
<tr>
<td>2001–2002</td>
<td>66.3</td>
<td>2.2</td>
<td>7.2</td>
<td>2.7</td>
<td>0.6</td>
<td>78.9</td>
<td>15.3</td>
<td>5.5</td>
<td>0.3</td>
<td>21.1</td>
</tr>
<tr>
<td>2002–2003</td>
<td>66.3</td>
<td>1.8</td>
<td>7.9</td>
<td>2.7</td>
<td>0.6</td>
<td>79.4</td>
<td>14.9</td>
<td>5.5</td>
<td>0.3</td>
<td>20.6</td>
</tr>
<tr>
<td>2003–2004</td>
<td>69.7</td>
<td>0.0</td>
<td>7.7</td>
<td>1.7</td>
<td>0.5</td>
<td>79.6</td>
<td>14.1</td>
<td>5.5</td>
<td>0.8</td>
<td>20.4</td>
</tr>
<tr>
<td>2004–2005</td>
<td>69.4</td>
<td>0.0</td>
<td>8.1</td>
<td>1.6</td>
<td>0.5</td>
<td>79.7</td>
<td>14.1</td>
<td>5.2</td>
<td>1.1</td>
<td>20.3</td>
</tr>
<tr>
<td>2005–2006</td>
<td>69.3</td>
<td>0.0</td>
<td>8.5</td>
<td>1.7</td>
<td>0.6</td>
<td>80.1</td>
<td>13.8</td>
<td>5.1</td>
<td>1.0</td>
<td>19.9</td>
</tr>
<tr>
<td>2006–2007</td>
<td>70.5</td>
<td>0.0</td>
<td>9.2</td>
<td>2.0</td>
<td>0.7</td>
<td>82.4</td>
<td>11.5</td>
<td>5.1</td>
<td>1.0</td>
<td>20.2</td>
</tr>
<tr>
<td>2007–2008</td>
<td>70.6</td>
<td>0.0</td>
<td>9.5</td>
<td>2.2</td>
<td>0.5</td>
<td>82.8</td>
<td>11.2</td>
<td>5.0</td>
<td>0.9</td>
<td>17.2</td>
</tr>
<tr>
<td>2008–2009</td>
<td>70.9</td>
<td>0.0</td>
<td>9.7</td>
<td>2.1</td>
<td>0.3</td>
<td>83.0</td>
<td>10.6</td>
<td>5.0</td>
<td>1.4</td>
<td>17.0</td>
</tr>
<tr>
<td>2009–2010</td>
<td>72.5</td>
<td>0.0</td>
<td>8.4</td>
<td>2.0</td>
<td>0.3</td>
<td>83.2</td>
<td>10.5</td>
<td>4.9</td>
<td>1.4</td>
<td>16.8</td>
</tr>
</tbody>
</table>

Source: MOH (2012e, p. 20).

a From 2003–2004, DHB operating deficits are reflected in the Ministry figures.
b Prior to 2003–2004, ACC was classified as ‘other government agencies’. Data series have been restated back to 2000 to reflect this recategorisation.
3.3.3 Pooling of funds

The structure of New Zealand’s health and disability sector is illustrated in Figure 2.1.

All Vote Health expenditure flows through the MOH, from where funding is divided into two key categories: Departmental spending and non-departmental spending. Allocation of resources is performed by the MOH after negotiation of budget appropriations with the Treasury. Departmental appropriations refer to those funds required for the functioning of the MOH, for example, administration and performance monitoring costs. Non-departmental appropriations are designated for the purchase of health services from providers. Figure 3.7 shows Departmental spending (i.e. the MOH) in 2010–2011, with over a third of funding going on information and payment services; a quarter on sector leadership and services; a fifth on strategy, policy and systems; and just under a fifth on regulatory and health emergency response services.

![Figure 3.7 2010–2011 Departmental operational appropriations – actual expenditure](chart)

Source: MOH (2011b, p. 84).
Notes: Total actual expenditure was NZ$205,227 million.
MCOA: Multi-class output expense appropriation, covering information technology services and payment services.
Figure 3.8 shows the Non-departmental appropriations, with over three quarters of funds going through DHBs. The boards of each DHB are responsible for planning, maintaining and managing the resources of their respective DHBs appropriately. DHBs receive public funds to purchase health services for a geographically defined population. DHBs allocate funds through service agreements to providers such as PHOs, pharmacists, laboratories, other private providers, community trusts and private hospitals. DHBs are also responsible for the delivery of health services to their geographical areas through their provider arm, commonly their own hospital, or through contracts with other hospitals (MOH, 2008e).

DHBs have high financial autonomy from the MOH, reserving the right to maintain cash surpluses over successive financial years. Additionally, DHBs can keep accounts with, and borrow from, private banks and markets (Healy, 2002). However, DHBs are directly responsible to the MOH, and must undertake priorities as set out each year in a ‘letter of expectations’, and meet service specifications and performance targets. At times, a portion of the received funds is also earmarked for specific services.

DHBs, responsible for planning and organizing health care services, absorbed 79.2% of the health budget in the 2010–2011 financial year (MOH, 2011b, p. 85). The remaining funding was spent on services that were directly purchased by the MOH.

Figure 3.8 2010–2011 Non-departmental operational appropriations – actual expenditure

Note: Total actual expenditure was NZ$12.738 billion.
DHBs are funded using a population-based funding formula (PBFF), re-introduced with the establishment of DHBs in 2001. The factors taken into consideration in the formula are:

- the DHB’s share of the projected New Zealand population, weighted according to the national average cost of the health services used by different demographic groups;
- an additional policy-based weighting for unmet need that recognizes the different challenges DHBs face in reducing disparities between population groups;
- a rural adjustment and an adjustment for overseas visitors, each of which redistributes a set amount of funding between DHBs to recognize unavoidable differences in the cost of providing certain health and disability support services (MOH, 2004c, p. 2).

A third category, capital expenditure, accounted for 2.0% of the health budget in 2008–2009. This category covered investment costs for DHB development, interest-free loans to assist people in long-term care and costs of purchasing assets for use by the MOH (Government of New Zealand, 2008).

New Zealand, like some other OECD nations, has (since 2002) largely adopted capitation as a method for allocating funds for PHC. Funding for PHOs is divided into different categories, and each capitation payment is based on the number of enrolees within different population sub-groups. Generally, child rates (ages 0–4 years) are the highest, followed by those aged 65 and over; and rates are higher for females (except for children 0–4), for Māori and Pacific peoples, and for those in the most deprived areas.

- Capitation payments for first-contact services are weighted by age, gender, PHO funding type based on the deprivation of its enrolled population (see section 3.7.1), and the numbers of people who are high users.
- Health promotion funding is weighted by deprivation and the percentage of Māori and Pacific people enrolled in a PHO.
- Services to increase access funding (for non-high-use enrolees) is weighted by age, gender, Māori and Pacific enrolees, and deprivation.
- Care Plus funding (for those PHOs that have engaged with this funding for increased services for people with chronic conditions) is a single payment per enrolled person.
• A rural ranking payment is also available, with higher capitation rates the more rural the service is.
• PHOs also receive a management fee, which is largely paid on a capitation basis and reduces with the number of enrolees in a PHO (MOH, 2011c).
• There are separate capitation rates (weighted by age) for practices that agree to ‘very low cost access’ arrangements. There are two different arrangements here: one for all practices that agree to keep co-payments at NZ$0 for those under six; and a separate scheme for those practices that agree to very low cost care for all groups (NZ$0, for those under 6; NZ$11.50 for those 6–17; NZ$17 for adults). (The latter scheme is now only available to those practices with more than 50% of their enrolees with high needs, i.e. Māori, Pacific, or with the lowest socioeconomic status.) (MOH, 2011s).
• Additional performance payments area also available on a capitation basis for those PHOs meeting specific targets.

Note that immunization payments remain on a fee-for-service basis.

Although PHOs are funded on a capitation basis, how they distribute funding to general practices is up to them. Research has found that most fund practices on the same basis as the PHO receives funding (i.e. via capitation), but that individual practitioners continue to be paid through a variety of means. A general practice may have one or more GP owners as well as GPs who work there but have not ‘bought into’ the practice. In a survey of 99 general practices, 82% of non-owners reportedly received their income via a fixed payment (e.g. a salary), but around a third of non-owners were receiving at least some income based on the number of patients seen or fees earned. Among practice owners, the list size affected payments for 52% of respondents, and payments made according to patients seen (59%) and fees earned (69%) were even more prevalent for this group (note that multiple responses were possible so the totals add to over 100%) (Smith & Cumming, 2009a).

3.4 Out-of-pocket payments

3.4.1 Cost-sharing (user charges)

Public funding covers PHC visits, prescription drugs, specialist consultation and hospital care. However, out-of-pocket payments (payment at the time of care) are still required, for example, in filling
prescriptions and health care provided in primary health care settings by GPs and practice nurses. These out-of-pocket payments vary according to the age of the patient, the type of PHO and the individual physician the patient is enrolled with, and often constitute the difference between government subsidies and physician fees at the time of service. Additionally, out-of-pocket payments are subsidized for higher-risk groups and low-income earners through CSCs, High Use Health Cards, and Pharmaceutical Subsidy Cards (see section 3.3.1).

Out-of-pocket payments increased with decreasing public financing during the 1980s and early 1990s. In 1980, private out-of-pocket payments accounted for 10% of total health revenue, increasing to 17% in 2003–2004 (amounting to around NZ$ 2.155 billion), before declining in each of the following years to 10.5% in 2009–2010 (MOH, 2012e), as the funding from The Primary Health Care Strategy led to reductions in co-payments. The major components of out-of-pocket payments are outpatient (PHC including dental care) (29.7%) and pharmaceuticals (21.8%) (MOH, 2010a). Co-payments account for the majority of out-of-pocket payments. Since the introduction of capitation and additional funding under The Primary Health Care Strategy, patient co-payments for general practitioner and practice nurse visits have generally fallen (Cumming, Bryson & Inder, 2008). Private health insurance companies commonly reimburse the majority of costs for those people that include such coverage in their policies; if the patient has an excess associated with their policy, the insurer bears most of the cost, but a portion is still contributed by the patient. Public hospital accident and emergency, medical, and surgical services are provided free of charge, leaving PHC as the major setting for out-of-pocket payments.

Older people in residential nursing care pay for these services unless they are eligible for a means-tested subsidy (see section 5.8.2).

### 3.5 Voluntary health insurance

The proportion of the population covered by private health insurance, which varies considerably by age group and income, was estimated in 2006–2007 at approximately 38.4% of New Zealand adults (MOH, 2008a), down from an estimated 51% in 1990 (OECD & ILIS, 2009). An estimated 31.3% of children were covered (MOH, 2008a). Adults aged 15–34 years and those over 65 were less likely to be covered; while Māori and Pacific adults and children were less likely to hold insurance than those of New Zealand European ethnicity.
Private health insurers are configured to supplement the well-established publicly funded system rather than directly competing for services supplied through government-funded programmes and agencies. Accordingly, private health insurance accounts for only 4.9% of total health care expenditure (2009–2010), down from 6.5% in 1995–1996. Expenditure trends from 1999–2000 to 2009–2010 indicate growth in private insurance expenditure: from NZ$560.9 million to NZ$974.9 million, equating to a real growth rate of 3.6% per year over the period 2003–2004 to 2009–2010 (MOH, 2012e). Private health insurance and out-of-pocket payments accounted for 15.4% of health expenditure in 2009–2010 (MOH, 2012e), lower than the OECD average of 23.9% (OECD & ILIS, 2009).

Two main types of health insurance are offered in New Zealand: comprehensive policies that cover both PHC user charges and hospital services, and hospital-only policies that cover specialist and hospital care. Within these two broad types of policies, New Zealanders can choose which specific services they want coverage for, e.g. dental care, optician services and glasses/contact lenses, physiotherapy, nutrition, hearing tests, clinical psychology consultations. Packages also differ in the proportion of costs (e.g. 10%, 20%) those insured pay for themselves and the annual maxima of reimbursements they are covered for. Insurers will also often reimburse only to a maximum schedule fee for particular services, and those insured pay above those maxima as well. Those insured can also agree to pay an ‘excess’, e.g. the first NZ$100 from each claim, to reduce premiums. Under the Human Rights Act, an exception allows discrimination on the grounds of sex, disability and age “if they are rationally related to insurance underwriting criteria” (Human Rights Commission, 2007, p. 5).

Private health expenditure is dominated by institutional care costs. In 2007–2008, institutional care accounted for 69% of total private expenditure, with specialist services and referrals making up the next largest component at 18% (see Figure 3.9) (MOH, 2010a).

In addition, life insurance companies offer lump sum payments to cover medical expenses for people diagnosed with a terminal illness or disability.
3.5.1 Market role, size and structure

Health insurance membership has been falling in recent years (see Figure 3.10). Coverage reached a high of nearly 50% in 1990 [OECD & ILIS, 2009], and then fell as tax deductions were removed and a fringe benefit tax began to apply where employers offered coverage. The proportion of people covered began to rise again in the early 2000s and is now falling again, perhaps in part due to the expanded coverage New Zealanders have for PHC and more clarity over waiting times for elective services.

Unlike other countries, most health insurance in New Zealand is sold on an individual basis, although employers are encouraged to offer insurance to their employees, usually with a discount available to acknowledge membership is being obtained through a group. But unlike other countries, packages are not tailored for individual employers.

New Zealand’s private health insurance industry is dominated by one major player: Southern Cross Health care. The Health Funds Association of New Zealand, however, lists 10 other insurers as members, including several general insurers and other not-for-profit insurers.

The Southern Cross Health care Group includes a not-for-profit medical care society, established in 1961 to provide an alternative for those facing long waiting times for elective surgery and increasing out-of-pocket PHC costs. The medical care society covers 61.13% of those insured in...
New Zealand (Southern Cross Medical Care Society, 2011). The Group also has a separate Health Trust that runs hospitals, travel insurance and, increasingly, PHC clinics, usually with discounts available for medical care society members.

**Figure 3.10 Percentage of population with health insurance cover 1990–2011**

![Percentage of population with health insurance cover 1990–2011](image)

Source: Health Funds Association of New Zealand (2011).

### 3.5.2 Public policy

There is no specific government regulation of private health insurance in New Zealand. General regulation for insurers as businesses and in relation to health and disability consumer rights apply, but unlike other countries, New Zealand does not regulate acceptance of members, premiums, premium increases or insurance packages.

In the past, health insurance premiums were tax deductible, but this is no longer the case. The industry regularly lobbies government for rebates, on the grounds that health insurance coverage is declining and that the government faces increased costs as a result (i.e. where people no longer have insurance coverage and instead obtain care through public funding). The New Zealand Treasury has rejected the call for such rebates, in part due to concerns over the deadweight losses that would occur (i.e. providing rebates for those who would choose to have insurance anyway), the potential for health insurers to capture increased profits, the uncertainty over the extent to which increased health insurance enrolment actually does reduce public-sector costs, as well as gaps in the case put forward by the industry (Treasury, 2004). It is recognized that the
public sector picks up the costs of, for example, laboratory and radiology tests undertaken for those who are receiving related private services paid for by their health insurance. Research has shown that those with private health insurance use more PHC and specialist services than those without such insurance (Blumberg, 2006). It has also been shown not to reduce the probability of using public hospital services, but does seem to reduce use of outpatient services. It was estimated that the public sector was therefore paying an extra NZ$40–100 million annually in additional services delivered as a result of private health insurance in New Zealand.

With little public regulation of the industry, private health insurers set their own terms and conditions around insurance policies and premiums. They may reject patients and many policies exclude pre-existing conditions for at least several years, if not forever. In previous years, particular premiums applied for large age ranges (e.g. children, young people, adults, those 65 years and over), but there has been an increasing trend for premiums to be set within smaller age bands, and for those in the older age group to face significant premium increases, as the market for insurance has become more competitive.

3.6 Other financing

3.6.1 External sources of funds

Not-for-profit organizations (known as nongovernment organizations or NGOs in New Zealand) constitute the remaining share of health expenditure: approximately 1.4%, or NZ$272.6 million in 2009–2010 (MOH, 2012e), [this is funding they themselves expend and excludes the considerable sums of government funding that they receive to deliver services on behalf of the government.] This estimate represents steady growth from NZ$32 million in 1999–2000, although not an increase in the proportion of total expenditure from these sources. Not-for-profit organizations offer health-related services funded from both their own fundraising and by the government (including the MOH and DHBs, and other central and local government agencies) (MOH, 2010a). Major organizations include the Royal New Zealand Plunket Society (services to babies, young children and their families), the NZ Family Planning Association, Barnados, the NZ Cancer Society, Diabetes NZ, NZ Catholic Social Services, Presbyterian Support Services, the Arthritis Foundation, and the Asthma and Respiratory Foundation. Many not-for-profit organizations also devote some of their funding to research; for example, the Cancer Society provides around NZ$3 million per year in research
grants aimed at detecting and treating cancer more effectively [Cancer Society of New Zealand, Undated].

NGOs are particularly active in alcohol and drug treatment, problem gambling and family support, with over 359 NGOs responsible for one third of total mental health expenditure [WHO, 2005].

3.7 Payment mechanisms

3.7.1 Paying for health services

New Zealand has universal, though not full, PHC funding. Prior to The Primary Health Care Strategy and the development of the PHOs, GPs were part-funded by the government largely on a fee-for-service part-subsidy basis, and charged patients an additional fee. Although GPs see the government subsidy as accruing to the patient, the system was set up so that the patients pay only the co-payment to the GP and the GP claims the government subsidy from the government (now through Health Benefits Limited).

The government subsidy generally failed to keep pace with rising GP fees and, as GPs have always had the right to set their own fees, New Zealanders had been paying an ever-increasing proportion of the GP fees themselves until subsidies increased with the introduction of PHOs. (See section 3.3.1.)

The population health focus of The Primary Health Care Strategy saw a shift to a capitated model of funding, with PHC funding now allocated through PHOs. PHOs are funded at two levels. ‘Access’ PHOs or GP practices were defined as those serving high-needs populations (more than 50% of their enrolled population were Māori, Pacific islanders or people living in the most deprived areas) and receive a slightly higher capitation rate for 0- to 14-year olds than ‘Interim’ PHOs. In 2002, Access PHOs’ entire enrolled populations started being capitation funded. Capitation funding for Interim PHOs’ enrolled population was progressively rolled out between 2003 and 2007 for successive age groups of patients. By July 2007, all eligible New Zealanders were covered by capitation funding subsidies, provided they were enrolled with a PHO. Those not enrolled in a PHO are not eligible for the new, higher levels of government funding for PHC. However, they are eligible for some funding if they hold a Community Services Card or High Use Health Card. Similar
arrangements hold for those receiving services outside of the practice they are enrolled with.

There are three main public funding streams for primary care: First Contact; Services to Improve Access (SIA); and Health Promotion (HP). First Contact is a capitation-based formula that provides the bulk of PHO funding (as above). It funds PHOs to provide or purchase first-contact services, such as GP or practice nurse consultations for enrolled populations. SIA funding is available for all PHOs to reduce inequalities among those populations that are known to have the worst health status: Māori, Pacific people and those living in New Zealand Deprivation index (NZDep) 9 to 10 decile areas. SIA funding is for new services or improved access to existing services, and is additional to the main PHO capitation funding for general practice-type care. HP funding is paid for health promotion activities carried out by PHOs.

In addition to the capitation funding, GPs retain the right to charge a patient co-payment. In general, funders have limited control over primary care co-payments charged to enrolled patients. The roll out of PHO capitation did create some oversight over charges for standard consultations during normal business hours. The annual statement of allowable fee increases guides how much practices can increase their standard consultation fees.

There are two areas where, in exchange for additional funding, the level of patient co-payment is determined by government. Most providers participate in the scheme for provision of free care for children under six years of age. There is also a Very Low Cost Access (VLCA) scheme whereby participating practices receive additional funding in return for a cap on the level of co-payment they can charge. The maximum charge for an adult enrolled in a VLCA practice is NZ$ 17.

As new funding was rolled out, the government became concerned that not all the new funding was being used to reduce patient co-payments and set out a framework requiring a certain proportion of the new funding to be used to reduce co-payments (Cumming & Mays, 2011). This has now developed into a process where annual acceptable increases in patient co-payment fees are determined by an independent body (based on increasing costs and increases in the capitation payments from government), with DHBs able to refer to an Independent Fee Review Committee.
As a result of these changes, by 2008, New Zealanders were paying lower co-payments for PHC services than in previous years.

New Zealanders are required to pay a co-payment of NZ$ 5 for each prescribed item that is on the pharmaceutical schedule. Prescriptions for children under six are free. Once a patient and/or their family have collected 20 prescription items in a year, they should receive a Pharmaceutical Subsidy Card, entitling them to free prescriptions for the remainder of the year (see section 3.3.1).

DHBs are not only responsible for funding and ensuring the provision of PHC services, but they also directly manage public hospitals, although there is usually a separation in the purchasing/funding and provision roles within the DHB (with hospitals called the ‘provider arm’ of the DHB). Public hospitals provide comprehensive free-of-charge health services, and are supplemented by a series of private hospitals that focus mainly on elective procedures. Specialist mental health services are publicly funded, with each DHB required to ring-fence a portion of their appropriated funds for the delivery of such services.

Long-term care in New Zealand is funded through both public and private mechanisms, with DHBs responsible for purchasing the publicly funded services. Such expenditure amounted to NZ$ 1.3 billion in 2009–2010, or 8.9% of health expenditure (MOH, 2012e).

As in most OECD countries, the private sector dominates the delivery of dental care services, with an estimated 70% of expenditures paid out-of-pocket. Public financing covers 25% of dental care expenditure, mainly through school-based dental services (Birch & Anderson, 2005) (see also section 5.12).

### 3.7.2 Paying health workers

In New Zealand, physicians are either salaried or charge on a fee-for-service basis, depending on whether they work in the public or private sector. Specialist physicians commonly devote their services to both public and private hospitals, and therefore receive both modes of income. Accordingly, physicians’ remuneration depends on both speciality and mode of employment. Self-employed specialists (those who charge on a fee-for-service basis) earn 8.4 times the national per capita GDP (equating to NZ$ 350 000–NZ$ 400 000 per year), the highest ratio in
the OECD. This ratio is not mirrored in the public sector, where salaried specialists earn an average of 3.5 times the national per capita GDP (OECD & ILIS, 2009), equating to NZ$ 160 000. With respect to hospital nurses’ remuneration, the relative income in 2002 was 1.4 times national per capita GDP, or NZ$ 47 000, the fourth highest in the OECD; this figure increased to NZ$ 67 000 in 2008. GPs may charge on a fee-for-service basis in addition to the income they receive from the government through capitated payments. Only a small proportion of GPs in New Zealand are salaried; most are self-employed and run their own practices; therefore figures on average remuneration are unreliable.
Chapter 4: Physical and human resources

Chapter summary

The Health Capital Budget is a capped funding provision for new debt and equity from which District Health Boards (DHBs) and the Ministry of Health’s (MOH) capital expenditure requirements can be funded. All DHBs need to maintain an asset management plan and to report annually on capital intentions through the District Annual Planning process. All the DHB asset management plans are consolidated centrally to inform a National Asset Management Plan. Prioritizing capital funding and investment in the health sector and advising the Ministers of Health and Finance on these matters is now the role of the Capital Investment Committee (CIC), a part of the National Health Board (NHB).

Medical equipment and devices are regulated for use in New Zealand. DHBs are responsible for purchasing the equipment they need. In 2010, New Zealand had 10.5 Magnetic Resonance Imaging (MRI) units per million population and 15.6 Computer Tomography (CT) scanners per million population (both lower than the average in Organisation for Economic Co-operation and Development [OECD] countries).

New Zealand hospitals have well-developed information technology (IT) systems, and general practitioner practices are also highly computerized. Electronic messaging is extensively used, including for sending referrals, payment claims, laboratory and pathology results, and hospital discharge summaries. Infrastructure planning of IT is now a role of the NHB. In 2010, the National Health IT Board (a sub-committee of the National Health Board) produced a National Health IT Plan, which aims to have electronic ‘virtual health’ records developed by 2014.

In 2010, there were 2.6 physicians per 1000 population (below the OECD average of 3.1) and 10 nurses per 1000 population (above the OECD average of 8.7). New Zealand has the highest proportion of migrant doctors among OECD countries and one of the highest for nurses: 52% of New Zealand’s doctors and 29% of its nurses are foreign-born; 36% of
New Zealand’s doctors and 23% of its nurses are foreign-trained. New Zealand also has high expatriation rates (health professionals born in New Zealand and working overseas): the third highest expatriation rate of doctors (28.5%) and the second highest expatriation rate for nurses (23%). Currently (2013), there are shortages of medical practitioners including some specialists such as psychiatrists, shortages of mental health workers, and there are long-standing problems in attracting professionals to rural areas and retaining them.

Gender representation in the health workforce varies significantly depending on the profession. Women make up 93% of nurses, 80% of physiotherapists, and 71% of psychologists, but only 40% of the medical practitioner workforce, 45% of GPs and 29% of dentists. Māori and Pacific people are markedly under-represented among health professionals.

There are two universities that train doctors (a six-year undergraduate course). Registered nurses are trained in three-year tertiary-level courses that are offered in both universities and polytechnics. Nurse practitioners undertake advanced training and may have prescribing rights within their specialist field. New Zealand also has Enrolled nurses who undergo an 18-month training programme and must practise under the direction and delegation of a registered nurse or nurse practitioner.

### 4.1 Physical resources

#### 4.1.1 Investments

The Health Capital Budget is a capped funding provision for new debt and equity from which District Health Boards (DHBs) and the Ministry of Health’s (MOH) capital expenditure requirements can be funded (MOH, 2003a, p. 2).

All DHBs need to maintain an asset management plan and to report annually on capital intentions through the District Annual Planning process. DHBs also need to work regionally and include capital planning in their regional strategic plan. Business cases are also expected to include a regional perspective and regional support.

Asset management planning involves a review of current assets and the financial burden of a proposed project, and medium- and long-term asset assessments. All DHBs’ asset management plans are consolidated centrally to inform a National Asset Management Plan.
All projects require a business case, which is a standalone document that assumes the reader has no prior knowledge. All business cases must comply with the Treasury Better Business Case Process.

Projects requiring significant investment require ministerial support. For example, all capital investments in fixed assets that require Crown equity, investment in projects that total more than 20% of a DHB’s assets or NZ$10 million, high-risk investment plans, investments that may affect the strategic performance of a DHB and certain investments in information systems require ministerial approval (MOH, 2003a, p. 3).

Prioritizing capital funding and investment in the health sector and advising the Ministers of Health and Finance on these matters is now the role of the Capital Investment Committee (CIC), a part of the NHB (see section 2.3.2). CIC uses a set of criteria to assess and prioritize proposals. DHBs notify CIC when they are thinking about developing a proposal and CIC will work with them to determine an appropriate timeline.

4.1.2 Capital stock and infrastructure

The MOH and DHBs are responsible for most public-sector health infrastructure costs, within their annual budget provided by the government. Private hospitals and private health care facilities are responsible for maintaining their own infrastructure. Public and private hospitals and health clinics are bound by identical legislation.

Public and private hospitals, rest homes, providers of hospital services and providers of residential care facilities with five or more residents need to meet national certification standards as required by the Health and Disability Service (Safety) Act 2001. Certification is overseen by HealthCERT, a division of the MOH. HealthCERT administers and enforces relevant legislation, reviews audit reports and manages legal issues relating to health care providers (MOH, 2012c). Certification can be issued for terms of 12 to 48 months (Health and Disability Systems Strategy Directorate, personal communication, 2009). Seven auditing agencies are designated to audit health care services (MOH, 2011b). Audits are based on Health and Disability Sector Standards, Infection Control Standards and, Restraint and Minimization and Safe Practise Standards set by Standards New Zealand (Health and Disability Systems Strategy Directorate, personal communication, 2009). Standards New Zealand is an operating arm of the Standards Council, an autonomous Crown entity operating under the Standards Act 1988 (Standards New Zealand,
Undated). Medical equipment licensing is overseen by Medsafe (see also sections 2.8.5 and 5.6).

Table 4.1 shows the number of hospital premises and beds in New Zealand in 1993, 2001 and 2009. Unfortunately, these are not directly comparable, as service definitions changed with the Health and Disability Services (Safety) Act 2001, under which providers (rather than facilities) are now certified. Therefore, the data reported to HealthCERT by individual providers are indicative only of the hospital bed capacity. With these provisos, the 2009 data show the total number of public and private hospitals in New Zealand is currently 151 with 11 248 beds overall, the majority (80%) of which are in the public sector.

Table 4.1 Hospital bed status, 1993–2009

<table>
<thead>
<tr>
<th>Number of premises</th>
<th>1993</th>
<th>2001</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private hospitals</td>
<td>200</td>
<td>125</td>
<td>71</td>
</tr>
<tr>
<td>Publicly operated hospitals</td>
<td>109</td>
<td>84</td>
<td>80</td>
</tr>
<tr>
<td>Old peoples’ homes</td>
<td>798</td>
<td>536</td>
<td>NA</td>
</tr>
<tr>
<td>Aged Care (both homes and hospitals)</td>
<td>711</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of beds</th>
<th>1993</th>
<th>2001</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private hospitals</td>
<td>7 149</td>
<td>11 377</td>
<td>2 150</td>
</tr>
<tr>
<td>Publicly operated hospitals</td>
<td>15 897</td>
<td>12 364</td>
<td>9 098</td>
</tr>
<tr>
<td>Total old people’s beds</td>
<td>23 537</td>
<td>24 769</td>
<td>37 522</td>
</tr>
</tbody>
</table>

Source: Health and Disability Systems Strategy Directorate (personal communication, 2009); New Zealand Health Information Service [2001].

a In the count of premises, some facilities are included in both the Total Old People’s Homes and Total Private Hospital numbers.
b Excluding private hospital exemption beds (i.e. medium or low level [non-hospital level] care beds).
c Including beds in old people’s homes and private hospital exemption beds.
NA, Data not available.

New Zealand has reduced its overall bed capacity over the last few decades. One reason for this 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. This applies particularly to population groups such as dependent older people, people with mental health problems, and those with physical or intellectual disabilities (as discussed further in section 5.8 Long-term care). A second reason is the push for greater cost-effectiveness in hospitals and hence shorter hospital stays and higher occupancy rates. A third reason is changes in patient management and treatment methods.
Figure 4.1  Total beds, and beds in acute hospitals per 1000 population in New Zealand and selected countries, 2010

Source: OECD Health data 2012.
Note: Trend data on beds are not available in New Zealand.

Figure 4.1 provides a comparison of beds in acute hospitals and total beds per 1000 population, showing that New Zealand is below the OECD average for both indicators. Total beds are roughly on a par with the United States and the United Kingdom, but there are fewer acute beds for the equivalent population. Average length of stay (ALOS) has been higher in New Zealand than in other OECD countries and fluctuated over the past 30 years (Figure 4.2). In 2010, ALOS was 8.1 days compared with 9.4 days in 1990.

Figure 4.2  Average length of stay, 1990 to latest available year

Note: The only operating indicator available for New Zealand is average length of stay.
4.1.3 Medical equipment

DHBs are responsible for purchasing public hospital consumables including new medical equipment. In 2004, the National Health Committee reviewed DHB decision-making about new health interventions (NHC, 2005, 2006). They found a complex decision-making environment, including political factors, funding constraints, risk minimization and the sub-specialization of medicine. Hospitals had a variety of decision-making processes, with strong clinical input but often poorly related to prioritization processes.

In the 2009 Ministerial Review Group report it was recommended that the Pharmaceutical Management Agency (PHARMAC) expand its work to include prioritization of medical devices, and this is now part of PHARMAC’s work programme (PHARMAC, 2011).

Private hospitals are free to purchase any medical equipment they require, as long as the equipment meets regulatory approval.

In 2010, New Zealand had 10.5 Magnetic Resonance Imaging (MRI) units per million population compared with the OECD average of 12.5, and 15.6 Computer Tomography (CT) scanners per million population (OECD average 22.6) (OECD, 2011).

For regulation of medical devices, see section 2.8.5.

4.1.4 Information technology

According to the 2006 New Zealand Census, 60.5% of New Zealand households had access to the Internet (Statistics New Zealand, 2007b). International comparison of Internet users in 2008 showed New Zealand had 70 Internet users per 100 inhabitants, Australia 56.8, the United Kingdom 79.9 and the United States 71.2 (ITU, 2009). The MOH web site includes a free online health information page, with links to the British Medical Journal (BMJ) BestTreatments and Cochrane Library web sites.

Health information management and technology became increasingly important in New Zealand health policy through the 1990s, a period of structural reform. The first ministerial strategy for health information was published in 1991, and the New Zealand Health Information Service was established the following year, its projects including the establishment of a national health index (NHI, a unique patient identifier), a national minimum data set (NMDS, which gathers national data on
public and private hospital discharges), and the collection of national statistics (Gauld, 2004).

New Zealand hospitals have well-developed information technology (IT) systems. General practitioner (GP) practices are also highly computerized: practices and a large proportion of other health care providers have begun to use electronic medical records software since 1992 (Jha et al., 2008). In 1998, the government made a one-off grant of about NZ$ 5000 to each general practice to purchase computers, along with giving notice that electronic claiming would become compulsory. By 2000, more than 95% of GPs used a computerized billing and appointment system, and this had reached 100% by 2008, with 75% also gathering clinical information on the computer system during patient consultations (Protti, Bowden & Johansen, 2008a, 2008b).

Electronic messaging is now extensively used, including for sending referrals, payment claims, laboratory and pathology results, and hospital discharge summaries. Currently (2013), almost all electronic messaging in the New Zealand health sector uses services provided by HealthLink, which is a privately owned company (Protti, Bowden & Johansen, 2008b). Sharing health information is aided by a person’s NHI, which has been in use since 1993, and covers approximately 95% of New Zealanders (National Health Information Service, 2012). The collection and sharing of health information associated with the NHI is governed by the Privacy Act and Health Information Privacy Code. In theory, coverage should be 100%, but some older people who have not consulted a doctor or been hospitalized since 1993 would not have been allocated an NHI explaining the missing 5%.

The New Zealand Health Information Strategy was developed in 2005, building on the earlier WAVE project (Working to Add Value through E-information) (Health Information Strategy Steering Committee, 2005; WAVE Advisory Board, 2001).

Infrastructure planning of IT is now a role of the NHB. In 2010, the National Health IT Board sub-committee produced a National Health IT Plan (National Health IT Board, 2010). The plan aims to achieve the eHealth Vision by 2014, whereby “each patient will have a virtual health record, with information stored electronically and accessible regardless of location by linking to: existing systems run by health care organizations (e.g. general practice, hospital-based systems), a regional clinical results repository and a shared care plan” (National Health IT Board, 2010, p. 7).
4.2 Human resources

4.2.1 Health workforce trends

New Zealand has fewer physicians per 1000 population than the OECD average (2.6 compared with 3.1 in 2010), but more nurses (10 compared with 8.7 per 1000 population in 2010) (see Figure 4.3), and hence also a higher ratio of nurses to doctors than the OECD average. The New Zealand proportions may be in part due to the role of midwives in providing primary maternity care and the role of Plunket nurses in children’s health (Plunket is a well-established NGO providing well-health nurses for new-borns and preschool children).

Figure 4.3 Number of physicians and nurses per 1000 population in the OECD, 2010

Source: OECD Health data 2012.
There have been small increases in the number of health professional groups in New Zealand per 1000 population since the 1990s, as shown in Figure 4.4 (physicians), Figure 4.5 (nurses), Figure 4.6 (dentists) and Figure 4.7 (pharmacists).

**Figure 4.4  Number of physicians per 1000 population in New Zealand and selected other countries, 1990–2010**

Source: OECD Health data 2012.

**Figure 4.5  Number of nurses per 1000 population in New Zealand and selected countries, 1995–2010**

Source: OECD Health data 2012.
Figure 4.6  Number of dentists per 1000 population in New Zealand and selected other countries, 1990–2010

Source: OECD Health data 2012.

Figure 4.7  Number of pharmacists per 1000 population in New Zealand and selected other countries, 2000–2011

Source: OECD Health data 2012.
The distribution of health care practitioners, especially GPs, receives considerable public attention. People in rural areas have reduced access to GPs and primary health care (PHC) services compared to people living in non-rural areas (see section 5.3.1).

The number of medical graduates per 1000 practising practitioners decreased between 1980 and 2006 in New Zealand. In 2006, New Zealand had 33.7 medical graduates per 1000 practising practitioners compared to 37.5 in 2000, 45.1 in 1990 and 47.7 in 1980 (OECD, 2008b).

The number of nursing graduates per 1000 practising nurses has varied minimally between 2000 and 2006, ranging from a low of 32.0 graduates per 1000 practising nurses in 2003, to a high of 35.4 in 2000. In 2006, there were 34.3 graduates per 1000 practising nurses (OECD, 2008b).

New Zealand has the highest proportion of migrant doctors among OECD countries and one of the highest for nurses: 52% of New Zealand’s doctors and 29% of its nurses are foreign born; 36% of New Zealand’s doctors and 23% of its nurses are foreign trained. New Zealand also has high expatriation rates (health professionals born in New Zealand and working overseas): the third highest expatriation rate of doctors (28.5%) and the second highest expatriation rate for nurses (23%) (OECD, 2008a).

In New Zealand, the health sector workforce comprises 5.5% of the total workforce population (OECD, 2008a). Predicting the future requirements for a health care workforce is not easy. Labour market factors influence supply and demand, but the health care workforce also involves long time lags in training health care professionals, although it has been expected to respond to rapid policy-driven changes. Currently (2013), there are shortages of medical practitioners including some specialists such as psychiatrists, shortages of mental health workers, and there are long-standing problems in attraction and retention of professionals in rural areas.

Health care professionals also work in an international market. Resident Medical Officer retention problems have been highlighted over recent years with many new graduates (often with significant debt from their training) heading overseas in search of better pay and conditions. Between 1995 and 2006, eighty-three per cent of graduates were retained on average by their second year after graduation, falling to between 63% and 68% in years 8 to 12 after graduation (Medical
New Zealand has the highest proportion of international medical graduates among OECD countries at about 40% (Medical Council of New Zealand, 2011b; Zurn & Dumont, 2008), which helps counter the strain on the health system of emigrating medical officers. However, retaining migrant doctors is also a significant issue, with data from 2000 to 2007 showing only an average of 50% of international medical graduates were retained in the year after initial registration, dropping to about 31% three years from initial registration (Medical Council of New Zealand, 2008).

Gender representation in the health workforce varies significantly depending on the profession. Women make up 93% of nurses, 80% of physiotherapists, and 71% of psychologists, but only 40% of the medical practitioner workforce, 45% of general practitioners and 29% of dentists (Clinical Training Agency, 2009; DCNZ, 2007; Medical Council of New Zealand, 2011b; MOH, 2011j). The ratio for medical practitioners is likely to change as more women are entering medical training and women account for 49% of all current postgraduate medical trainees (Medical Council of New Zealand, 2008).

Māori and Pacific people are markedly under-represented among health care professionals. Greater Māori participation in the health sector requires improvements in Māori education as well as more resources for professional training and development. Efforts to address this include the Māori Provider Development Scheme and Hauora Māori health training scholarships (MOH, 2012i). The Auckland Medical School offers a one-year foundation programme Certificate in Health Sciences aimed at preparing Māori and Pacific students for health sciences courses, and a Māori and Pacific Admission Scheme for medicine, health sciences, pharmacy and nursing courses (University of Auckland, Undated). Otago University has a number of initiatives to support Māori and Pacific students’ academic pathways to and through professional health care programmes. These include access to a one-year foundation programme aimed at preparation for health science study, and a range of tailored academic support programmes aimed at increasing the number of Māori and Pacific students within the intakes for all its health professional courses (University of Otago, Undated).

From 2001 to 2011, there were small increases in the proportion of the medical workforce identifying as Māori or Pacific islanders. In 2001, Māori medical practitioners were 2.6% of the workforce and 2.8% in
2011 (compared with their population proportion of about 15%), while Pacific practitioners were 1.1% of the workforce in 2001 and 1.6% in 2011 (compared with their population proportion of about 8%) (Medical Council of New Zealand, 2001, 2011b).

**Medical practitioners**

Primary health care practitioners and hospital-based doctors receive the same initial training, six years of medical school (including one year as a trainee intern) and usually two years as a house officer. Doctors are initially granted provisional registration with a general scope of practice for up to two years. After this, they become eligible to be registered in a general scope and may then go on to study to become a specialist or GP, with the relevant vocational scope of practice. The currently (2013) available vocational training areas are listed in Table 4.2. Medical speciality training and standards are set through the respective colleges, many of which operate jointly with Australia, such as the Royal Australasian College of Physicians or the Royal Australasian College of Surgery.

**Table 4.2 Medical specialist training (vocational training) areas**

<table>
<thead>
<tr>
<th>Vocational training area</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and medical practice</td>
<td>Pathology</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Clinical genetics</td>
<td>Public health medicine</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Radiation oncology</td>
</tr>
<tr>
<td>Diagnostic and interventional radiology</td>
<td>Rehabilitation medicine</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>Sexual health medicine</td>
</tr>
<tr>
<td>Family planning and reproductive health</td>
<td>Sports medicine</td>
</tr>
<tr>
<td>General practice</td>
<td>Surgery: cardiothoracic</td>
</tr>
<tr>
<td>Intensive care medicine</td>
<td>Surgery: general</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>Surgery: neurosurgery</td>
</tr>
<tr>
<td>Medical administration</td>
<td>Surgery: orthopaedic</td>
</tr>
<tr>
<td>Musculoskeletal medicine</td>
<td>Surgery: otolaryngology</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>Surgery: paediatric</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>Surgery: plastic and reconstructive</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Surgery: urology</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Surgery: vascular</td>
</tr>
<tr>
<td>Palliative medicine</td>
<td></td>
</tr>
</tbody>
</table>

Source: Medical Council of New Zealand (2011b).
The number of active medical practitioners in New Zealand has increased steadily from 1.56 per 1000 people in 1980 to 2.25 in 2000 and 2.3 in 2006 (Medical Council of New Zealand, 2008; OECD, 2008a, 2008b). In 2008, there were 10 552 practising medical practitioners, of whom 3435 (33%) were GPs.

**Nurses**

The number of registered nurses in New Zealand has increased substantially since 1980, with large increases in the early 1990s. There are three scopes of nursing practice in New Zealand: general nurses, enrolled nurses (who are required to work under the supervision of a registered nurse or medical practitioner) and nurse practitioners. In addition, midwives are trained separately. At 10 nurses per 1000 population, New Zealand is slightly above the OECD average of 8.7 (see Figure 4.5). However, there have been shortages of nurses in some locations and some areas of the health sector since the late 1990s (such as aged care) (Nursing Council of New Zealand, 2009, p. 19).

Midwifery is a separate branch of nursing within New Zealand, with its own three-year degree course. Pregnant women choose a Lead Maternity Carer (LMC) who can be a midwife, GP or obstetrician (see also section 5.4.3); over 75% have a midwife (Future Workforce Nursing & Midwifery Workforce Strategy Group, 2009). There were 2639 actively working midwives in 2010, of whom 99% were female, with a median age of 48 years, and 54.8% identified as having New Zealand European ethnicity, 7.5% Māori, less than 2% Pacific islanders and the remainder, other ethnicities (MOH, Undated-g). For 51.6%, their main employment setting was a public maternity service within a DHB, 28.2% were self-employed, 4.8% worked in a private maternity hospital and the remainder for other organizations or did not report this information (MOH, Undated-g).

Demand for midwives has increased since the organization of maternity care was changed and with increased birth rates between 2002 and 2008 (Future Workforce Nursing & Midwifery Workforce Strategy Group, 2009). At the same time, an ageing workforce and insufficient numbers of midwives trained in the 1970s and 1980s mean a small but persistent under-supply of midwives is predicted to 2026 (Future Workforce Nursing & Midwifery Workforce Strategy Group, 2009). The number of active midwives in New Zealand decreased between 2005 and 2008 (Table 4.3).
Table 4.3  Number of active midwives in New Zealand 2005–2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of actively working midwives</th>
<th>Live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>2828</td>
<td>57,745</td>
</tr>
<tr>
<td>2006</td>
<td>2358</td>
<td>59,193</td>
</tr>
<tr>
<td>2007</td>
<td>2511</td>
<td>64,044</td>
</tr>
<tr>
<td>2008</td>
<td>2471</td>
<td>64,343</td>
</tr>
<tr>
<td>2009</td>
<td>2547</td>
<td>62,543</td>
</tr>
<tr>
<td>2010</td>
<td>2639</td>
<td>63,897</td>
</tr>
<tr>
<td>2011</td>
<td>2647</td>
<td>61,403</td>
</tr>
<tr>
<td>2012</td>
<td>2910</td>
<td>61,178</td>
</tr>
</tbody>
</table>

Midwifery Council of New Zealand (Undated); MOH (2011j, Undated-c, Undated-d, Undated-e, Undated-f); Statistics New Zealand (Undated-b).

In 2001, the MOH and the Nursing Council of New Zealand launched a new scope of nursing practice, the Nurse Practitioner, who is an expert nurse working within a specific area of practice (Nursing Council of New Zealand, Undated). In 2011, there were 98 nurse practitioners working in a wide range of settings (general practices, hospitals, aged care facilities and in the community) and specialties (with 30% in PHC) (Nursing Council of New Zealand, 2011a). Sixty-seven of the nurses were authorized to prescribe medicines related to their scope of practice.

Scopes of practice for midwives and nurse practitioners have expanded over time. Limited prescribing rights were given to registered midwives under the Nurses Amendment Act 1990 (see section 5.4.3), and the Medicines Amendment Act 1999 extended these rights further to nurses and to other health professions including the use of standing orders. Standing orders are written instructions issued by an authorized prescriber (generally a doctor) allowing another health practitioner (here, a nurse) to supply or administer a specified medicine in circumstances defined by the order. For example, at a school health clinic staffed by nurses, some medication may be able to be supplied to students under a standing order from a local GP, avoiding the need for students to visit a GP to obtain a prescription.

Nurse prescribing was introduced with considerable caution and close regulation. For nurses in rural practices, in particular, limited prescribing rights are expected to be a useful and cost-effective complement to the services provided by rural GPs and to increase people’s access to timely services (MOH, 1999c, p. 28).
The role of nurses was emphasized in The Primary Health Care Strategy, and there is some evidence that their role has expanded (see also Chapter 6), although nurses have called for further changes to enable a greater nursing contribution to achieving the goals of The Primary Health Care Strategy (New Zealand Nurses Organisation & College of Nurses Aotearoa NZ, 2007).

Health Workforce New Zealand’s Workforce Innovation Programme funds demonstration projects trialling new and extended workforce roles, new scopes of practice and new models of care (HWNZ, Undated-b). Those related to nursing include diabetes nurse specialist prescribing, primary care registered nurse credentialing to provide mental health care, and gerontology nurse specialists in primary care (HWNZ, Undated-a).

**Allied health professionals**

Each recognized health occupation (see section 2.8.3) has a governing board that performs an annual workforce survey of all their practitioners applying for their annual licence. The survey provides demographic data and descriptive information including the number of active practitioners. Table 4.4 shows the number of, and demographic data for, different allied health professions. The majority of allied health professionals work for a private practice or are employed by a DHB.
Table 4.4 Number in workforce and demographic data for allied work professionals in New Zealand

<table>
<thead>
<tr>
<th>Profession</th>
<th>Year</th>
<th>Number</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>European (%)</th>
<th>Māori (%)</th>
<th>Pacific islander (%)</th>
<th>Number/1000 population</th>
<th>Survey response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentists</td>
<td>2006</td>
<td>2006b</td>
<td>70.8</td>
<td>29.2</td>
<td>63.0</td>
<td>0.7</td>
<td>0.3</td>
<td>0.48</td>
<td>95.0</td>
</tr>
<tr>
<td>Dental therapists</td>
<td>2006</td>
<td>650</td>
<td>1.4</td>
<td>98.6</td>
<td>84.4</td>
<td>4.4</td>
<td>1.2</td>
<td>0.16</td>
<td>64.4</td>
</tr>
<tr>
<td>Dental hygienists c</td>
<td>2006</td>
<td>233</td>
<td>4.0d</td>
<td>96.0a</td>
<td>63.3</td>
<td>1.2</td>
<td>0.4</td>
<td>0.06</td>
<td>77.4</td>
</tr>
<tr>
<td>Dental auxiliaries e</td>
<td>2006</td>
<td>49</td>
<td></td>
<td>44.7</td>
<td>2.1</td>
<td>0.0</td>
<td>0.01</td>
<td>0.01</td>
<td>64.4</td>
</tr>
<tr>
<td>Orthodontic auxiliaries f</td>
<td>2006</td>
<td>97</td>
<td></td>
<td>81.3</td>
<td>1.1</td>
<td>1.1</td>
<td>0.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental technicians</td>
<td>2006</td>
<td>338</td>
<td>18.9</td>
<td>81.1</td>
<td>57.9</td>
<td>1.2</td>
<td>1.5</td>
<td>0.08</td>
<td>64.4</td>
</tr>
<tr>
<td>Psychologists</td>
<td>2007</td>
<td>1791</td>
<td>30.0</td>
<td>66.1</td>
<td>86.1</td>
<td>3.8</td>
<td>0.8</td>
<td>0.42</td>
<td>67.4</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>2007</td>
<td>3245</td>
<td>20.2</td>
<td>79.0</td>
<td>84.6</td>
<td>3.8</td>
<td>0.8</td>
<td>0.77</td>
<td>64.4</td>
</tr>
<tr>
<td>Medical laboratory scientists</td>
<td>2007</td>
<td>1631</td>
<td>27.2</td>
<td>72.5</td>
<td>77.2</td>
<td>1.5</td>
<td>1.6</td>
<td>0.39</td>
<td>77.4</td>
</tr>
<tr>
<td>Medical laboratory technicians</td>
<td>2007</td>
<td>1277</td>
<td>8.0</td>
<td>91.7</td>
<td>69.8</td>
<td>4.8</td>
<td>3.8</td>
<td>0.30</td>
<td>77.4</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>2007</td>
<td>558</td>
<td>67.5</td>
<td>30.6</td>
<td>80.6</td>
<td>3.6</td>
<td>1.2</td>
<td>0.13</td>
<td>75.5</td>
</tr>
<tr>
<td>Medical radiation technologists</td>
<td>2007</td>
<td>1657</td>
<td>11.1</td>
<td>88.1</td>
<td>86.8</td>
<td>3.1</td>
<td>1.7</td>
<td>0.39</td>
<td>62.2</td>
</tr>
<tr>
<td>Dieticians</td>
<td>2007</td>
<td>487</td>
<td>4.4</td>
<td>94.3</td>
<td>87.9</td>
<td>2.3</td>
<td>1.0</td>
<td>0.12</td>
<td>85.8</td>
</tr>
<tr>
<td>Pharmacists g,h</td>
<td>2008</td>
<td>2978</td>
<td>42.3</td>
<td>57.7</td>
<td>72.8</td>
<td>1.6</td>
<td>0.4</td>
<td>0.70</td>
<td>100.0</td>
</tr>
</tbody>
</table>

a Number and demographic data based on returned workforce surveys. Registered practitioners who did not respond to the survey are not included.
b Total number of registered dentists (i.e. not affected by survey response rate).
c Dental hygienists’ major role is to provide oral health education and to help prevent surgical treatment of periodontal diseases.
d Combined percentage for all three disciplines of dental hygienists.
e Dental auxiliaries comprise a subset of dental hygiene practitioners who do not have a recognized qualification in dental hygiene and as such have a limited scope of practice (this particular scope of practice was revoked in September 2009).
f Orthodontic auxiliaries assist the dentist or orthodontist in implementing orthodontic treatment through performing some orthodontic procedures.
g Of the 2978 pharmacists, 2367 are community pharmacists and 339 are hospital pharmacists.
h Only includes information on registered pharmacists with a licence to practise. There are 1023 registered but non-practising pharmacists.
i Contains 100% response rate as pharmacists must provide this data to receive a licence to practise.
New Zealand has fewer dentists per 1000 population than some other OECD countries (see Figure 4.6) with 0.45 per 1000 population in 2009 compared with 0.67 in France and 0.82 in Germany the same year.

New Zealand has fewer pharmacists per 1000 population than some other OECD countries (see Figure 4.7) with 0.73 per 1000 population in 20011 compared to 1.1 in France and Australia in the same year.

4.2.2 Professional mobility of health workers
Some under section 4.2.1.

4.2.3 Training of health workers
The Ministry of Education part-funds undergraduate education and the training of health professionals and students also pay fees. Separate purchasers are set up for graduate and post-graduate training, so that most professional education is funded through the tertiary education sector with clinical training purchased from health providers. The Clinical Training Agency was established in 1995 to plan and manage the purchase of post-entry clinical training for New Zealand health professionals (MOH, 2008j). In October 2009, this was reformed by the Minister of Health into the Clinical Training Agency Board to oversee the rationalization of workforce planning, education, training, development and purchasing within the health and disability services sector (HWNZ, 2010). Subsequently renamed the Health Workforce New Zealand Board, it is responsible to the Minister of Health, and is to advise on the consolidation of existing health workforce work programmes; plan, develop and implement a national health workforce plan; link with relevant government agencies and sector representatives; and advise on the implementation of other government workforce priorities (HWNZ, 2010).

University Medical Schools in Auckland (University of Auckland), Dunedin, Christchurch and Wellington (all part of the University of Otago) train medical practitioners in six-year undergraduate courses that are accredited with the Australian Medical Council. There are no graduate entry medical programmes in New Zealand, although both the Auckland and Otago intakes include some graduates. In 2008, the Medical Training Board recommended increasing the number of medical students trained as part of the response to workforce needs (Coleman, 2011; Medical Training Board, 2008). In response, the government announced funding
for 200 additional places between 2010 and 2014. The Medical Council of New Zealand regards the majority of the primary medical qualifications listed in the Avicenna Directory of medical schools as an acceptable standard of qualification to be considered for registration to practise in New Zealand (Medical Council of New Zealand, 2011a). However, they may also be required to pass an English language assessment and a New Zealand registration examination.

Overseas-trained doctors must apply to the Medical Council of New Zealand for registration and have their qualifications and experience assessed and verified. They may be required to sit an English language test and the New Zealand registration examination (NZREX), and may initially be granted provisional registration and/or have conditions of oversight (see mcnz.org.nz).

Registered Nurses are trained in three-year tertiary level courses that are offered in both universities and polytechnics. Training consists of both theoretical and practical placements, with clinical experience being introduced from the first year. Graduates are eligible for registration as Registered Nurses who may practise in a wide variety of clinical contexts. After a minimum of four years’ experience in a specific area of practice and completion of a clinically focused Master’s Degree programme, nurses may be eligible for registration as a Nurse Practitioner and work at an advanced level within a specific area of practice.

New Zealand also has Enrolled Nurses who undergo an 18-month training programme and must practise under the direction and delegation of a registered nurse or nurse practitioner (Nursing Council of New Zealand, 2011b).

New Zealand has reciprocal nursing registration only with Australia. Other overseas-trained nurses are assessed in accordance with the requirements of the Health Practitioners Competence Assurance Act 2003, and may have to meet English language requirements and demonstrate their competency to practise through their educational equivalence and/or a Nursing Council-approved competence assessment programme or individualized assessment programme (Nursing Council of New Zealand, 2008).

Each recognized health occupation has its own board or council that licenses and regulates its members under the Health Practitioners
Competence Assurance Act (see section 2.8.3), including requirements for continuing professional development. Registration boards or councils also set standards of competence that educational providers use for curriculum development. They monitor educational providers and educational standards of students by examination (in some instances set by the registration board) or in formal approval/accreditation processes.
Chapter 5: Provision of services

Chapter summary

Public health services in New Zealand are largely provided by District Health Boards (DHBs) through 12 DHB-owned Public Health Units, including environmental and communicable disease control, health promotion and preventive services.

Since 2001, primary health care (PHC) has been coordinated through primary health organisations (PHOs) which receive capitation funding for their enrolled populations, and which contract General Practitioner (GP) practices and other providers to deliver PHC services. GPs can also charge patient co-payments.

New Zealand has an average ratio of medical practitioners and nurses for its population comparable to other Organisation for Economic Co-operation and Development (OECD) countries. However, the 2011–2012 New Zealand Health Survey found 27% of adults and 20% of children had had an unmet need for PHC in the previous year.

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. Hospital outpatient and inpatient services are mainly provided by public hospitals that are owned and administered, or funded by, the DHBs. There are no charges for inpatient or outpatient treatment in public hospitals. Patients are prioritized for access to publicly funded elective services.

Mental health care is largely community- and outpatient-based. Maternity services are provided through a Lead Maternity Carer, 75% of whom are midwives. Basic dental care is free for children under 18 years, but there is limited publicly funded dental treatment for adults, other than for emergencies. There are two main providers of ambulance services, staffed with paramedics and volunteers. Many forms of complementary and alternative care are available in New Zealand.
The Pharmaceutical Management Agency (PHARMAC) manages the Pharmaceutical Schedule and negotiates the purchase of drugs from suppliers. The Medicines and Medical Devices Safety Authority (Medsafe) administers legislation and regulations about medicines and therapeutic products.

The Accident Compensation Corporation (ACC) is a comprehensive, government-funded no-fault personal injury scheme that funds treatment, rehabilitation and compensation for people who are injured in New Zealand.

New Zealand’s health system is now also responsible for services to people with disabilities. The Ministry of Health funds services for those aged under 65 years, while DHBs fund services for those 65 years and over. Many private for-profit and not-for-profit providers deliver these services.

5.1 Public health

New Zealand’s first Public Health Act was legislated in 1872 in response to concerns about outbreaks of infectious diseases and allowed for central boards of health in each province with additional local boards (Dow, 1995). This resulted in tensions between competing authorities and attempts to shift responsibility, until the 1900 Public Health Act replaced local boards with one central agency and a Chief Officer of Health, plus six Health Districts with District Health Officers (Dow, 1995). In 1909, the Department of Public Health amalgamated with the Department of Hospitals and Charitable Aid (Dow, 1995). Various incremental changes continued over the years, including restructuring of the public health division within the Department of Health (from 1920) and changes to health districts (of which there were seven in 1920, thirteen in 1948, seventeen in the 1960s and eighteen by 1974) (Dow, 1995).

With the establishment of Area Health Boards (AHBs) under the 1983 Act, public health services became part of their core responsibility “to promote, protect, and conserve the public health, and to provide health services” (section 9a). With subsequent reforms, public health came under the Crown Health Enterprises, then the Hospital and Health Services companies, and now the District Health Boards (DHBs). There are currently 12 DHB-owned public health units which deliver services for their region (some aligned with a single DHB and others working with two
or three DHBs). These public-sector units provide basic health protection services, such as water and food safety, and health promotion services such as antismoking programmes. Their employees include public health physicians and other health care professionals, as well as officers who monitor and enforce public health legislation, such as the Tuberculosis Act 1948, the Health Act 1956, the Food Act 1981 and the Smokefree Environments Act 1990. General practitioners (GPs) 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. A number of other agencies provide public health services, such as infectious disease surveillance. The Ministry of Health (MOH) also funds a range of national public health services directly (rather than through DHBs/primary health units).

The voluntary (not-for-profit) sector is active in prevention and promotion as well as some patient support and advocacy. Not-for-profit organizations offer health-related services with funding from their own fundraising and from government contracts.

5.1.1 Environmental and communicable disease control

Environmental and communicable disease control services include monitoring public health risks, advice on public health protection and regulatory services, investigating public health complaints, and taking action where necessary to protect public health. Public health protection and regulatory services run by public health units cover the following areas (although in some cases another organization, such as local government, is the lead agency):

- contaminated land
- drinking water quality
- sewage treatment and disposal
- waste management
- hazardous substances
- resource management
- environmental noise management
- air quality
- burials and cremation
- food safety and quality
- biosecurity and quarantine
- communicable disease control.
The Notifiable Disease Surveillance system in New Zealand currently (2013) covers about 50 conditions for which reporting by medical practitioners is mandatory. Notification data are recorded on a computerized database installed in each public health service and are used to guide local control measures. The data are collated, stored and analysed at national level by the Institute of Environmental Science and Research (ESR) [ESR, Undated-b]. Monthly, quarterly and annual surveillance reports are published that contain data and commentary on notifiable disease trends and events [ESR, Undated-a]. The MOH monitors the national rates of communicable disease and immunization coverage, develops policy, and promulgates regulations in fulfilment of national and international requirements. The MOH also provides oversight of statutory public health officers employed by DHB PHUs (Medical Officers of Health and Health Protection Officers).

New Zealand has had an Influenza Pandemic Action Plan since 2002, which has subsequently been revised in light of the international concern about the evolving threat from H5N1 influenza and the influenza A (H1N1) 2009 pandemic (MOH, 2010b). A number of actions in the plan are authorized under relevant statutes, namely the Health Act 1956, the Civil Defence Emergency Act 2002 and the Epidemic Preparedness Act 2006 (MOH, 2010b).

5.1.2 Health promotion and education

Services are provided in the following areas:

- social environments, such as healthy school and healthy community programmes;
- Well Child services, such as the promotion of immunization;
- injury prevention, such as the promotion of child restraints in cars and community-based injury prevention programmes;
- mental health measures, such as programmes to reduce the stigma associated with mental illness;
- nutrition and physical activity, such as programmes to promote healthy diet and physical exercise;
- sexual health, such as ‘safer sex’ and family planning programmes;
- alcohol and drugs, such as services to reduce and/or prevent drug-related harm;
- tobacco, such as tobacco control programmes including monitoring and compliance with smokefree legislation and public smoking-education programmes.
These services are provided by a variety of organizations, including DHBs, PHUs, government departments and agencies (such as Regional Sports Trusts and Sport and Recreation New Zealand) and not-for-profit organizations.

### 5.1.3 Preventive services

Preventive services are targeted at a range of conditions and population groups, and are linked to environmental and communicable disease control and to health promotion services. These programmes often involve a range of other organizations and providers. Some key programmes are outlined below.

#### Immunization

Immunization has contributed significantly to the control of many infectious diseases, although some vaccine-preventable diseases continue to be public health problems, such as pertussis and measles (Immunization Advisory Centre, Undated).

Immunization 2000, the national immunization strategy, was launched in 1996, and had five elements:

- a simplified immunization schedule
- immunization certificates for school/early childhood centres
- standards for immunization providers
- local immunization coordination
- improved immunization surveillance.

The New Zealand Health Strategy includes 13 priority population health objectives, of which one is “ensuring access to appropriate child health services including well child and family health care and immunization” (King, 2000, p. 13). In May 2009, the Minister of Health announced a simplified set of six health targets for DHBs to focus and report on, including “increased immunization” (MOH, 2009d; Ryall, 2009b). The new goal is to fully immunize 95% of eight-month olds by December 2014 and maintain this to June 2017. To achieve this goal, the health target by July 2013, is for 85% of eight-month olds to have had their primary course of immunization at six weeks, three months and five months on time, increasing to 90% by July 2014 and 95% by December 2014. The most recent data (for April–June 2013) showed that overall, DHBs had achieved
90% full immunisation of eight-month olds (range 83–96%); 18 of the 20 DHBs exceeded the 85% target (MOH, 2013f). Of particular note is the increase in the Māori immunisation rate, from 67% in 2007 to 85% in 2010 (MOH, 2011r).

Children born from 2005 are placed onto a National Immunization Register (NIR), which is a computerized information system that holds immunization details of New Zealand children. The NIR has two main aims: to help health professionals quickly and easily find out which vaccines a child has been given and to provide a more accurate record of immunization coverage rates (HealthEd, 2011). Immunization coverage data, nationally and by DHB (and including by ethnicity and deprivation), is available on the MOH web site (http://www.health.govt.nz/our-work/preventative-health-wellness/immunization/immunization-coverage/national-and-dhb-immunization-data).

Childhood immunizations are free of charge. The Immunization Schedule (MOH, 2012k) currently protects children and adolescents against 11 serious diseases: diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, hepatitis B, pneumococcal conjugate, Haemophilus influenzae type b (Hib) and human papilloma virus (HPV). Children can receive the full primary immunization course in four visits ideally occurring at 6 weeks, 3 months, 5 months and 15 months. There is a fifth visit for measles/mumps/rubella and diphtheria/tetanus/pertussis/polio boosters at age 4, and a sixth for tetanus, diphtheria and pertussis at 11 years of age. Females aged between 12 and 18 may receive the HPV vaccine as part of the free immunization programme (MOH, 2012d).

Babies considered being at high risk of contracting tuberculosis, and those whose mothers are hepatitis B carriers are offered immunization for those diseases at birth. The New Zealand National Immunization Schedule is reviewed every two years by an expert advisory committee (Immunization Technical Working Group), which provides recommendations to the MOH, with the Minister of Health responsible for approving any changes (MOH, 2012k).

An annual influenza vaccination is available free to people aged over 65 or who have chronic health conditions.
Other preventive programmes

New Zealand has a range of active preventive programmes at national, regional and local levels; some key programmes are described below.

Family planning aims to assist people to make informed choices about their reproductive and sexual health. Family planning advice is offered from various sites: GPs, private specialists, Family Planning Association clinics, student health clinics, sexual health clinics, and marae-based health services (Māori community centres). Some public hospitals have a family planning clinic (FPC) within their obstetrics and gynaecology department (Family Planning Association, 2007).

The National Breast Screening Programme (Breastscreen Aotearoa New Zealand) was established in December 1998. Through early detection, it aims to reduce breast cancer mortality by offering free mammography services to women aged 45–69 years every two years (NSU, 2012a). Other high-risk groups of women continue to have access to publicly funded mammograms, including women who have had breast cancer, those with a family history of breast cancer, and those who had breast histology demonstrating an at-risk lesion. A team of health professionals assesses a woman where an X-ray suggests a problem (NSU, 2012a). Breast cancer accounts for 80% of all cancer deaths in New Zealand women 50 years and over (MOH, 1998, p. 204). Māori age-standardized rates of breast cancer are higher than non-Māori rates (32 and 25 per 100 000, respectively).

The National Cervical Screening Programme (NOSP) was established in 1990. It is coordinated nationally but managed and delivered locally. The service providers include GPs, nurses and midwives, lay smear-takers, health educators and laboratories. Local coordination of the national programme and register is managed through 14 geographical sites that are linked to a central database. Cervical cancer is a largely preventable disease if detected early. The goal is to reduce mortality and disability from squamous cell cancer of the cervix by ongoing nationwide screening that can detect precancerous changes. Treatment at this stage is very successful. Screening is offered every three years for women aged 20–69 years. Over 95% of all eligible women are enrolled in the screening programme. A review of the first 10 years of the programme found that the incidence of cervical cancer had reduced by 40% (from 12 per 100 000 in 1991 to below 7 per 100 000 in 2002), and deaths had reduced by 60% (from 5 per 100 000 in 1990 to 2 per 100 000 in 2001) (NSU, 2005).
Public confidence in the cervical screening programme was shaken by revelations that some laboratories were misreading slides resulting in missed diagnoses before 2000. The most prominent of these cases was in Gisborne where a single pathologist was responsible for reading all the region’s slides. The Gisborne case resulted in a ministerial inquiry, which found that there was an unacceptably high level of under-reporting, and suggested a number of areas of improvement (MOH, 2001a). Subsequently, all of the inquiry’s recommendations were implemented (NSU, 2012b).

Between 2005 and 2007, some 71.5% of all eligible women had a smear or histology result recorded on the NCSP register. Coverage rates differed among ethnic groups, with Māori women (48.0%) and Pacific women (47.5%) receiving less coverage compared to non-Māori non-Pacific women (77.4%) (Brewer, McKenzie & Wong, 2008).

Anti-smoking programmes are actively pursued in New Zealand. According to the national New Zealand Health Survey 2006/07, some 19.9% of adults were then current smokers (currently smoking at least once per month). The prevalence of cigarette smoking was higher among Māori (42.2%) than among Pacific islanders (26.9%) and those of European descent (18.6%) (MOH, 2008a). In 1990, the government passed the Smoke-free Environments Act. The Act banned smoking in office workplaces and certain other enclosed public spaces apart from clearly defined smoking areas; restricted tobacco advertising and sponsorship; mandated labelling of products with health messages; and established the Health Sponsorship Council (now part of the Health Promotion Agency). Graphic pictorial warnings on all tobacco packages sold were required from February 2008. The warnings include pictures of gangrenous toes, rotting teeth and diseased lungs. Also, information on quitting smoking had to appear on cigarette packages (MOH, 2008c). Legislation passed in 1997 raised the age at which people may legally be sold tobacco products from 16 to 18 years, and banned the sale of single cigarettes and small packs of tobacco (Statistics New Zealand, 1998, p. 172). A Smoke-free Environments Amendment Act was passed in 2003. Since the Act became law, the buildings and grounds of schools and early childhood centres have become smoke-free areas. Indoor areas of licensed premises (bars, restaurants, cafes, sports clubs and casinos) are smoke-free. Also, other workplaces including offices, factories, warehouses and work dining areas are smoke-free. The display of tobacco products in retail outlets has been restricted, and ‘smoking kills’ signs have to be erected near tobacco displays. Further, herbal smoking products are included in smoking bans and their sale or supply to under 18-year olds is prohibited (MOH, 2005c).
In recognition of significant mortality caused by smoking and the opportunity cost to the health sector of smoking, a health target, ‘Better Help for Smokers to Quit’, has been introduced. This target is designed to prompt providers to routinely ask about smoking status as a clinical ‘vital sign’ and then to provide brief advice and offer support to help current smokers quit. The health target is that by July 2012: 95% of patients who smoke and are seen by a health practitioner in public hospitals, 90% of patients who smoke and are seen by a health practitioner in primary care, and 90% of pregnant women who identify themselves as smokers at the time of confirmation of pregnancy in general practice or booking with their Lead Maternity Carer are offered advice and support to quit.

Performance data on this health target are available on the MOH’s web site, updated quarterly. The most recent data (April–June 2013) show that 18 DHBs achieved the hospital component of the Better Help for Smokers to Quit target (95%) and the remaining two were close (90 and 93%) (MOH, 2013f). In primary care, only one DHB met the target (90%), the remainder ranging from 35 to 80% achievement. However, 15 DHBs had improved their performance compared with the previous quarter.

Alcohol programmes are also a public health priority. The 2006/07 New Zealand Health Survey found 17.7% of adults (aged 15 and over), and just over half the men aged 18–24 years, had a potentially hazardous drinking pattern (MOH, 2008a). Heavy drinking over a long period has been linked to a number of health problems, particularly liver and heart damage, hypertension and some cancers. The National Alcohol Strategy released in 2001 outlines initiatives in three areas: supply control, demand reduction and problem limitation. A wide range of government and nongovernmental providers offer alcohol-related health promotion and treatment services. The Health Promotion Agency includes a focus on alcohol, continuing the work of the former Alcohol Advisory Council of New Zealand (established in 1976). The HPA has the specific function of “giving advice and making recommendations to government, government agencies, industry, nongovernmental bodies, communities, health professionals, and others on the sale, supply, consumption, misuse, and harm of alcohol” (Health Promotion Agency, 2012).

In 2009, the Law Commission produced an issues paper, Alcohol in Our Lives, which reviewed the regulatory framework relating to the sale and supply of liquor (Law Commission, 2009). Submissions were invited and the Law Commission produced its final report with 153 recommendations.
for the government, including restrictions on the places and times alcohol can be sold and increasing the purchase age from 18 to 20 (Law Commission, 2010). Subsequently, the government introduced new legislation which drew wide public interest and submissions. The Sale and Supply of Alcohol Act was passed in December 2012, retaining the existing minimum purchase age of 18. Alcohol may be supplied “in a responsible manner” to people under 18 by a parent or with the express consent of the parent (section 241 (3)). Maximum trading hours (which apply from December 2013) are from 8 a.m. until 4 a.m. the next day for on-licence premises and 7 a.m. to 11 p.m. for off-licences. Territorial authorities may choose to develop local alcohol policies, which may restrict the number or location of licensed premises or their trading hours.

5.1.4 Occupational health services

New Zealand workplaces are bound by the 1992 Health and Safety in Employment Act and its amendment in 2002, which aim to prevent harm to people at work and set out responsibilities for achieving this. Work-related diseases and injuries have a significant impact on New Zealand’s health system and productivity. Every year, between 700 and 1000 workers are estimated to die prematurely as a result of work-related diseases; around 100 workers receive fatal injuries; and over 200,000 occupational injuries result in a claim to the ACC (see section 5.7).

The majority of work-related injuries and diseases occur in males (>75%) (Workplace Health and Safety Strategy, Undated-a). The Department of Labour (now part of the Ministry of Business, Innovation and Enterprise) developed the Workplace Health and Safety Strategy for New Zealand to 2015 to provide a national vision and strategic direction for workplace health and safety (Department of Labour, Undated). The strategy aims to prevent work-related injuries and disease by: raising awareness of workplace health and safety; coordinating and prioritizing the actions of a wide range of organizations; and improving the infrastructure that supports workplace health and safety (Workplace Health and Safety Strategy, Undated-b). The strategy emphasizes working together as the strategy requires commitment from the government, employer and industry organizations, unions, workplaces and other NGOs to be successful (Workplace Health and Safety Strategy, Undated-b). The strategy is monitored and evaluated by the Ministry of Business, Innovation and Employment.
5.2 Patient pathways

In the first instance, New Zealanders who are unwell may rest or use over-the-counter medicines (e.g. paracetamol, cough and cold medicines), available through pharmacies, to manage their condition. They may get advice from pharmacists or contact one of two general healthlines, HealthLine and PlunketLine, for advice.

If, however, they have a condition that they think requires assessment or treatment they will contact their usual primary health care (PHC) practitioner (e.g. GP, nurse practitioner, Māori health provider, Pacific health provider). In 2006–2007, some 97.4% of children and 93.3% of adults had such a PHC provider that they visit first; for 99% of children and 97.8% of adults this is a GP clinic (MOH, 2008a). The PHC practitioner will assess the person’s condition and discuss their options, including whether to undertake further diagnostic tests, prescribe medication or refer them to a hospital specialist. The PHC practitioner may charge a patient co-payment (see section 3.4.1).

In emergencies, or after hours, people may visit an accident and emergency clinic, with such services available free to service users through public hospitals, although charges are incurred at private clinics.

If the patient is referred to and accepted by a publicly funded and employed specialist (working in a publicly owned hospital), they will first determine whether a case is urgent (i.e. the patient must be admitted immediately) or semi-urgent (for admission within seven days). Beyond this time frame, the patient becomes an ‘elective’ patient, and a specialist must first decide whether specialist assessment is required and notify the patient and primary care provider of this decision within 10 days. People accepted for referral must currently be seen within six months (MOH, 2011p); the National Party has pledged to reduce this to four months by the end of 2014 (New Zealand National Party, Undated). The PHC practitioner will care for the patient while they are waiting for their specialist appointment. The specialist appointment will be fully funded by the government, whereas ongoing primary care practitioner appointments may incur co-payments. DHB performance on achieving the targets for referral and treatment is monitored by the MOH and results are available on its web site (Elective Services Patient Flow Indicators, ESPIs).
If a patient does not want to wait for a specialist appointment they may choose to receive private treatment through a private hospital, which they would pay for themselves or through private health insurance. A private specialist appointment, and subsequent treatment in a private hospital if required, will usually be obtainable more quickly than in the public system. Sometimes, people may be referred back to a public hospital for their treatment, especially where they cannot afford treatment in a private hospital or where specialist services are only provided in the public system. Thus, by paying for specialist assessment appointments privately, people can avoid longer waits but still receive care through the public system.

A publicly funded specialist will determine the patient’s options based on currently funded treatments. If publicly funded services are not available for a patient they will continue to receive care from their primary care practitioner. If publicly funded services are available (e.g. elective surgery), the patient should receive treatment within six months (also about to be reduced to four months). An elective services booking system governs this process (see section 5.4.5).

After specialist treatment, the patient will receive follow-up treatment from their specialist or their primary care practitioner, and perhaps by other community health services or allied professionals. Long-term follow-up care will be provided by a PHC practitioner.

5.3 Primary/ambulatory care

Traditionally, GPs have provided most primary medical care from their own private practices. In 2011, there were approximately 3614 general practitioners working either full- or part-time (0.82 full-time equivalent [FTE] GPs per 1000 population) (Medical Council of New Zealand, 2011b). About 39% of GPs work in privately owned practices, 40% in jointly owned practices, 7% for community-based trusts and 2% in a tertiary institution (Mel Pende, 2008). Most sole private practices involve one doctor working alongside a practice nurse and possibly a receptionist, while larger practices can have managers and other health professionals such as physiotherapists, pharmacists, social workers and community workers working as part of a PHC team. A 2007 general practice survey found the mean number of FTE GPs in a practice was 3.01, (similar to recent MOH data which showed PHO practices averaged three GPs), with the largest number of GPs reported from a single practice being 16 (Raymont & Cumming, 2009).
Other PHC services include:

- nurse-led services (including nurse practitioners); Māori and Pacific health services (providing prevention, treatment and wider social services) (see section 2.3);
- diagnostic services provide laboratory tests and diagnostic imaging in private community-based facilities on referral from a primary care practitioner;
- pharmaceutical services include a comprehensive range of subsidized medications available through community pharmacists;
- therapeutic and support services include physiotherapy, speech therapy, dietary advice, meals on wheels and home-help services, some of which require a referral from a GP.

People visit GPs more frequently than any other health professional. According to the 2011/12 New Zealand Health Survey, about 74% of children and 78% of adults had visited a GP at least once in the preceding year (MOH, 2012q, 2012f). GPs perform a gate-keeping role since an individual cannot access public secondary and tertiary services unless they are referred by their GP (except for accident and emergency services). This is also the practice in the private health sector – specialists only see patients referred by a GP.

Figure 5.1 shows that doctor visits per person in New Zealand are low compared with other OECD countries (although the comparison is also affected by the methodology used for calculation).

The release of The Primary Health Care Strategy in 2001 announced the creation of PHOs (MOH, 2001d). These not-for-profit bodies manage capitation funds for enrolled patients with funds allocated by the local DHBs. Patients are free to choose or change their GP and can enrol with any GP they choose, limited only by the provider’s ability to take on new patients. Some PHOs facilitate this by referring patients to GPs who can take new patients. (See Chapter 6 for further information about PHOs.)
Figure 5.1 Doctor visits per person in the OECD, 2010

Note: Since 2008, New Zealand has used a different method to calculate doctor visits per capita, and in 2007 the estimate was much higher (4.3). Source: Government of Lao PDR and the United Nations, 2006.

5.3.1 Distribution and access

There is considerable variation in the distribution of GPs, with rural areas, poorer towns and poorer areas in cities generally underserved. The number of people per GP within territorial local authority (TLA) cities averages 3.46 per 1000 population, but varies significantly from 0.8 (Upper Hutt) to 5.66 (Auckland City), while rural districts average 1.42 per 1000 population (range 0.23–3.72) [Medical Council of New Zealand, 2011b]. Data from the 2006/07 New Zealand Health Survey showed that,
on average, four out of five adults and children see a GP every year. Pacific children were more likely to see a GP compared to children of other ethnicities and European adults were more likely to see a GP compared to other adults of other ethnicities (though these differences are not statically significant). There is no difference in the utilization of general practice visits for adults or children based on neighbourhood deprivation (based on NZ Deprivation Index). Children under six living in more deprived areas are more likely to receive a free GP visit compared to children living in less deprived areas (MOH, 2008a).

A key measure of access in New Zealand is unmet need.

The 2011/12 New Zealand health survey found most adults and children were able to access health care (MOH, 2012q, 2012f). However, 27% of adults aged 15 years and over, and 20% of children aged 0–14 years, had an unmet need for PHC in the previous 12 months. The causes of this unmet need included the following:

- they were unable to get an appointment at their usual medical centre within 24 hours (16% of adults and 14% of children);
- they did not visit a GP because of the cost (14% of adults and 5% of children);
- they did not visit an after-hours medical centre because of the cost (7% of adults and 5% of children);
- they did not visit a GP because of lack of transport (3% of adults and children);
- they did not visit an after-hours medical centre because of lack of transport (2% of adults and children);
- they did not visit a GP because of a lack of childcare (2% of children).

Additionally, about 8% of adults and 7% of children did not collect one or more prescription items because of cost in the previous 12 months.

Unmet need was much more common among women aged 25 to 44 years, Māori and Pacific adults and children, and people living in more deprived areas, across many of the above indicators.

Time trends showed that fewer adults were unable to get an appointment at their usual medical centre within 24 hours in 2011–2012 (16%) than in 2006–2007 (18%). No other trends over time were obtainable, because of changes in question wording between surveys.
5.3.2 Rural health services

Rural areas in New Zealand have small, dispersed populations, a smaller number and range of health care providers, and greater distances for people to travel for treatment and assistance. Rural communities also have specific needs that must be taken into account as follows: poor health status among Māori and lower socioeconomic groups; people with disabilities who require assistance; more children and older adults; and a higher injury rate.

Rural communities have difficulty attracting and retaining physicians and other health professionals despite some incentive payments and premiums on contracts. Funding was introduced in 2002 for ‘reasonable rosters’ (to reduce on-call time for rural doctors and nurses) and workforce retention funding (to assist with recruiting and retaining health professionals in rural areas); the level of these grants is based on the rural ranking scale of the practice. In addition, a rural innovations fund provides one-off funding for new projects to provide rural health services (MOH, 2011p, 2011q). The MOH’s rural ranking score takes into account travelling time from a doctor’s surgery to a major hospital; on-call duty; being on call for major trauma; travelling time from a doctor’s surgery to the nearest GP colleague; travel time to most distant practice boundary; and whether or not peripheral clinics are held regularly (MOH, 2004a). Rural practices are defined as those scoring 35 or more on the scale. The rural workforce retention funding rates (in addition to standard capitation funding) are shown in Table 5.1.

Table 5.1 Rural workforce retention capitation rates

<table>
<thead>
<tr>
<th>Rural ranking score (points)</th>
<th>Rate per capita (NZ$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>35–40</td>
<td>7.72</td>
</tr>
<tr>
<td>45–50</td>
<td>11.60</td>
</tr>
<tr>
<td>55–65</td>
<td>15.46</td>
</tr>
<tr>
<td>70+</td>
<td>19.31</td>
</tr>
</tbody>
</table>

Source: MOH [2011c].

The doctor-to-patient ratios in rural areas are lower than those in non-rural areas, and professional and lifestyle factors make rural practice a less attractive career choice. Ongoing professional development is critical for good-quality and safe care and to overcome professional isolation. The Primary Health Care Strategy (2001) indicated the need to develop a
coherent approach to rural health service provision, including the difficult issues of retaining and attracting the appropriate workforce (MOH, 2009i). In 2002, the Rural Expert Advisory Group to the MOH produced a report detailing strategies to achieve the rural-focused goals of The Primary Health Care Strategy.

A voluntary bonding scheme was set up in 2009 that provides recent medical, nursing and midwifery graduates the opportunity to work in hard-to-staff areas in exchange for incentive payments. Initially 350 positions (100 medical graduates and 250 nursing or midwifery graduates) were made available, but this was extended to 893 positions (115 medical graduates, 95 midwives and 683 nurses) due to the high response of applicants (Ryall, 2009c). However, not all applicants may work in rural areas as the scheme also funds graduates who are willing to work in hard-to-staff disciplines (e.g. general practice and psychiatry), who may work in cities and not in rural locations (HWNZ, 2012; Radio New Zealand, 2009). The scheme provides repayments of student loans (or cash payments if the holder does not have a student loan) for up to five years while the person works in a hard-to-staff area or discipline. The annual after-tax credits (paid in a lump sum after three years and annually thereafter) are NZ$10 000 for doctors, NZ$3500 for midwives and NZ$2833 for nurses (HWNZ, 2012).

5.3.3 School health clinics

New Zealand schools do not have a standardized on-site health service, although the work of public health nurses (funded by DHBs, PHOs or public health units) can include health assessment, health promotion and immunization programmes in schools. A 2008 survey of secondary schools found that three quarters had a nurse in attendance or visiting regularly; one third of these nurses were employed by the school and the remainder by DHBs, PHUs, PHOs or another organization (Buckley et al., 2012). In 38% of these schools, the nurse provided less than 5 hours consultation time a week; a further 17% provided 5–20 hours; and the remainder, over 20 hours. In 2012, the prime minister announced funding for youth mental health, including trained youth workers in low-decile schools to identify students with mental illnesses and facilitate their access to care (New Zealand Government, 2012b).
5.3.4 After-hours care

After-hours care is defined as “primary health care that is designed to meet the needs of patients which cannot be safely deferred until regular or local general practice services are next available” (After Hours Primary Health Care Working Party, 2005). Fewer people in New Zealand (33%) report difficulty getting care on nights, weekends and holidays without going to an emergency department compared to other developed countries (e.g. the United Kingdom, 43%; Australia, 54%; Canada, 59%) (After Hours Primary Health Care Working Party, 2005). Primary health organisations are responsible for providing after-hours medical care and must demonstrate to their respective DHB that they have arrangements in place for all service users for all hours of each day [i.e. ‘24/7’ service] (After Hours Primary Health Care Working Party, 2005).

5.4 Specialized ambulatory care/inpatient care

Specialist physicians and surgeons provide ambulatory care 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. Hospital outpatient and inpatient services are mainly provided by public hospitals that are owned and administered, or funded by, the DHBs.

The boundary between secondary and tertiary care is no longer clear since, with advances in technology including noninvasive surgery, procedures initiated in tertiary care hospitals are rapidly adopted in regional and district hospitals. Tertiary care services usually refer to high technology services of high cost and low volume. A second distinction, particularly for surgery waiting lists, is between acute services for urgent conditions that need immediate treatment, and elective services for nonurgent conditions. A third distinction is between acute care and long-term care hospitals. Hospitals now mainly treat people for conditions that require short-term and intensive treatment, with long-stay treatment and care being shifted to private nursing homes.

DHB provider arms (hospitals) provide most secondary and tertiary hospital services, including all acute and most elective services. Private hospitals offer services to patients who choose to use them and may also provide some elective services under contracts with DHBs. The National Party-led government elected in 2008 has encouraged greater
use of private hospitals for publicly funded elective surgery, and publicly funded surgical procedures in private hospitals (excluding ACC cases) have increased from 1245 cases in 2005–2006 to over 11 000 in 2008–2009, representing 9% of elective operations funded by DHBs (Ashton, 2010). Most of these procedures are purchased through short-term, spot contracts in order to reduce waiting lists and spend budgets before the end of the year (Ashton, 2010).

The majority of private hospitals and rest home services are represented by either the New Zealand Private Surgical Hospitals Association (NZPSHA) or Health care Providers New Zealand (HCPNZ). The NZPSHA represents 22 member organizations comprising 35 surgical facilities, 1755 surgical beds including intensive care units, recovery beds and resourced beds, and 2990 FTE staff (NZPSHA, Undated). The NZPSHA member hospitals provide a full range of elective surgery including complex neurosurgery and cardiothoracic surgery. Apart from the DHB-funded procedures, there are few interactions between public- and private-sector hospitals. HCPNZ is a not-for-profit, national membership organization that represents more than 500 aged care providers (more than 75% of the sector).

5.4.1 Access issues

There are currently no charges for inpatient or outpatient treatment in public hospitals. This has been the case since 1938, with the exception of charges for inpatient and outpatient services that applied briefly during the early 1990s.

New Zealand has a good geographic distribution of hospitals: 90% of the population live within one hour’s drive of a district hospital [MOH, 1999b]. The average travel time is 20.9 minutes for all hospital types, 25.7 minutes for secondary and tertiary hospitals, and 91 minutes for tertiary hospitals (Brabyn & Skelly, 2001). The increasing use of helicopters has reduced access time for emergency cases in rural areas, while telemedicine is bringing diagnosis and treatment closer to patients. However, detailed data on how many helicopters are in use and how many patients they transport is not publicly available.

Considerable policy attention has focused upon waiting lists for hospital services and the equitable access to elective surgery. Most research on elective surgery has focused on the Clinical Priority Assessment Criteria
(CPAC) tools. Different CPAC tools have been used by various physicians for the same condition, which may lead to inconsistencies in referral practices between different hospitals and different DHBs. Further, all DHBs create their own treatment thresholds based on previous workload. If regional inequalities exist, this practice will not help reduce regional access issues. Also, patients with private health insurance may receive an appointment privately with a surgical consultant quicker than a noninsured patient, and thereby reduce the time to surgery. Research suggests that Māori and Pacific people with cardiac conditions receive a surgical consultation when their condition is more serious compared to non-Māori and non-Pacific people (Derret, 2005).

DHBs have to report quarterly on the elective surgery they have provided. These details are then analysed by the MOH and are available on a government web site for public review (MOH, Undated-a). In a comparison of OECD countries, 26% of patients in New Zealand waited more than four months for elective surgery, which is similar to Canada (27%) and Australia (23%), less than the United Kingdom (38%), but more than the United States (5%) (Siciliani & Hurst, 2003).

5.4.2 Hospital management

Since the merging of the Department of Public Health and the Department of Hospitals and Charitable Aid in 1909, public hospitals in New Zealand have experienced several changes in management. By the 1950s, most public-sector hospitals were fully funded and also owned and managed by the central Department of Health. Prior to the 1980s, a triumvirate management approach existed where a chief executive, a chief medical officer, and a chief nurse were responsible for the hospital’s business management, medical services or nursing services, respectively. The triumvirate management approach ended in 1988 as AHBs began to take over between 1985 and 1989 (Ashton, 1993; Malcolm, 1991).

AHBs were charged with appointing their own chief executives who were responsible for the day-to-day running of the health services and accountable to the board. AHBs only endured for a short time before being transformed into Crown Health Enterprises (CHE) after 1993. Five years later (1998) in a largely cosmetic change, these enterprises were converted into nonprofit statutory companies called Hospital and Health Services. From 2000, hospitals were moved under the management and ownership of DHBs.
In the early 1990s, under CHEs, managers with business credentials, with experience outside of the health sector, were recruited to run New Zealand hospitals, but efficiencies did not reach the levels expected (see Chapter 6). By the mid-1990s, those more experienced in health and clinicians were being brought back into management roles, although there is no requirement for hospital chief executives to have medical backgrounds. However, most hospitals now have a Chief Medical Officer (practising physician) as part of a hospitals executive team (Cumming, Bryson & Inder, 2008).

More management training opportunities began to emerge for clinicians in the late 1990s. For example, in 1998 New Zealand joined the Royal Australasian College of Medical Administrators, which offers a three-year postgraduate specialization programme in medical administration (Alexander, 2000; Royal Australasian College of Medical Administrators, Undated). Further, some New Zealand universities offer Master’s programmes in public health management and health services management.

Hospitals have been expected to operate according to commercial principles since the 1990s, funding not only services, but also repairs, maintenance and capital development from their own funds. Since 2001, the management of public hospitals has been overseen by DHBs.

5.4.3 Maternity services

Prior to 1990, all births had to be supervised by a doctor. The majority of labour and birth care occurred in maternity hospitals with midwives working rostered shifts. GPs attended part of labour and birth, and obstetricians would provide specialist care when required. A woman might therefore receive care from several maternity providers during the course of her pregnancy. This style of service was seen as impersonal, and women and the midwifery profession lobbied for reform. In 1990, the Nurses Act was amended to allow midwives to operate as fully independent providers of pregnancy and childbirth services, including prescribing medications without the supervision of a medical practitioner. This allowed midwives to provide maternity care in the community from pregnancy to six weeks post-birth, in addition to general practitioner and obstetrician care (Health Funding Authority, 2000; MOH, 2008i). In 1996, a new Notice was issued under Section 51 of the Health and Disability
Services Act 1993, which introduced the concept of a Lead Maternity Carer (LMC) who would have overall clinical responsibility for a woman’s maternity care (Health Funding Authority, 2000). An LMC can be a general practitioner, a midwife or an obstetrician (MOH, 2013m). There was significant controversy after the changes to the Nurses Act and the introduction of the LMC model, particularly from doctors concerned about their reduced role in pregnancy care.

The National Health Committee (NHC) reviewed the system in 1999 and identified areas for improvement but did not propose substantive changes to the framework (NHC, 1999). Recommendations included the need to closely align primary maternity services with other primary care services, and improve the cooperation between the different maternity providers. A Maternity Services Strategic Advisory Group was set up by the MOH in partnership with the DHBs to develop the strategic vision for maternity services. In 2002, a Primary Maternity Services Notice Guide was developed and later updated in 2007 (MOH, 2007c). The guide assists providers of primary maternity services with information on required service specifications, quality requirements, and claiming processes for funding (MOH, 2007c). As part of the quality and safety programme for maternity services, New Zealand Maternity Standards were published in 2011 with guidance for the provision of equitable, safe and high-quality maternity services throughout New Zealand (MOH, 2011m).

Currently, over 75% of lead maternity carers are midwives (Future Workforce Nursing & Midwifery Workforce Strategy Group, 2009), which is a major change from the previously general practitioner-dominated maternity care. In May 2009, the government provided an extra NZ$103 million for maternity services, which will fund a 24-hour telephone help line, meet the costs of extra births in subsequent years, and provide opportunities for GPs to receive obstetric training or refresher courses for those who want to return to maternity care (Ryall, 2009a). The New Zealand Medical Association welcomed the increased funding but believes maternity services require restructuring and integration into the PHO framework. The association feels this will improve women’s continuity of medical care throughout pregnancy and improve coordination of medical and maternity services (New Zealand Medical Association, 2009), but there are no data to substantiate this.
5.4.5 Elective surgery

Access to elective services is based on assessment of the patient’s need and ability to benefit (Cumming, 2013). In New Zealand, the booking system refers to the entire medical pathway from an initial consultation with a GP [Derret, 2005] to a patient’s confirmed surgical date. The system was developed from the 1990s onwards because of major concerns over the management of waiting lists and long waiting times for surgery. Thus, in 1991, it was estimated that about 62,000 people were on a waiting list for elective surgery, of whom 45% would wait less than six months while 15% would wait more than two years [Upton, 1991]. Major reforms to the system were introduced in the mid-1990s onwards, with the current approach set out below.

When a GP sends a letter of referral to an outpatient centre, the referral letters are triaged by clinicians to prioritize patients so that the most urgent referrals are seen before less urgent ones (MOH, 2013g).

In the case of consultations where surgical treatment is an option, patients are provided a score based on the CPAC [Derret, 2005; MOH, 2013g]. Once a CPAC assessment has been conducted a patient may be booked for surgery.

A final booked status is based on the Treatment Threshold (TT), which is a CPAC score at which a patient is eligible to receive publicly funded elective surgery. The TT score is based on the capacity (including available funding) of DHBs to perform elective services [Derret, 2005].

To predict future elective surgical needs an Actual Treatment Threshold (aTT) is produced. An aTT is the CPAC score at, or above, which 90% of patients received treatment for a service in the preceding 12 months [Derret, 2005, p. 6]. The score provides DHBs with a useful measure for planning future capacity requirements.

Patients who would benefit from elective care but who cannot receive treatment due to provider or capacity constraints, and patients who currently do not meet the TT but may meet the TT in the near future, are assigned to the Active Review (AR) health care pathway [Derret, 2005; MOH, 2013g]. An AR patient will receive treatment when capacity allows, or if their condition worsens, thereby increasing their TT score and priority to receive treatment.
Table 5.2 shows the numbers of people waiting more than six months for treatment and for first specialist assessment.

**Table 5.2 Numbers of people waiting more than six months for treatment and first specialist assessment (FSA), 2000–2011**

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>No. waiting &gt;6 months for treatment</th>
<th>No. waiting &gt;6 months for FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>June</td>
<td>1 349</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dec</td>
<td>2 310</td>
<td>41 903</td>
</tr>
<tr>
<td>2001</td>
<td>June</td>
<td>3 899</td>
<td>37 152</td>
</tr>
<tr>
<td></td>
<td>Dec</td>
<td>5 152</td>
<td>36 251</td>
</tr>
<tr>
<td>2002</td>
<td>June</td>
<td>6 868</td>
<td>39 694</td>
</tr>
<tr>
<td></td>
<td>Dec</td>
<td>7 428</td>
<td>32 197</td>
</tr>
<tr>
<td>2003</td>
<td>June</td>
<td>8 134</td>
<td>28 056</td>
</tr>
<tr>
<td></td>
<td>Dec</td>
<td>7 059</td>
<td>28 040</td>
</tr>
<tr>
<td>2004</td>
<td>June</td>
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Source: MOH (personal communication).

Note that these figures are not likely to be consistent with waiting-list numbers in other countries. The elective services system balances out those who are assessed as likely to benefit from treatment (i.e. those who score at or above TT) with the ability of each DHB to treat patients within a six-month period. No data are reported on the numbers of patients returned back to their GP for care, which might equate with numbers on waiting lists in other countries.
DHBs do have incentives to deliver on the elective services programme: they must ensure delivery of a certain number of FSAs and operations, and they can have funding withheld if they are not meeting elective services targets. The volume of elective surgery provided has also increased over time as the government has had a target of increasing the number of operations by 4000 each year since 2007–2008. These increases in elective surgery have been supported by additional funding available to the DHBs since 2006–2007, totalling around NZ$761 million up to 2010–2011 (Office of the Auditor General, 2011).

In the election campaign of late 2011, the then governing National Party (which subsequently formed a coalition government at the end of 2011), promised to further increase the number of elective operations performed and reduce waiting times, such that patients will wait no more than five months in 2013 and four months by the end of 2014 for their FSAs and operations (New Zealand National Party, 2011; Ryall, 2012).

5.4.6 Day care

See section 7.5.2.

5.5 Emergency care

Full emergency services (primary, secondary and tertiary care) are based in public hospitals. Some private medical centres provide urgent primary care in cities.

5.5.1 Ambulance services

Ambulance services (both road and air) are independent service providers, which contract with the Accident Compensation Corporation, the MOH, and DHBs to provide emergency trauma and medical services (National Ambulance Sector Office, 2009). They also provide medical transport services to hospitals, and particularly with regards to the air ambulance, rely quite heavily on sponsorship for funding.

There are two main providers of ambulance services in New Zealand (both NGOs) staffed by trained paramedics, St John and Wellington Free Ambulance. St John (www.stjohn.org.nz) provides ambulance services 24 hours a day, seven days a week and covers 90% of the country’s population. St John utilizes conventional ambulances, helicopters and motorcycles to improve response times and access isolated people. St
John has four funding streams: contracts with DHBs, ACC and the MOH (80% of funding); patient part charges for medical emergencies; patient full charges for non-emergency transports; and community donations and fundraising. Patient part-charges range from about NZ$65 to NZ$85 (St John New Zealand, 2012b). St John’s workforce relies heavily on volunteers, with 900 paid and 2800 volunteer ambulance officers (St John New Zealand, 2012a). St John works independently of government and business, and operates as a charitable organization (St John New Zealand, Undated).

Wellington Free Ambulance (WFA) is an incorporated society run by its own board of management and is the only free (to the patient) metropolitan ambulance service in New Zealand. It serves people in the lower North Island (covering a population of about 500 000) (WFA, 2012). WFA is part funded by government agencies, including the MOH and ACC, with the shortfall funded from sponsorship, grants, donations, fundraising events and public appeals.

The Life Flight Trust operates a nationwide air ambulance service, transporting critically ill patients (including neonates) who require specialist hospital services (Life Flight Trust, 2012).

In 2008 and 2009, an Ambulance Service Strategy was developed. The aim of the strategy is to help produce a sustainable, quality, cost-effective and efficient ambulance service. The strategy is comprised of 10 initiatives, including developing a transparent and sustainable funding model for ambulance care by aligning ACC and MOH funding, developing performance indicators of ambulance service providers, and developing a unit that is accountable to the ACC and MOH that oversees the implementation of the strategy. This unit is the National Ambulance Sector Office (Cunliffe, 2008; National Ambulance Sector Office, 2009).

Currently, the MOH and ACC purchase services from ambulance providers under a non-mandatory standard, with a key performance indicator of response time (from the ambulance crew receiving a call to arrival at the patient), but compliance with the standards is not monitored (Al-Shaqsi, 2010). Patients are transported to the closest hospital with an emergency department, where they will be assigned a triage code number based on the severity of their condition. Shorter stays in emergency departments is one of six current national health goals. DHBs report quarterly on their performance against the target of “95% of patients admitted, discharged or transferred from an emergency department within six hours.”
5.5.2 Emergency management

The Civil Defence and Emergency Management Act came into force in 2002. The act outlines the roles and responsibilities of key government agencies, including the MOH, in an emergency. In 2004, the National Health Emergency Plan: Infectious Diseases was developed in response to the threat of the Severe Acute Respiratory Syndrome virus (MOH, 2009c). The plan continues to evolve and in 2008 the National Health Emergency Plan (NHEP) was developed. The National Health Emergency Plan (NHEP) provides an overarching direction to the health and disability sector, and all other government sectors (MOH, 2008k). For the NHEP to be implemented there must be an expectation that the usual health resources are overwhelmed or have the potential to be overwhelmed. The definition is deliberately “loose to allow providers the flexibility in assessing a pending, developing or current emergency” (MOH, 2008k, p. iv). The NHEP is supported by the New Zealand Influenza Pandemic Action Plan (MOH, 2006b), which was used during the 2009 ‘Swine Flu’ pandemic and is also the basis of preparations for a possible second wave of infection.

5.6 Pharmaceutical care

In 2009, there were over 900 pharmacies (excluding hospital pharmacies) in New Zealand, and 3223 practising pharmacists in 2011 with an average of 0.7 pharmacists per 1000 population (Lakes DHB, 2009; Pharmacy Council of New Zealand, 2011; WHO, 2011).

Two government organizations control the use of pharmaceuticals in New Zealand: the New Zealand Medicines and Medical Devices Safety Authority (Medsafe), and the Pharmaceutical Management Agency (PHARMAC). Most pharmaceutical products are imported into New Zealand, with a small amount of local production.

Medsafe administers the Medicines Act 1981 and Regulations 1984, and parts of the Misuse of Drugs Act 1975 and Regulations 1977, in order to manage the risk of avoidable harm associated with the use of medicines. Medsafe is also responsible for ensuring that the therapeutic products available in New Zealand can be expected to have greater benefits than risks if used appropriately. Pre-marketing approval must be obtained for new and changed medicines. Data that satisfactorily establish the quality, safety and efficacy of the product, for the purposes for which it is to be used, must be submitted for evaluation before consent can be
granted. Post-marketing surveillance monitors the safety of medicines and medical devices in use. Products shown to be unsafe are removed from use, and prescribers are advised about new safety information for products. Medsafe thus is the gatekeeper of the New Zealand market, charged with ensuring that medicines are safe and effective, and PHARMAC decides on subsidy levels after Medsafe has approved drugs for use.

PHARMAC was set up in 1993 as a Crown Agency to manage the country’s positive list called Pharmaceutical Schedule, and then became a limited liability not-for-profit company under the Health Funding Authority. Following the New Zealand Public Health and Disability Act 2000, PHARMAC became a separate Crown Agency with its functions and responsibilities largely unchanged.

The PHARMAC Board makes decisions on listing, subsidy levels, and prescribing guidelines and conditions, with input from independent medical experts on the Pharmacology and Therapeutics Advisory Committee and its specialist sub-committees. Pharmaceutical suppliers may apply to have a medicine listed on the Pharmaceutical Schedule for subsidy, following MOH registration of the product. PHARMAC publishes updates of the Pharmaceutical Schedule, which involves continual assessment of drug performance and cost, usually by reviewing trends within defined groups of drugs (therapeutic group reviews). PHARMAC sets its review priorities by taking into account the reports of the National Health Committee, known patient needs, the size of the therapeutic group relative to total drug use, and cost trends within that therapeutic group.

A wide range of subsidized medicines, approved appliances and related products are listed on the Pharmaceutical Schedule, and can be prescribed by medical practitioners, midwives, some nurses, and dentists. Consumers make a small co-payment while concession mechanisms are intended to ensure that people can afford drugs (see section 3.3.1).

The Pharmaceutical Schedule lists over 2000 drugs and services that are subsidized by the government. This schedule, updated monthly and reprinted three times a year, also sets out prescription guidelines, and records the price of each drug and the subsidy (PHARMAC, 2009). PHARMAC decides which drugs should be listed on the Pharmaceutical Schedule based on evidence of effectiveness, and also decides the
price that government is prepared to pay the supplier. As a monopsony purchaser with considerable bargaining power, PHARMAC has applied supply-side controls. It uses a range of strategies to control pharmaceutical expenditure, including reference pricing with suppliers. PHARMAC manages pharmaceutical expenditure through negotiations and contracts with pharmaceutical suppliers, and is estimated to have saved DHBs over NZ$ 5 billion since 2000. “This estimate is based on pharmaceutical prices in 1999 mapped onto actual prescribing activity, and compares actual spending with what would have happened had PHARMAC taken no action. By 2010, the difference in that year alone was NZ$ 937 million” (PHARMAC, 2012, p. 16). Total pharmaceutical expenditure as a percentage of the total expenditure on health has fallen from a high of 15.8% in 1994 to 9.3% in 2009 (OECD, 2011). This compares with the United Kingdom’s pharmaceutical expenditure of 11.6% of total health expenditure (2008), the United States’ 12.0% (2009), Australia’s 14.6% (2008) and Germany’s 14.9% (2009) (OECD, 2011).

Reference pricing is based on the classification of pharmaceuticals into therapeutic groups and sub-groups. A ‘therapeutic group’ is defined as a set of pharmaceuticals that are used to treat the same or similar conditions, and a ‘therapeutic sub-group’ is defined as a set of pharmaceuticals that produce the same or similar therapeutic effect in treating the same or similar conditions. The application of reference pricing means that all pharmaceuticals in a given sub-group are subsidized at the level of the lowest priced pharmaceutical. PHARMAC can consult on the method for calculating the reference price and is not bound to apply reference pricing in every situation where pharmaceuticals have been classified into a therapeutic sub-group.

Demand-side controls have been less successful. The Health Funding Authority contracted with GPs to manage pharmaceutical budgets although GPs retained up to one half of these ‘savings’; slightly more efficient contracts were negotiated with pharmacies; and more efficient and effective prescribing by GPs and specialists was encouraged, including use of generic drugs.

Consumer co-payments for pharmaceuticals were also intended to manage consumer demand and contain expenditure (Statistics New Zealand, 1998, pp. 15–16). An initiative of the primary health care strategy increased the subsidy for pharmaceutical prescriptions, reducing the price that the public pays for prescriptions. People who are eligible for
publicly funded health and disability services, and whose medication is funded by PHARMAC will pay a maximum of NZ$5 per item prescribed for their prescription (for a maximum of 20 prescriptions per year).

New Zealand complies with the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement. When the TRIPS agreement started in New Zealand the patent length for pharmaceuticals increased from 16 years to 20 years and patent extensions were no longer allowed (Lynch, 2003; WTO, Undated). The pharmaceutical industry has pushed to have a supplementary protection certificate (SPC) system developed in New Zealand so that New Zealand trading laws are in line with some of its trading partners. SPC systems currently operate in Japan, the United States, Australia and the European Union (Lynch, 2003). A ‘Bolar provision’ exists in legislation which allows the production, sale or use of a patented product, without the patent owner’s permission, solely for the purpose of obtaining marketing approval. In New Zealand, the Bolar provision is termed Springboarding and came into force in December 2002 (Ministry of Economic Development, 2003).

Two types of pharmacy operate in New Zealand, community pharmacies and hospital pharmacies. Community pharmacies are located in towns and cities throughout the country and dispense prescriptions, sell pharmacy-related products and provide counselling on the maintenance of good health. There are over 900 community pharmacies in New Zealand (Pharmacy Council of New Zealand, 2007). Hospital pharmacies operate from all the major hospitals and provide the pharmaceutical needs of inpatients (outpatient prescriptions are dispensed through community pharmacies) (Pharmacy Council of New Zealand, 2007).

The licensing of pharmacies is legislated by the Medicines Act 1981. All pharmacies are required to operate under the supervision and control of a registered pharmacist. A company or person may only operate or hold a majority interest in a maximum of five pharmacies. Pharmacies can operate within health centres, in conjunction with other businesses and within other businesses (e.g. operate within a specified area of a supermarket). GPs cannot own pharmacies and there are restrictions on authorized prescribers of pharmaceutical medicines having an interest in a pharmacy unless the licensing authority “is satisfied that there are sufficient safeguards to prevent the issue of prescriptions, the manner in which prescriptions are issued, or the other provision of health care by the authorized prescriber being influenced by the commercial or financial
prescriber or any other person holding an interest in the pharmacy” (Medicines Act 1981 section 42C(3)).

5.7 Rehabilitation/intermediate care

The ACC is the cornerstone of rehabilitation management. The ACC was established in 1974 under the Accident Compensation Act. The ACC provides 24-hour comprehensive no-fault personal injury cover (financial cover) for New Zealand residents and visitors to New Zealand. People can apply for help regardless of how their injury occurred, or whose fault the injury was (ACC, 2012a). In return for cover, the ability to sue for personal injury has been removed, except for exemplary damages. Exemplary damages are not awarded as compensation to an injured person, but instead aim to reform or deter the person who caused injury, and others, from following the same course of action that caused the injury (ACC, Undated-b).

The ACC pays for a wide variety of medical costs including, but not limited to, GP visits, specialist fees and prescription costs, visits to allied health professionals, acupuncturists, audiologists, and some hospital treatment and surgery (ACC, Undated-c). People can only receive ACC-funded care from providers that have pre-registered with the ACC. Further, people can receive weekly compensation while they are out of work due to an injury, of 80% of their pre-incapacity income (ACC, Undated-c). Common causes of personal injury that the ACC frequently cover include physical injuries (sprain, laceration, fracture), work-related gradual process diseases or infections, mental injury caused by a physical injury, and mental injury caused by sexual abuse or assault (ACC, 2012a). The ACC does not cover stress, hurt feelings, injuries related mainly to ageing, non-traumatic hernias and non-occupational gradual process injuries (ACC, 2012a).

The ACC has several sources of funding. It receives some funding from general taxation to cover injuries to non-earners. Workplace and motor vehicle injuries are funded through levies on people’s earnings, businesses’ payrolls, petrol, and vehicle licensing fees.

Research by the ACC suggests that some groups access ACC’s services at a lower rate compared to other groups. Groups with the lowest knowledge of ACC include Māori, Pacific and Asian people, and older and disabled people. To increase the knowledge of ACC services to these people, the ACC developed strategies specific to each group (ACC, 2008a). The
strategies focused on creating communication links to ensure people had knowledge and education about ACC’s services.

ACC operates under the Accident Compensation Act 2001. The purpose of the Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury. The mains goals of the Act are to minimize both the overall incidence of injury in the community, and the impact of injury on the community, including economic, social and personal costs (New Zealand Government, 2001).

5.8 Long-term care

This section reviews three areas that are closely linked to the health care system: disability support services, the care of dependent older people, and care of people with chronic conditions. Strategies and programmes that target these three areas are often interlinked and are not mutually exclusive.

5.8.1 Disability support services

Disability support services aim to increase the independence of people with long-term disabilities and to promote their participation in the community. The disability sector in New Zealand has adopted a social model of disability, and has an active disability rights movement. The social model of disability focuses on removing barriers to a person’s opportunities for independence and participation in community life.

In 2006, about 17% of the total population had some form of disability, ranging from 10% of children under 15 to 45% of those aged over 65. Not all disabilities require government services. Eighty-two per cent of people with a disability were adults living in households, 5% were adults living in residential care facilities, and 14% were children under 15 years (Statistics New Zealand, 2007a).

Just over half (52%) of disabled children had a single disability, while the remainder had multiple disabilities (Statistics New Zealand, 2007a). The most common were special education needs (46%), chronic conditions or health problems (39%) and psychiatric or psychological disabilities (21%); smaller percentages had speaking, intellectual, hearing or seeing impairments. Special education needs include children receiving special education support because of long-term conditions or health problems;
children who have an Individual Education Programme (IEP) or Individual Programme (IP) because of learning or developmental difficulties; and children with learning difficulties such as dyslexia, attention deficit disorder or attention deficit hyperactivity disorder (ADD/ADHD) (Statistics New Zealand, 2007a). Just over half (52%) of disabled children were disabled from birth; 26% from disease or illness; 3% from an accident and 31% from other or unspecified causes (more than one cause could be counted). Among disabled adults aged 15 and over, about two thirds had a physical disability, 42% a sensory disability (hearing and/or seeing) and 39% other disabilities (note that people could report more than one type of disability) (Statistics New Zealand, 2007a). Ten per cent had been disabled from birth, 37% through disease or illness, 29% by accident or injury, 27% through natural ageing and 34% from other or unspecified causes.

Funds and responsibilities for disability support services were transferred from the Department of Social Welfare to the MOH between 1993 and 1997. The MOH is the predominant government funder of disability support services, which are usually community-based and delivered by private and not-for-profit agencies, ranging from very small groups to large monopoly providers (MOH, 2002a). The various purchasing authorities throughout the 1990s shifted more funds to smaller community groups. On 1 October 2003, planning and funding for disability support services for people over 65 was separated from disability support services for people under 65. DHBs became responsible for support services for people generally over 65, while the MOH continued to plan and fund care for people generally under 65.

A person who meets the MOH definition of disability can have an individual needs assessment to determine their support needs and then, where appropriate, a process to identify the services and support options to meet their assessed need within available funding. This might include disability support services such as personal care, household help, equipment and home modifications, and residential care. Children under 16 usually receive free access to disability support services, but some adults have to pay for some services. For example, ‘household management’ services, including meal preparation and housework, are only free for people with a community services card (MOH, 2011k).

In 2011–2012, the MOH began transitioning to a disability support system that increases disabled people’s choice and control over the support they
receive and the lives they lead. Key aspects of the new model are:

- a stronger focus on information and personal assistance, particularly through the appointment of Local Area Coordinators;
- a move towards allocating funding rather than types and levels of service, with broad guidelines around what funding can and cannot be used for;
- more choice and control for people over the support they purchase through making individualized funding available to most people and for most support, and through making contracted supports and services more flexible;
- stronger accountability arrangements that reflect the accountabilities to disabled people, providers and the ministry, and a stronger monitoring focus on whether people are living an everyday life.

Other government departments and agencies also provide services to people with disabilities. For example, the Ministry of Education funds Special Education initiatives in schools; the ACC provides support for people disabled as a result of an accident; and the Ministry of Social Development (via its service arm Work and Income New Zealand) administers benefits and allowances for people with disabilities. There are strong intersectoral linkages between many of these services, and boundary tensions may result (MOH, 2002a).

The New Zealand Disability Strategy released in April 2001 laid out a national strategic plan intended to eradicate barriers to participating in society for people with disabilities. The Disability Strategy encompasses people with all types of impairments – physical, sensory, neurological, psychiatric or intellectual. Other strategies complement the Disability Strategy including the New Zealand Health Strategy, the Māori Health Strategy, 'Ala Mo‘ui (the Pacific health plan) and the Health of Older People Strategy. In 2002, responsibility for the oversight of the Disability Strategy moved from the MOH to the Ministry of Social Development’s Office for Disability Issues (ODI) (MOH, 2002a). The ODI monitors government agencies’ implementation of the Disability Strategy and the Minister for Disability Issues reports annually to Parliament on progress.

5.8.2 Aged care

Many disability support services also apply to older dependent people. The care of older people will become a more important public policy issue in New Zealand, since the proportion of people aged 60 years and over
is projected to increase from 15.6% of the population in 2000 to 29.3% in 2050 (United Nations Population Division, 2000).

The Health of Older People Strategy (MOH, 2002c) was released in 2002 and aims to draw together health services for older people in a more integrated way to improve the delivery of care. The MOH and DHBs are responsible for implementing the strategy. The strategy increased the emphasis on providing older people with community care to support them to live in their own homes. Care may include such things as home visits by nurses, assistance with housework or meals-on-wheels-based services.

The MOH is responsible for certifying and monitoring nursing homes for older people. DHBs are responsible for ensuring the supply of residential care rooms; in doing so, they consult with providers of rest homes and dementia and geriatric hospital-level facilities. Patients in these homes are means-tested for their ability to pay for their own care. Since July 2005, the threshold for eligibility for the Residential Care Subsidy has been progressively rising each year. As at 1 July 2012, people qualify for the subsidy if:

- they do not have a spouse/partner and have assets valued at NZ$213 297 or less;
- have a spouse/partner who is also in residential care and combined total assets valued at NZ$213 297 or less;
- have a spouse/partner who is not in care and either combined total assets of NZ$116 806 not including the value of their car and home (where this is the primary residence of the spouse/partner or a dependent child) or combined total assets of NZ$213 297 including the value of their house and car (Work and Income, Undated-c).

5.8.3 Chronic conditions

Chronic conditions have significant social and financial costs for society and the health sector. Chronic conditions account for 80% of preventable deaths in New Zealand, and mismanagement of chronic conditions is the leading cause of hospitalizations (NHC, 2007). The most common chronic conditions include diabetes, heart disease, chronic obstructive pulmonary disease, and diseases associated with obesity. Māori and Pacific people have higher rates of chronic conditions compared to other ethnic groups (MOH, 2008b; NHC, 2007).
Care for people with chronic conditions is initiated by a person’s PHC practitioner, who may treat the patient themselves or refer them to a specialist in a hospital or private practice. People may also receive help from not-for-profit and volunteer support groups. ‘Care Plus’ provides additional funding to PHOs (for 5% of the population overall) for people with high health needs because of a chronic condition, acute medical or mental health needs, or terminal illness (see section 6.1.5).

Much attention is currently being paid to improving care for people with chronic conditions, with a focus on strengthening PHC services. Improving clinical integration, which is about bringing organizations and health care professionals together to improve outcomes and experiences for patients, is a high priority for the current government (2011–2014). In addition, there are many initiatives at local level to improve the coordination of care, such as the Counties Manukau DHB chronic care management programme, as well as joint work up to the late 2000s by DHBNZ to identify the critical components of effective interventions for chronic conditions (Connolly et al., 2010; Wellington et al., 2003).

5.9 Services for informal carers

An informal carer is anyone who supports a person with ill health, a disability, mental illness or addiction, or in their old age (Carers New Zealand, Undated). In the 2006 New Zealand Census, approximately 420,000 people reported that they had supported an individual with ill health or a disability within the previous month. Approximately 47% of these carers were supporting someone outside their household, 38% were helping someone inside their household and 15% were doing both (Carers New Zealand, Undated, p. 7). Most informal carers are unpaid, although a small proportion are eligible for the means-tested Domestic Purposes Benefit – Care of Sick or Infirm if they care full-time at home for someone other than their spouse or partner who would otherwise need hospital, rest home or residential disability care. However, a group of parents of adult disabled children took a case to the Human Rights Review Tribunal, challenging the MOH’s refusal to pay them for providing disability support services to their family members. The Tribunal (and later the Court of Appeal) found in their favour and the MOH subsequently developed a new policy, Funded Family Care, which came into effect on 1 October 2013 (MOH, 2013c). However, payment for family members is restricted to a small group of family members (other than a spouse) who
care for a disabled person aged 18 or over who is assessed as having high or very high needs (through existing needs assessment processes) (MOH, 2013c).

A national Carers’ Strategy was published in 2008 and was the first time in New Zealand that a ministerial strategy focused solely on informal carers (Carers New Zealand, Undated). The strategy was developed by the Ministry of Social Development in partnership with the New Zealand Carers’ Alliance and other government agencies. It has five objectives: provide information, protect the health and well-being of carers, enable carers to take a break, provide financial support for carers, and provide training and pathways to employment for carers (Carers New Zealand, Undated, p. 14). Each objective is supported by a number of actions. The strategy is being implemented by three government departments (MOH, Ministry of Social Development and Department of Labour) and the ACC. A new action plan is being developed for 2013 to 2015.

Many NGOs provide support for people with disabilities or chronic conditions and their families and informal carers. Two important umbrella organizations advocate specifically for carers: Carers New Zealand, a national charitable trust that provides information and support to carers, and the New Zealand Carers’ Alliance, a network of about 45 NGOs formed to lobby government about policy to address carers’ needs (Carers New Zealand, Undated; MSD, 2008).

The MOH funds a number of disability support services for disabled people and their families/carers. Eligibility for these services is determined by a Needs Assessment Service Co-ordination (NASC) process which identifies support needs, coordinates services and allocates resources within a fixed budget (MOH, 2012j). Carer Support allows unpaid primary carers of a person with a disability to receive short-term breaks from care (MOH, 2013b). The programme is designed to be flexible and relief care may be provided by friends, some family members, neighbours or formal services such as a rest home, with Carer Support reimbursing some of their costs (MOH, 2013b). Respite services are available to disabled people to provide short-term out-of-home breaks in a community setting (MOH, 2013k).

5.10 Palliative care
The government funds palliative care and related services, as set out in
The New Zealand Palliative Care Strategy (MOH, 2001c). The strategy noted a number of service issues that needed addressing, including variable access to services, variation in services and variability in funding. The strategy aims to provide a systematic and informed approach to the provision and funding of palliative care services. The strategy has two underlying objectives: to develop a set of essential services for dying people who could benefit from palliative care, and to develop a flexible service configuration that is coordinated between existing services and the aims of the strategy. The first priority of the strategy is to ensure that all people requiring palliative care have access to at least one palliative care service within their DHB geographical region, and access to specialist palliative care services within their wider region (e.g. Wellington, Auckland and Hamilton). Palliative care for a patient is usually initiated by the patient’s GP or primary care nurse. Other key stakeholders include Hospice New Zealand (the national body for many hospices in New Zealand), other health professionals, research institutions and community groups. Palliative care is provided in three locations: at a person’s home, in day-care facilities or in inpatient facilities. Specialized paediatric palliative care is provided at the Starship Children’s Hospital in Auckland. Though palliative care is government funded through DHBs, hospices are also supported by corporate sponsorship, public donations and volunteers.

5.11 Mental health care

‘Mental health services’ describe a range of services for the treatment of mental illness and drug and alcohol dependency, as well as support services for the chronically mentally ill. As in many other countries, the field of mental health services has changed radically over the last few decades. New Zealand overhauled its mental health services in the 1990s. The main change was the closure of large mental hospitals and the movement of care into the community, facilitated by new drugs and pushed by the deinstitutionalization movement. The rights of patients were protected under the Mental Health (Compulsory Assessment and Treatment) Act 1992, which aimed for a balance between personal rights and protection of the public.

New Zealand embarked upon a national mental health strategy with the publication of Looking Forward (MOH, 1994b), followed by an implementation plan Moving Forward (MOH, 1997). The strategy focused on the severely ill (estimated to be 3% of the population), while the
implementation plan outlined steps for achieving more and better services, and set targets and delivery dates. Funding for social support services was transferred from Social Welfare to Health between 1993 and 1997 to improve the links between clinical services and social support.

The government’s interest in mental health and substance abuse was broadened in 2005 by the second mental health and addiction plan and the strategic document Te Tāhuhu – Improving Mental Health 2005–2015 (MOH, 2005d), which built on the earlier Looking Forward and Moving Forward. The plan outlines government expectations from all state services (which comprise all departments and Crown entities) with regards to mental health and addiction services (MOH, 2005d).

Building on previous plans, Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012–2017 was published in 2012. It sets out actions over the five years to improve outcomes, support better system integration and performance, increase access to services, make more effective use of resources, and strengthen whole-of-government partnerships (MOH, 2012n).

A national survey on the prevalence of mental disorders and the effect of mental disorders in adults was completed in 2006 and found that up to 46% of the population are predicted to meet criteria for a disorder at some time in their lives and around 20% of the population had a mental disorder in the preceding 12 months (Oakley Browne, Wells & Scott, 2006). This compares with an estimated 27% of the EU population having been affected by at least one mental disorder in the previous year (Wittchen & Jacobi, 2005). Further, the prevalence of mental disorders is higher in Māori and Pacific people than for other ethnic groups. Females are more likely to suffer from anxiety disorder, major depression and eating disorders than males, and males are more likely to suffer from substance use disorders than females (Oakley Browne, Wells & Scott, 2006).

The New Zealand Suicide Prevention Strategy 2006–2016 builds on and replaces the earlier (1998) New Zealand Youth Suicide Strategy (Associate Minister of Health, 2006) and is accompanied by an action plan for 2013–2016 (MOH, 2013j). New Zealand suicide rates were relatively stable from 1948 to the mid-1980s, then increased in the following years to a peak 15.1 deaths per 100 000 in 1998 before declining again to 11.5 per 100 000 in 2010 (Associate Minister of Health, 2006; MOH, 2012p). This places New Zealand in the medium suicide frequency bracket along with most
of the other high-income OECD countries such as the United Kingdom, Germany, Spain, Australia, the United States and Canada (WHO, 2012). Māori have higher age-standardized suicide rates than those of New Zealand European/other ethnicity, followed by Pacific people and with Asians having the lowest rates (Associate Minister of Health, 2006). There were 3.2 male suicide deaths for every female death in 2001–2003; although women make more suicide attempts, more men succeed in dying (Associate Minister of Health, 2006).

Mental health services, both hospital and community based, are predominantly publicly funded and are offered by a mix of public, NGO and private providers. Most specialist services are provided by DHBs, and most community-based residential and day and support services are provided by about 359 NGOs. Typically, a person with a psychiatric disability living in the community is treated by a public-sector community mental health team, but receives day-to-day support from NGOs.

Those with a less severe mental health problem (e.g. mild to moderate depression) access PHC services through their GP. Medication is funded by the government and, since 2005, a limited amount of public funding has been made available for primary mental health services, which include access to free or subsidized counselling services for the eligible population.

Māori mental health is of particular concern given higher rates of drug and alcohol problems, suicides, and various mental disorders (Horwood & Fergusson, 1998). By the time treatment is sought, Māori patients tend to be sicker and need specialist mental health services, and so are more likely to be hospitalized. Te Tāhuhu notes the growth since the 1990s of mental health and addiction services for Māori, workforce development and research and evaluation (MOH, 2005d). However, continuing to improve Māori mental health is still a priority and whānau (family) wellness is central to this: “There is a strong link between health and culture, and the wellness of tangata whaiora [people seeking wellness] both depends on and is affected by the wellness of whānau. Services will improve when Māori take an active role in planning and delivering services, and when models of practice incorporate a better understanding of the importance of whānau, and the interface between culture and clinical practices” (MOH, 2005d, p. 13).

People with a mental disorder or an intellectual disability who are
charged with or convicted of an imprisonable offence may have to accept involuntary treatment or care and rehabilitation. If an accused person has a mental disorder the court may make a Special Patient Order requiring the person to accept treatment until they are no longer a danger to themselves or others. If an accused person has an intellectual disability, the court may make a Compulsory Care Order lasting up to three years, which can be extended by the family court (MOH, 2005a).

Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, people can also be made to receive compulsory treatment without having committed a criminal offence if the mentally ill person is a danger to themselves or others, or their mental state is such that it seriously diminishes their capacity to care for themselves. A strict set of protocols is followed when compulsory care or treatment of an individual is initiated. The rights of patients with mental disorders are covered by the Mental Health (Compulsory Assessment and Treatment) Act 1992. The development of the United Nations Convention on the Rights of Disabled People may result in legal challenges by people with an intellectual disability of discrimination or breaches of rights if they receive involuntarily treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MOH, 2005a).

There are ongoing MOH-funded education initiatives for workers within the mental health field and funded public education programmes. ‘Let’s get real’ is a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services. It aims to improve the competence and capability of the mental health workforce (MOH, 2008h). ‘Like Minds, Like Mine’ is a public education programme that started in 1997 with the aim of reducing the stigma and discrimination faced by people with mental illness or people who have previously experienced of mental illness. Surveys reviewing the success of the campaign show it has produced positive benefits in reducing the stigma and increasing people’s awareness of mental illness (Like Minds, Like Mine, 2009; Wyllie, Cameron & Howearth, 2008).

5.12 Dental care
The Good Oral Health, for All, for Life document was developed in 2006 and serves as the strategic vision for oral health in New Zealand (MOH, 2006a). The key principles underlying the strategy include: improving the
oral health status of disadvantaged groups – particularly Māori, Pacific peoples and people from lower socioeconomic groups; developing strong preventive programmes that complement examination and treatment services (e.g. oral health promotion in schools and water fluoridation); and ensuring there is a robust and appropriately trained workforce that provides a high-quality service. The DHBs have the primary responsibility to ensure that high-quality oral health services are available to all people within their geographical boundary (MOH, 2006a).

A major public health approach to dental care is water fluoridation. The naturally occurring level of fluoridation in New Zealand water supplies is not sufficient to be of benefit to dental health, so most of New Zealand’s public drinking water is fluoridated to levels between 0.7 parts per million (ppm) to 1 ppm. Hastings was the first community to have fluoridated water in 1954 (MOH, Undated-b). Local authorities, who are responsible for supplying water in their district, have the responsibility of deciding whether or not to add fluoride. There are 49 water-treatment plants supplying fluoridated water to 2.3 million New Zealanders (about half the population) in 48 communities (Drinking Water for New Zealand, 2011). Not all communities’ water supplies are fluoridated, as some communities have held referendums that stop water fluoridation and some rural communities do not have access to fluoridated supplies.

The majority (80%) of children between 2 and 14 years see an oral health worker at least once per year, whereas only half of adults see an oral health worker at least once a year. An oral health worker can be a dentist, dental nurse, dental therapist, or a specialist such as an orthodontist. Ethnicity and neighbourhood deprivation also affect the likelihood of people visiting an oral health worker. Adults from the most deprived quintile neighbourhoods are less likely to visit an oral health worker (37%) than adults from the least deprived quintile neighbourhood (62%) in a year period. Europeans are more likely to visit a dental care worker than Māori, Pacific people and Asians (MOH, 2008a).

The Dental Council of New Zealand is the statutory body constituted under the Health Practitioners Competence Assurance Act 2003 for maintaining self-regulation of the dental professions. The main purpose of the council is to ensure that oral health practitioners are safe and competent to practise (DCNZ, Undated-b).

Two tertiary institutions provide training for dental professionals. The
University of Otago’s Dental Faculty offers several programmes: five-year Bachelor of Dental Surgery (leading to registration as a dentist or, later, dental specialist), three-year Bachelor of Dental Technology (to register as a dental technician, responsible for producing prostheses prescribed by a dentist), and three-year Bachelor of Oral Health (leading to registration as a dental therapist or dental hygienist). Dental therapists provide oral health prevention, assessment and treatment for children and adolescents up to age 18, and dental hygienists provide oral health education for patients and nonsurgical treatment of periodontal diseases under the supervision of a dentist [DCNZ, Undated-a; University of Otago, 2006, 2009].

There are 54 places for the Bachelor of Dental Surgery each year, 40 for the Bachelor of Oral Health and 30–35 for the Bachelor of Dental Technology. The Auckland Institute of Technology also offers a Bachelor of Science in Oral Health for training dental therapists and dental hygienists.

Children are entitled to free basic health care from birth to the end of year 8 schooling (age 12–13) from dental therapists, who usually operate from school grounds either in on-site or mobile clinics. Dental therapists are employed by DHBs or NGO health providers contracted by DHBs. Dental therapists provide oral health assessment (dental examinations), restorations (fillings) for both primary and permanent teeth, pulp-capping in primary and permanent teeth, extraction of primary teeth, preventive dentistry including the placement of fissure sealants and application of fluorides, and oral health education and promotion [NZDA, Undated-b].

Free basic dental services for adolescents up to their 18th birthday are provided by private dentists who choose to contract with their DHBs under the Service Agreement for the Provision of Oral Health Services for Adolescents (OHSA) and Special Dental Services for Children and Adolescents (SDSA). The agreement is commonly known as the Combined Dental Agreement (CDA) [NZDA, Undated-b]. The SDSA component of the CDA provides dental services that a dental therapist could not provide under the dental therapy scope of practice. As of 30 September 2012, some 713 dental practices had contracts for the OHSA component of the CDA, 454 practices had contracts for the SDSA component of the CDA, and in total, 724 practices had contracts for OHSA and/or SDSA (MOH, personal communication).

Most adult New Zealanders must pay for private dental treatment (or
purchase health insurance for this). Limited services are available from most public hospitals for people on low incomes (though there may still be a part-charge) [NZDA, Undated-b]. People on benefits may also be eligible for some financial assistance for emergency dental treatment through Work and Income [Work and Income, Undated-b]. Dental treatment required following injury or accident is funded by ACC. Hospital dental departments also treat disabled people or those with medical conditions that compromise their ability to receive dental care from private community dentists [MOH, 2009e].

In 2009–2010, the MOH funded just over NZ$200 million of outpatient dental care, and ACC funded NZ$28.7 million [MOH, 2012e]. In addition, the Department of Corrections funds just over NZ$1 million annually for prisoners’ oral health treatment and the New Zealand Defense Force over NZ$6 million annually for dental treatment for personnel [MOH, personal communication].

5.13 Complementary and alternative medicine

Complementary and alternative medicine (CAM) is a group of diverse health care systems, practices and products that are not generally considered part of conventional medicine [National Center for Complementary and Alternative Medicine, 2009]. CAM products and practitioners are subject to a variety of legislative provisions [MACCAH, Undated-c]. Chiropractors and osteopaths are regulated by the Health Practitioners Competence Assurance Act (2003). The purpose of the Act is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions [MACCAH, Undated-c]. The Act has a provision to allow other CAM treatments to be included into the legislation in the future [MOH, 2011h]. Other CAM providers are not regulated by specific legislation, though other regulations, such as the Fair Trading Act and the Code of Health and Disability Consumers’ Rights do have an impact on how CAM practitioners can operate [MACCAH, Undated-c].

There are estimated to be around 70 different CAM groups in New Zealand [MACCAH, 2003]. These groups primarily function as separate, autonomous professional organizations. There have been a number of attempts to create umbrella organizations, but these have not been particularly successful. The various professions still tend to work within their own educational standards and professional regulatory processes.
There are currently two organizations claiming an umbrella role for CAM groups. Natural Health Practitioners New Zealand claims to represent natural health practitioners in about 80 CAM groups (Natural Health Practitioners New Zealand, 2012). However, the degree of their representation is not widely accepted by other CAM organizations. The Natural Health Council represents the more highly qualified CAM professions, including six professional organizations and seven education providers as affiliate members (http://www.naturalhealthcouncil.org.nz/).

CAM products are currently regulated on the basis of how the manufacturer markets the product, either as a food or as a medicine. For example, a product marketed as a medicine is subject to stringent regulations, whereas a product marketed as a dietary supplement is subject to minimal regulations (Natural Health Practitioners New Zealand, 2012). A new light-touch regulatory scheme for natural health products has been proposed. This will run separately from the regulation of food and medicines. The Natural Health Products Bill was introduced into Parliament in September 2011 and it is likely to be enacted by mid-2013. After its second reading in March 2013, the name was changed to Natural Health and Supplementary Products Bill; it is currently awaiting its third reading.

On average, one in five adults sees a complementary or alternative health worker each year. Over half of these see a massage therapist, and around 25% see a homoeopath, naturopath or an acupuncturist. Three per cent of children see an osteopath or a chiropractor (now defined as a health worker rather than a CAM practitioner), 4.4% of adults see an osteopath and 5.4% of adults see a chiropractor each year (MOH, 2008a). CAM practitioners operate from a variety of settings, from multidisciplinary clinics that may also offer mainstream GP services to other practitioners that operate informally out of their own homes (MACCAH, Undated-b). Some CAM treatments are subsidized by the ACC, including acupuncture, chiropractic and osteopathy services provided by specified providers. Work and Income (part of the Ministry of Social Development, providing employment services and financial assistance to New Zealanders) may pay a disability allowance to cover the cost of CAM treatment that a person requires due to a disability. However, the CAM treatment must be provided by a registered health professional – a chiropractor, an osteopath, a medical practitioner who practises homoeopathy or acupuncture, or a physiotherapist who practises acupuncture (MACCAH, Undated-c). People who are not eligible for ACC subsidies or a disability allowance pay out-of-pocket for CAM services.
In a 1997 Consumer’s Institute survey, over 66% of people told their GP they were seeing a CAM provider. GPs were most supportive where the CAM practitioner was an acupuncturist, aromatherapist or an osteopath. GPs were least likely to support herbal medicine or naturopathy treatments (MACCAH, Undated-b). Training in CAM techniques is usually provided by major training establishments that are registered with the New Zealand Qualification Authority. Mainstream health care providers may receive some CAM training during their education (MACCAH, Undated-b).

The Ministerial Advisory Committee on Complementary and Alternative Health was established in 2001. The committee informed the Minister of Health on issues to do with complementary and alternative health, and provided advice on areas such as regulation, consumer information needs, research and integration. The committee was disbanded in 2004 (MACCAH, Undated-a). Between 2003 and 2006 the MOH funded a web site to publish evidence-based information on complementary and alternative therapies. The web site was discontinued due to limited resources and had produced only a limited number of evidence-based summaries. As an alternative, the MOH purchased national subscriptions to two online health resources, the Cochrane Library, and the ‘Best Treatments’ web site run by the British Medical Journal (MOH, 2009b).

The MOH appointed a Chief Advisor for Integrative Health Care in 2008. The purpose of this role is to provide the ministry and ministers with professional leadership, direction and advice on the development of the CAM professions, and on the potential for integration of CAM with conventional health care, particularly in the area of primary care and chronic care conditions (MOH, 2011e).

5.14 Health services for specific populations
See sections 2.3.7 and 2.3.8 for Māori and Pacific health services, respectively.
Chapter 6: Principal health reforms

Chapter Summary

During the 20th Century, the New Zealand Government gradually picked up the overall financing of hospitals which were progressively amalgamated into larger units as hospital care became more technologically driven and birth rates fell. The first Labour government’s (1935–1938) aim of a comprehensive and integrated public health care system was never fully achieved, with compromises including fee-for-service funding for independent general practitioners (GPs); user charges, which rose over time as subsidies did not keep pace with costs (raising concerns about equity of access); and hospital specialists able to practise privately. Health funding and service delivery continued to be fragmented.

Since the 1980s, the New Zealand health system has undergone a series of reforms. From 1984, fourteen Area Health Boards (AHBs) were established, funded on a population basis and responsible for funding and providing secondary and tertiary health care and public health services (primary health care funding remaining with the Department of Health). AHBs became increasingly accountable to central government, for example, through ministerial appointments to governing boards, contractual requirements and performance targets.

In the early 1990s, a National Party government introduced separation of funding and provision of services with four Regional Health Authorities responsible for purchasing all personal health and disability services for their regional populations from both public and private providers. Twenty-three public Crown Health Enterprises (CHEs) ran hospitals, community and public health services as commercial entities. Other developments included the establishment of the government’s community drug-buying agency, Pharmaceutical Management Agency (PHARMAC), the formation of Independent Practitioner Associations of GPs to facilitate collective contracting, growth of Māori health providers and services, and deinstitutionalization (particularly of mental health and
disabled service users), with growth in the role of the private sector in delivering community-based services. However, implementation of these reforms was costly and aspects were unpopular with both the public and clinicians.

In 1998, a single Health Funding Authority was formed to purchase services. CHEs became Hospital and Health Services (HHSs) which were no longer required to make a profit. These changes were short-lived as a Labour–Alliance coalition government elected in 1999 introduced further reforms, returning to a model similar to that of the 1980s with AHBs.

The New Zealand Public Health and Disability Act 2000 introduced 21 (now 20) majority locally elected District Health Boards (DHBs), responsible for planning and purchasing or providing services for their region. Since 2002, primary health organisations (PHOs, currently 31) have been established to coordinate primary health care (PHC) services for an enrolled population, funded on a capitation basis. Significant new funding has reduced user charges and improved patient access in PHC.

Recent reforms have concentrated on increasing care coordination and integration in the health system. The National Party-led government elected in 2008 has focused on increased ‘frontline’ services and reduced bureaucracy. It has implemented a new National Health Board (advising the Minister of Health) to plan and fund national health services, and a Shared Services Agency to undertake administrative and support services on behalf of DHBs to reduce duplication. It has sought improved collaboration between DHBs and reductions in the numbers of PHOs (down from over 80 to 31), and is seeking ‘better, sooner, more convenient’ services, in particular focusing on new arrangements for delivering PHC services and shorter waiting times for assessment and treatment in elective services.

6.1 Analysis of recent reforms

This chapter provides an overview of the principal health care reforms in New Zealand between 1970 and 2013. Earlier developments are discussed in section 2.2, Historical background. The reforms are summarized (Box 6.1) and discussed in more detail, considering their aims and background, content and implementation.
Box 6.1 Major health care reforms and policy measures

<table>
<thead>
<tr>
<th>Date</th>
<th>Key reforms</th>
</tr>
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<tbody>
<tr>
<td>Pre-1980s</td>
<td>Primary health care (PHC) funded on a fee-for-service basis with patient co-payments; services delivered largely by general practitioners (GPs) running independent businesses. Local hospital boards oversee a large number of small hospitals; these are amalgamated over time to 27 in the early 1980s. Public health services run by the Department of Health, through 18 district public health units. From the 1960s, large psychiatric hospitals close through an increased emphasis on community care and services provided in general hospitals.</td>
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<tr>
<td>1983–1990</td>
<td>Area Health Boards Act 1983 establishes 14 AHBs responsible for funding and providing secondary and tertiary health care and public health services. AHBs replace local hospital boards and incorporate Department of Health district public health units. Population-based funding formula introduced.</td>
</tr>
<tr>
<td>1991–1996</td>
<td>Health and Disability Services Act 1993 separates ownership, purchase and provision of health services. Four public Regional Health Authorities are established to purchase all personal health and disability services for their regional populations from both public and private providers. Twenty-three publicly owned Crown Health Enterprises are formed from the AHBs to run hospitals, community and public health services as commercial entities. All disability services now part of the health system. RHAs contract with a wide range of providers, including CHEs, GP practices, pharmacists, laboratories and community providers (e.g. NGOs, Māori and Pacific providers).</td>
</tr>
<tr>
<td>1997–1999</td>
<td>RHAs abolished and a single purchasing authority formed (Health Funding Authority). CHEs are converted into 23 Hospital and Health Services which continue to run hospitals, community and public health services, but are no longer required to make a surplus.</td>
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<tr>
<td>2000 onwards</td>
<td>The New Zealand Public Health and Disability Act 2000 replaces the HHSs with 21 majority locally elected District Health Boards, responsible for planning and purchasing services for their region. DHBs contract for PHC, and community services delivered by private providers, and provide secondary services and some community services themselves. DHBs are funded according to a population-based funding formula.</td>
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<tr>
<td>2001 onwards</td>
<td>The Primary Health Care Strategy is published in February 2001, with increased focus on population health, coordination of care and collaboration between practitioners. From July 2002, primary health organisations have been established. PHOs are responsible for the provision of PHC services (through a network of providers) for an enrolled population, funded on a capitation basis. There was a peak of 80 PHOs; mergers have resulted in the current 31 PHOs.</td>
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<tr>
<td>2009 onwards</td>
<td>A government-appointed Ministerial Review Group made recommendations to improve the quality and performance of the public health system. Subsequently, a National Health Board was established as a business unit within the Ministry of Health and a Shared Services Agency established to manage back-office functions across DHBs. After the merger of two DHBs in 2010, there are now 20 DHBs. Emphasis is on ‘better, sooner, more convenient’ health services, including enhanced integration and coordination of services.</td>
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6.1.1 1983–1990: Area Health Boards

The formation of Area Health Boards (AHBs) in the mid-1980s was the first major reform of the New Zealand health system since the establishment of the welfare state under the first Labour government (1935–1949). In the intervening period, the state had failed to achieve an integrated, national health service, with dual public–private provision continuing, and fragmentation of services (Department of Health, 1974). Thus, prior to the establishment of AHBs, New Zealand had a highly fragmented health system, with a national Department of Health overseeing policy and 18 regional public health units; the gradual amalgamation of locally governed but nationally funded hospital boards, with 31 boards in existence in 1969; separately funded fee-for-service general practitioner (GP) services; and a number of grants for other national service providers. Hospitals were managed by a ‘triumvirate’ of three executives (a doctor, a nurse and an administrator), with shared authority and responsibility, and each with the power of veto, a system which the Gibbs Report claimed “stifles leadership, dilutes accountability and makes for poor management relationships at lower levels of the organisation” (Gibbs, Fraser and Scott, 1988, p. 19).

The concept of regional health authorities was first proposed in a 1974 White Paper, A Health Service for New Zealand (Department of Health, 1974). It was suggested that 14 regional health authorities be established to coordinate all services in their geographic area, and also that there be a split between the funding and provision of services. No reforms were, however, enacted before there was a change of government in 1975. The new National government set up a Special Advisory Committee on Health Services Organisation, which also proposed the establishment of 14 regional ‘Area Health Boards’ (Gauld, 2009). The government chose to pilot these in two areas and consult further with stakeholders rather than introduce them nationally all at once, before finally passing the Area Health Boards Act 1983, which allowed for the voluntary establishment of 14 AHBs (Gauld, 2009). These were formed between 1984 and 1989, during a Labour government.

AHBs were responsible for secondary and tertiary health care (mainly hospitals) and public health services, while the Department of Health maintained responsibility for subsidizing primary health care (PHC) and for services delivered by national providers. AHBs were organized around at least one large district hospital, from the merger of existing hospital boards and public health offices in the Department of Health.
Under the Area Health Boards Act, AHBs had three objectives: to promote, protect and conserve the public health, and to provide health services; to provide for the effective coordination of the planning, provision and evaluation of health services between the public, private and voluntary sectors; and to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services [section 10]. They were governed by boards of up to 14 members, the majority elected but with the option for some members to be appointed on the recommendation of the Minister of Health. From 1983, the government introduced a population-based formula to allocate funding to hospital boards/ABHs, replacing the earlier ‘cost-plus’ funding model.

AHBs were formed during a period when the Labour government also undertook significant economic and public-sector reforms. These included the State-Owned Enterprises Act 1986 (which restructured some government departments, separating trading activities into more business-like enterprises in order to promote their improved performance); the State Sector Act 1988 (introducing managerialism and performance objectives to state services); and the Public Finance Act 1989 (reforming public financial management systems to incentivize the effective and efficient use of financial resources by government departments).

The Labour government also commissioned two reviews of health policy in this period. The 1986 Health Benefits Review was “to ensure that the subsidisation of health services, particularly primary health services, contributes as effectively as possible to the government’s broad social and economic goals of equity and efficiency” and “to examine the existing system of health benefits, review the options open to Government, and recommend broad principles and directions for reform of these benefits and related services” [Scott, Fougere & Marwick, 1986, p. v]. The report discussed existing arrangements and set out five possible options for the state as a funder of health services: modification of the existing system; two options where the state would be the residual funder of services (the state as residual funder operating a safety net for high-risk/low-income groups; or the state as regulator in a competitive system or health maintenance organizations); and two options where the state would be the dominant funder of services (either funding and directly providing services itself, or being the dominant funder but with services provided through a mix of state provision and contracts with private and voluntary
agencies) (Scott, Fougere & Marwick, 1986). The Health Benefits Review had little immediate impact as the government was more concerned at the time with problems in the public hospital system, and a second review of this sector was therefore commissioned (Gauld, 2009).

The Hospital and Related Services Taskforce “conducted a review of the New Zealand hospital system and international developments in health economics and the management of health systems” (Gibbs, Fraser & Scott, 1988). The resulting ‘Gibbs Report’ identified problems with equity of access, particularly with high and growing surgical waiting lists; low efficiency within hospital services, with a lack of incentives to change to less-costly care options outside hospital settings, and poor integration between primary and secondary care; and a range of management deficiencies, including inefficient triumvirate consensus management by a doctor, a nurse and an administrator; lack of management information systems; lack of cost consciousness in decision-making; and an absence of productivity monitoring (Gibbs, Fraser & Scott, 1988). The Taskforce proposed separating the purchasing and provision functions of AHBs by establishing six Regional Health Authorities which would be funded by the government to purchase health services for the people of their region from public and private hospitals, through a competitive contracting process. The Gibbs Report was delivered to a new Health Minister, David Caygill, who opted not to implement the report’s proposals, but to further develop the existing AHBs, giving them progressive responsibility for all health services in their region (including the primary care budget) (Caygill, 1988). Some management changes were introduced into the AHBs, including general management replacing the triumvirate system in 1988; installation of information systems and development of performance indicators; preparation of the first operating and strategic plans by boards in 1989–1990, with these forming the basis of contracts between the boards and the Minister of Health; and internal restructuring within many boards, including the internal separation of purchasing and providing roles (Ashton, 1995).

One further important development in this period was the 1985 introduction of a NZ$ 1 flat charge on all prescriptions (Bassett, 1993). In 1988, this increased to NZ$ 5 for adults and NZ$ 2 for children, beneficiaries and some other groups, with an individual exemption after 25 items and family exemption after 40 items. There was a further increase in 1991 to NZ$ 15 for adults and NZ$ 5 for children, beneficiaries and others, with an individual exemption after 10 items and family
exemption after 15 items (Norris, 1992). (Pharmaceutical co-payments have been progressively reduced since July 2004 with the introduction of additional funding for PHOs. Currently, medicines prescribed for children aged under six are free [for fully subsidized items on the pharmaceutical schedule], and most other prescriptions have a NZ$5 charge per item [for a maximum of 20 items per year].)

Strengths and weakness of AHBs were identified in a 1991 study commissioned by Health Boards New Zealand, comparing the New Zealand health system with that of five other countries (the United States, Canada, the United Kingdom, the Netherlands and Germany) (Ashton et al., 1991). Strengths noted were a generally simple health system structure; low and relatively stable costs alongside increased throughput of patients in the previous decade; the government as dominant funder (said to allow greater control over total costs than in a multiple-funder system); integrated service planning by AHBs; community participation in the planning of health services; national health goals and targets; and accountability of AHBs via a business plan and contract with the Minister of Health. Weaknesses identified were the lack of integration of primary and secondary care; high user charges for primary care; long hospital waiting lists; the high proportion of expenditure on hospitals and pharmaceuticals compared with other countries and a lower proportion on out-of-hospital care; perverse incentives for specialists working in both the public and private sectors not to reduce public-sector waiting lists; lack of incentives for internal efficiency at the clinical level; and inadequate information about service costs and outputs, particularly in primary care.


During the 1980s, New Zealand economic and social policy focused on major reforms, aimed at improving the performance of the New Zealand economy. In spite of concerns over the performance of the health sector, and two major reports during the 1980s, the health system had escaped major reform by the end of the 1980s. However, the National government, elected in late 1990, assumed governance over a poorly performing economy and set up a number of social policy taskforces to consider further policy reform, including the Ministerial Taskforce on the Funding and Provision of Health Services (Gauld, 2009). The Taskforce’s recommendations were published by the Minister of Health as a ‘Green and White Paper’ Your Health and the Public Health (Upton, 1991).
The review identified a number of problems with the existing system:

- lengthy public hospital waiting times;
- conflict in the roles of AHBs as both purchasers and providers of services;
- legislative constraints on the way AHBs could operate;
- fragmented funding of services;
- problems of access to services (including cost, geographical access and whether or not a person was entitled to Accident Compensation Corporation funding);
- lack of financial incentives for doctors and patients to choose the most effective and affordable health services;
- lack of consumer control;
- lack of fairness in funding and treatment criteria, and inequalities in health status and access to services (Upton, 1991).

In response to these problems, the government had decided to reform the health system by separating the purchasing and provision of health services (rather than retaining AHBs with these joint roles). Four Regional Health Authorities (RHAs) would be established to purchase health services for their populations, some of which would be delivered by competitive Crown Health Enterprises (CHEs). The new structure was intended to:

- improve access for all New Zealanders to a health care system that is effective, fair and affordable;
- encourage efficiency, flexibility and innovation in the delivery of health care to the community;
- reduce waiting times for hospital operations;
- widen the choice of hospitals and health care services for consumers;
- enhance the working environment for health care professionals;
- recognize the importance of the public health effort in preventing illness and injury and in promoting health;
- increase the sensitivity of the health care system to the changing needs of people in New Zealand society (Upton, 1991, p. 3).

The AHBs were disbanded in July 1991 and two years of intensive activity followed in planning the transition to a new system (Ashton, 1995).

The Health and Disability Services Act 1993 was based upon the concept of separation between ownership, purchase and provision. The Crown remained the owner and RHAs were established (North Health, Midland
Health, Central RHA and Southern RHA) whose Boards were appointed by the Minister of Health. The separate funding streams for GP services and for hospitals were merged, all disability support services funding was brought into the health Vote, and each RHA was given a budget to purchase all personal health and disability services for their regional populations. RHAs could then purchase services from both public and private providers. This integration of funding was intended, first, to reduce cost-shifting between agencies and services and, second, to make it easier to redirect resources as appropriate from institutional to community care, from secondary to PHC, and from treatment to health promotion. Funding for public health services was assigned to a new body, the Public Health Commission, which was responsible for coordinating and contracting for the provision of public health services, monitoring the public health, and identifying areas of need in order to advise the Minister of Health (Health and Disability Services Act 1993 section 28). The provider arms of the 14 AHBs were converted into 23 CHEs, which ran hospitals, community and public health services. The CHEs were to function as commercial entities, being established as limited liability companies with government shareholders consistent with the 1986 State-Owned Enterprises Act. The newly created portfolio of Minister of Crown Health Enterprises, and later the Minister of Finance, represented the ownership shareholding interest of the government in the CHEs.

The legislation also provided for the establishment of a National Advisory Committee on Core Health and Disability Support Services (Core Services Committee; later National Health Committee) to advise the Minister of Health on the kinds and relative priorities of health services that should be publicly funded, relative service priorities, and other matters that the Minister specifically requested. At this time, the Department of Health was renamed the Ministry of Health (MOH), focusing more on strategic policy advice and monitoring of the health sector.

A separate operational unit of the Treasury, the Crown Company Monitoring Advisory Unit (CCMAU), was set up in 1993, to represent the government’s interest as a shareholder in all Crown companies, which included CHEs. It advised the Ministers of Health, Crown Health Enterprises and Finance on ownership and monitoring aspects of CHEs. The advice included protecting the Crown’s investment, setting service targets, and considering the impact on CHEs of proposed policies. It also advised ministers on how well the CHEs were performing against
government objectives, and managed the appointment and performance assessment of company directors.

The Public Health Commission was disestablished in late 1995 with its policy advisory function being transferred to the Core Services Committee, re-named the National Advisory Committee on Health and Disability (the National Health Committee), and its purchasing function to the RHAs. Public health activities were protected thereafter by ring-fencing funds (pursuant to the Public Finance Act 1989) rather than through a separate administrative agency.

There were a number of positive developments from these reforms (Ashton, Mays & Devlin, 2005; Cumming & Mays, 2002; Cumming, Mays & Daubé, 2010; Gauld, 2009).

First, the reforms resulted in better information being made available on the services provided and the resources used to provide them, allowing for better-informed purchasing decisions. Providers needed to be clear about the range and volume of services they were producing, and the relative resource costs involved. Such information supported their business decisions as well as contract documentation and performance reporting.

Second, the reforms did successfully achieve some competitive tendering, leading to savings in hospital services. Foster (1994) reported savings of about NZ$300 000 and NZ$365 000 for 1993–1994 and 1994–1995, respectively, as a result of tendering. Hoskins, Blaxall & Sceats (1996) reported on a joint private venture–CHE initiative which reduced waiting times and increased the numbers of patients treated (although re-admissions increased). Lovatt (1996) notes that tendering allowed shortened waiting times for some services for residents in the Midland region.

Third, the reforms included the formation of the Pharmaceutical Management Agency (PHARMAC) in 1993 to manage the funding of community pharmaceuticals (those dispensed outside hospitals), which aimed to reduce pharmaceutical expenditure and maximize their health contribution. PHARMAC has been seen to be a significant success in New Zealand. PHARMAC operates within a fixed budget and a key component of its decision-making is the relative cost-effectiveness of medicines which might be publicly funded in New Zealand.
PHARMAC also uses a range of tools – e.g. negotiations over price with pharmaceutical companies, sole-supply contracts, and reference pricing – to manage prices and overall expenditure on pharmaceuticals in New Zealand. Although its decisions have been controversial at times, very few decisions have been overturned and PHARMAC retains the support of a wide range of stakeholders in New Zealand (Cumming, Mays & Daubé, 2010). Since 2000, PHARMAC’s activities have saved District Health Boards (DHBs) a cumulative total of more than NZ$5 billion (PHARMAC, 2012).

Fourth, an unexpected gain was the formation of groupings of GPs into networks to facilitate collective contracting for primary health services. Independent Practitioner Associations (IPAs) and other networks have also survived the reforms, and provide support for general practice services. They continue to play a key role in PHC policy and service delivery today (see below).

Fifth, use of capitation and budget holding by PHOs led to some savings (e.g. in laboratory spending and pharmaceuticals prescribing) and paved the way for the wider introduction of capitation in the 2000s (Cumming & Salmond, 1998).

Sixth, the ability of the RHAs to allocate resources to any provider enabled them to better support by-Māori for-Māori health services. The number of such providers increased from about 20 in 1993 to over 220 in 2000 and such providers continue to play a key role in PHC and public health services (King, 2001a). Increasing numbers of Pacific-led providers were also established during this time.

Seventh, the national Advisory Committee on Core Health Services was established to define services that would be publicly funded, and although it did not achieve this goal (see below), its work resulted in an increased focus on effectiveness and guideline development, and led to the development of the elective services priority-setting and booking system, which has provided greater clarity over elective services treatment for many New Zealanders (see section 5.4.5).

A number of difficulties and compromises also arose with the implementation of the reforms (Ashton, Mays & Devlin, 2005; Cumming & Mays, 2002; Cumming, Mays & Daubé, 2010; Cumming & Salmond, 1998; Gauld, 2009).
First, the implementation of these health reforms involved considerable financial cost (reports ranging from NZ$ 80 million to NZ$ 800 million) (Gauld, 2009), including consultants involved in preparing for the new system; new RHA staff to manage the administration and monitoring of contracts; and remuneration of board members and CHE management. The overall cost of the reforms themselves thus became a major political issue for several years.

Second, the National Advisory Committee on Core Health Services, which was established to define which services would be publicly funded, found that explicit ranking and rationing of services were controversial, and firm decisions did not eventuate. Only recommendations and guidelines were made to the purchasing agencies, which then made their own resource allocation decisions.

Third, the autonomy of CHE boards was in fact limited. Their ability to stop providing certain services was constrained by ministers due to the potential for high political costs, and to ensure continued access to services.

Fourth, the Health and Disability Services Act 1993 allowed for the establishment of ‘Health Care Plans’ which would compete with RHAs to purchase services and thus offer patients choice. However, these were not in fact developed because of the risk that less-healthy patients would not be attractive to private funders and would be left to RHAs to manage, because of the failure to define a ‘core’ of services which would have to be provided by all purchasers, and because of the major criticisms being made of the reforms generally.

Fifth, the model was seen to involve very high costs in contracting and enforcement. By 1997–1998, it was reported that there were around 4580 contracts in the sector (Mays & Hand, 2000). Some contracts were also criticized for having insufficient attention to quality.

Sixth, user charges for inpatient and outpatient hospital services, introduced in 1991, proved to have high administrative costs (exceeding the revenue they generated), in part due to the need to set up new collection systems, and public resistance. Inpatient charges were abandoned after only one year, and outpatient co-payments ceased in 1997.
Seventh, few CHEs made a surplus and deficit levels increased. The incentive to improve efficiency and contain costs was also considerably weakened by a lack of competition among providers for many services and by government deficit support for CHEs.

Eighth, one of the key goals of the reforms was to reduce long waiting lists and times, but the lack of efficiency gains and savings from the reforms meant that waiting lists and times actually increased. Between March 1993 and March 1995, waiting lists increased by 11.8% to 85,624, and increased further by 11.5% to 95,470 by March 1996 (Cumming & Salmond, 1998). In terms of waiting times, aggregate data on the number of months required to clear waiting lists showed some stability, at 7 months in 1991 (McKendry, Howard & Carryer, 1994), 6.1 months in 1993–1994, and 6.8 months in 1994–1995 (MOH, 1994a).

Ninth, political concerns over the work of the Public Health Commission led to its demise in 1995 (Hutt & Howden-Chapman, 1998), with a consequent reduced emphasis on public health.

Finally, there was reduced morale among health professionals and conflict between managers and clinical staff as a result of the reforms.

Overall, the reforms were very unpopular from their inception, with health continually in the media spotlight throughout the reform process. This led to increasing public concerns over the state of the publicly funded health system. Several Ministers of Health were appointed during this time, but health remained a major concern in the mid-1990s, with changes consequently made following the election of New Zealand’s first coalition government under the Mixed Member Proportional (MMP) representation system in 1996.

### 6.1.3 1996–1999: Health Funding Authority and Hospital and Health Services

Following the change to a new electoral system of proportional representation (MMR), New Zealand’s first coalition government (National–New Zealand First) took office in 1996. The coalition document ‘Policy Area: Health’ section, described a health system in which “principles of public service replace commercial profit objectives”, with cooperation and collaboration rather than competition between services (New Zealand First & New Zealand National Party, 1996). The focus shifted away from a quasi-market model approach, acknowledging that strict competition was not viable in the health sector.
The coalition also wanted to reduce administrative costs and eliminate geographic inequities. For example, the four RHAs had proved administratively expensive for a small country, while the effects of market competition could not prevail since the government, as shareholder, had little choice but to meet the budgetary shortfalls of the CHEs (Gauld, 1999). CHE debts had risen from NZ$ 189.4 million in 1993–1994 to NZ$ 219.3 million in 1996–1997.

In mid-1997, the Transitional Health Authority (THA) was formed to oversee the amalgamation of the four RHAs into a single central purchasing agency, and in January 1998 (following amendment to the Health and Disability Services Act 1993), this became the Health Funding Authority (HFA). As a purchasing authority, the HFA continued the split between purchase and provision. It contracted with a range of providers for the provision of medical, hospital, public health, disability and other health services, and was also responsible for purchasing postgraduate clinical training. Its other functions were to monitor the need for health services and to monitor the performance of providers.

At the same time, the CHEs were converted into 23 companies called Hospital and Health Services (HHSs), which continued to run hospitals and related services, community and public health services. These companies had independent legal and financial status and continued to operate in a framework of commercial law. A 24th HSS was established to manage blood services, being the only publicly owned national-level health provider. The HHSs contracted with the HFA for their funding. They were relieved of the requirement to make a surplus; however, as the HFA was committed to capping funding levels, HHSs continued to function in a profit-orientated way and sought to reduce service provision commitments (Gauld, 1999).

HHSs continued as by far the largest health care providers, receiving about half of the government health budget each year (Poutasi, 2000). Other providers included community trusts (including Māori health providers), voluntary sector providers (such as church-sponsored services), private ‘for-profit’ providers such as dentists, pharmacies and general practices.

In 1998, the National Advisory Committee on Core Health and Disability Services was renamed the National Advisory Committee on Health and Disability Services (National Health Committee, NHC) and given new
terms of reference, continuing existing work and providing comment on the range, mix and quality of services the HFA was providing (Gauld, 2009).

Other developments during this period of reform included the establishment of some integrated services projects; some budget devolution in primary care, particularly through Independent Practitioner Associations (IPAs); and the development of a booking system for elective surgery in response to lengthy waiting lists, lack of transparency in their management, and disparities in waiting times between different parts of the country (Gauld, 2009).

6.1.4 2000 Onwards: District Health Boards

At the end of 1999, a Labour–Alliance coalition government was elected. The Labour Party’s health manifesto stated its objectives, which included the restoration of a noncommercial health system with the focus on the provision of quality services, the involvement of community representatives in decisions about their local health services, significant improvements in the effectiveness of health services delivery to Māori and Pacific peoples, and well-integrated primary and secondary care (New Zealand Labour Party, 1999). The health services structure would be reorganized once again with the establishment of majority-elected District Health Boards (DHBs). This was in spite of some suggesting that the HFA model was beginning to work well and major concerns over having yet more substantial reforms in the health sector.

The health programme of the incoming government was swiftly enacted under the New Zealand Public Health and Disability Act 2000 (NZPHDA). The objectives of the Act included the public funding and provision of health services to improve, promote and protect the population’s health; reducing health disparities for Māori and other population groups; and providing for community voice in health and disability services (section 3). The Act required the development of a New Zealand Health Strategy (King, 2000) and a New Zealand Disability Strategy (Minister for Disability Issues, 2001) to provide frameworks for the government’s direction in these areas. Subsequently, a number of other strategies have been developed, including a Cancer Control Strategy, Health of Older People Strategy, Primary Health Care Strategy, and He Korowai Oranga: Māori Health Strategy (see http://www.health.govt.nz/).
The NZPHDA established 21 DHBs as Crown Entities to replace the HHSs, and the HFA was disestablished, its role being split between the new DHBs and an expanded MOH. The legislation allowed a phasing-in period during which the MOH took responsibility for existing service contracts until the new DHBs were set up and functioning. The shift to DHBs ended the purchaser–provider split, as DHBs now hold their own budgets for the services they provide, while also continuing to purchase a proportion of their services from other agencies. This includes primary care, which is now largely coordinated through primary health organisations (PHOs) which began to be established from 2002 (see below). DHB funding is determined by a population-based funding formula.

Community involvement in DHBs is achieved in a number of ways. DHBs are governed by boards consisting of both elected and appointed members. Seven members may be elected at the time of local body elections, up to four are appointed by the Minister of Health (who also selects the Board chairperson), and there must be at least two Māori members on the Board. DHBs must establish three committees – community and public health advisory committee, disability support advisory committee, and hospital advisory committee – whose meetings are generally open to the public. The NZPHDA required public consultation when DHBs developed their District Strategic Plans and District Annual Plan, but this requirement has been removed in the Amendment Act 2010.

An evaluation of this latest restructuring (focused on the process of the reforms) was undertaken by an independent research team between 2002 and 2005, including key-informant interviews, Board-member surveys and documentary analyses (Mays, Cumming & Tenbensel, 2007). The research found the following.

- Widespread support for the new model, particularly the local focus of DHBs, the emphasis on community engagement, the focus on collaboration rather than competition between DHBs, and opportunities for greater integration among services.
- While some participants considered 21 DHBs too many for a population of only 4 million, there was little support for forced mergers, and in practice a number of new forms of collaboration had developed such as shared services agencies, Regional Mental Health Networks and a national association of DHBs (District Health Boards New Zealand, now DHB Shared Services).
• In general, participants were reasonably positive about the new governance system and it appeared to be functioning reasonably well.
• DHBs were engaging and consulting with their local communities as they are required to do, but DHB members argued the government directed their foci, which were primarily aimed at minimizing deficits and implementing government priorities.
• Population-based funding was generally supported and considered likely to result in a more equitable allocation of funds than funding via contracts; however, there were some concerns about inequities due to differences in the cost of providing services by different DHBs, and concern about whether payments for inter-district outpatient services provided by one DHB for another were adequate to meet these costs.
• DHBs had clearly moved towards a more strategic focus on population health goals and their population’s needs rather than focusing just on running public hospitals; strategic and annual planning, and prioritization, were undertaken in different ways by different DHBs and the research showed plans were only indirectly related to the specific resource allocation and purchasing decisions made by DHBs.
• In terms of improving Māori health, key issues identified were ensuring sufficient resources for Māori health needs, good ethnicity data collection, and continued attention to improving skills and supporting the Māori health and disability workforce; the importance of effecting obligations for Māori health under the Treaty of Waitangi was reiterated.
• Improving Pacific health was one of the key goals of the New Zealand Health Strategy, supported by a Pacific Health and Disability Action Plan (King, 2002b); the research found that, although it is difficult to say that the reforms have had a major influence on the overall health status of Pacific people, there are strengths in the NZPHDA model which have had major impact on the service delivery for Pacific peoples and there is also more representation of Pacific people at governance level.
• Assessing and comparing health system performance is not straightforward, but the researchers concluded that since the reforms, the public health system had shown some signs of greater equity of access to services; better financial performance in terms of deficit reduction; no obvious sign of efficiency improvements and possible reductions in some areas; some signs of an improvement in responsiveness in high-profile areas such as elective surgery; and a higher level of public acceptability, all occurring against a background of substantial real terms expenditure increases.
6.1.5 2002 onwards: primary health organisations

Prior to 2001, most primary medical care was provided by GPs in private practice (working with practice nurses), and a small number of community-governed providers. In February 2001, the Minister of Health published The Primary Health Care Strategy (PHCS) (King, 2001c) which outlined a new vision for PHC, including moving to a system where services are organized around the needs of an enrolled population with a greater emphasis on population health, health promotion and preventive care. Funding is based on population needs rather than the then existing fee-for-service model. The PHCS envisages improved coordination of care across service areas and the involvement of a wider range of professionals. There is also a strong emphasis on reducing health inequalities between different groups.

Primary health organisations (PHOs) were the local structures designed to implement this new model of PHC. These are not-for-profit organizations which fund and manage a network of PHC providers. They are expected to involve their communities in their governing processes, with all providers and practitioners involved in the organization’s decision-making. PHOs are funded by DHBs to provide PHC services (including services to improve, maintain and restore health) through their member network for their enrolled population.

Membership of a PHO is voluntary for both practitioners and patients, but government funding can only be accessed through PHOs. The PHCS envisaged that PHOs would develop over five to ten years, but implementation occurred more rapidly. The first two PHOs were established in July 2002, increasing to 45 by July 2003 (covering about half the population), 68 by June 2004 (covering about three quarters of the population), peaking at 80 in 2009 and declining through mergers to 31 as at March 2013, covering almost all the population (MOH, 2005c, 2009a, 2011a, 2012l; MOH & Minister of Health, 2008).

The government was to make available significant new funding to implement the PHCS: NZ$ 2.2 billion over seven years (Hodgson, 2005). Originally, there were two capitation-based funding formulae: an ‘Access’ formula for PHOs defined as serving high-needs populations (having 50% or more of their enrolled population being Māori, Pacific islanders and people living in the 20% most deprived areas according to the New Zealand deprivation index) and an ‘Interim’ formula for all others (MOH, 2007b). Access PHOs received more funding initially, but over time,
successive groups of patients within Interim PHOs became eligible for increased funding (6–17 year olds in April 2004, over 65 year olds in July 2004, 18–24 year olds in July 2005, 45–64 year olds in July 2006, and 25–44 year olds in July 2007) (MOH, 2007b). At the same time, pharmaceutical co-payments were reduced from a maximum of NZ$ 15 to NZ$ 3 per fully subsidized item, initially for prescriptions obtained from a patient’s usual general practice, extended in September 2008 to cover prescriptions from other sources such as public hospitals, after-hours services, midwives and hospices (MOH, 2013h); the cost per item subsequently rose to NZ$ 5 in January 2013. In October 2006, a Very Low Cost Access (VLCA) payment was introduced for practices, typically serving high-needs populations, that agree to keep their fees within specified thresholds (zero fees for children 0–5 years; NZ$ 10.50 maximum for children 6–17 years; and NZ$ 16 maximum for adults 18 years and over) (MOH, 2008b). Since January 2008, an additional payment has been available to practices that commit to providing free consultations to children under 6 only (and excluding those already receiving the VLCA payment) (MOH, 2011t).

The Minister of Health expected the higher government patient subsidies would result in lower patient fees, but in response to GP concerns that were slowing down the development of PHOs, eventually assured them that their existing right to set a fee would not be removed and fees would not be fixed (King, 2002a). Following concerns in the early allocations of new funding, the government established a process by which PHOs must notify DHBs of their providers’ standard consultation fees. Where the DHB considers these unreasonable, they may refer them to a fee review committee to consider, as outlined in the current PHO Service Agreement (version 18) (see DHBSS, 2012b).

An evaluation of practice data between 2001 and 2005 (Cumming & Gribben, 2007) found that fees had generally fallen for the groups where new funding had been provided by the government (except for children, who had not benefited from higher capitation rates), although the fall was not always as high as the government had sought.

Consultation rates had increased across almost all age, deprivation and ethnic groups in both Access and Interim practices (see above). In Access practices, the greatest increases in consultation rates had occurred among those aged 65 years and over (1.6 mean additional annual consultations, or a 22% increase), 18–24 year olds (0.4 consultations,
22%), under six year olds (0.8 consultations, 19%) and 45–64 year olds (0.8 consultations, 18%). In Interim practices, there had also been an overall increase in consultation rates over the study period, but the percentage increases were lower than in Access practices except for those aged 65 years and older (1.7 mean additional annual consultations, 25% increase). Consultation rates increased at a similar rate for Pacific, Māori and ‘other’ ethnic groups (0.5, 0.6 and 0.7 mean additional annual consultations, respectively, or 16%–18% increases) (Cumming & Gribben, 2007).

As well as capitation payments, PHOs also receive a number of other funding streams. Services to Improve Access (SIA) funding is allocated to PHOs on the basis of the number of enrolled patients who are Māori, Pacific islanders or living in the 20% most deprived areas according to the New Zealand deprivation index, and is intended to reduce inequalities for these groups (MOH, 2007e). ‘Care Plus’ provides additional funding (for 5% of the population overall) to people with high health needs because of a chronic condition, acute medical or mental health needs, or terminal illness. In addition to reducing the cost of services for these users, it aims to improve chronic-care management, reduce inequalities and improve PHC teamwork (MOH, 2011d). Management services fees are paid to PHOs on the basis of their size (with additional funding for small PHOs) and a small amount of funding is available to PHOs for health promotion activities.

The PHO Performance Management Programme began in January 2006 and aims to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs (DHBSS, Undated-c). Participating PHOs are eligible to receive payments for improvements in performance against agreed indicators. All indicators are measured against the total PHO population and for the ‘high needs population’, defined as Māori or Pacific island people or those living in lower socioeconomic areas. These groups have been shown to have poorer health and one of the programme’s aims is to reduce the health ‘gap’ between high-needs and other patients (DHBSS, Undated-b). The current (2013) indicators and their achievement rates are set out in Table 6.1: only three of the 11 indicators had been met or exceeded their targets, although all had improved compared with the same period two years earlier.
Table 6.1 PHO performance indicators

<table>
<thead>
<tr>
<th>Indicatora</th>
<th>Goal for PHO population</th>
<th>PHOs achieving goal for high needs population (%)b</th>
<th>PHOs achieving goal for total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>70% or more of women aged 45–69 years have had a mammogram within 2 years</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>75% or more of women aged 20–69 years have had a cervical screen within 3 years</td>
<td>66</td>
<td>73</td>
</tr>
<tr>
<td>Ischaemic cardiovascular disease (CVD) detection</td>
<td>90% or more of people aged 30–79 years estimated to have ischaemic CVD have been identified and coded by their GP or primary care provider</td>
<td>116</td>
<td>99</td>
</tr>
<tr>
<td>Cardiovascular risk assessment</td>
<td>90% or more of the target population (varies by ethnicity, gender and age) have been assessed for their risk of developing CVD</td>
<td>54</td>
<td>52</td>
</tr>
<tr>
<td>Diabetes detection</td>
<td>90% or more of people aged 15–79 years estimated to have diabetes have been identified and coded by their GP or primary care provider</td>
<td>112</td>
<td>110</td>
</tr>
<tr>
<td>Diabetes detection and follow up</td>
<td>90% or more of those aged 15–79 years diagnosed with diabetes have had an annual diabetes review</td>
<td>66</td>
<td>64</td>
</tr>
<tr>
<td>Influenza vaccination coverage</td>
<td>75% or more of people aged 65 years and over have had a flu vaccination by 30 June in any year</td>
<td>63</td>
<td>64</td>
</tr>
<tr>
<td>Age-appropriate vaccination for 2 year olds</td>
<td>95% or more of 2 year old children have are fully immunized</td>
<td>90</td>
<td>89</td>
</tr>
<tr>
<td>Indicatora</td>
<td>Goal for PHO population</td>
<td>PHOs achieving goal for high needs population (%)b</td>
<td>PHOs achieving goal for total population (%)</td>
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<tr>
<td>Age-appropriate vaccination for 8 month olds</td>
<td>85% or more of target population have completed age-appropriate vaccination by July 2013 (rising to 90% in July 2014 and 95% in December 2014)</td>
<td>88</td>
<td>93% other populationc</td>
</tr>
<tr>
<td>Smoking status recorded</td>
<td>90% of 15–74 year olds have had a smoking status recorded</td>
<td>79</td>
<td>80% other populationc</td>
</tr>
<tr>
<td>Smoking brief advice and cessation support</td>
<td>90% of current smokers who have been seen in general practice have been given brief advice and/or given or referred to cessation support services in the last 12 months</td>
<td>38</td>
<td>42% other populationc</td>
</tr>
</tbody>
</table>

Source: DHBSS (2012a).

a Indicators as at 1 July, 2012
b For most indicators, this is Māori, Pacific island and decile 9 or 10 patients.
c These indicators are reported for the high-needs population and the ‘other’ (non-high needs) group (rather than the total population).

A review of the first year of PHO implementation was undertaken in 2003, followed by a full evaluation from 2003–2008 (Cumming et al., 2005; Perera et al., 2003). Thirty-four PHOs were established in the first year, a period characterized by some teething difficulties in moving to new systems of PHO formation, patient enrolment and capitation funding. Patient co-payments decreased in all Access-funded practices over the period, and a wide range of new services was being provided or planned under the new model (Perera et al., 2003). The first evaluation report presented findings from key-informant interviews (Cumming et al., 2005). Most were positive about the goals of the PHCS, and considered fee reductions had improved access to primary care and that there were opportunities to improve patient care through more flexible service delivery with increased focus on prevention. Some informants were concerned by what they saw as imprecise targeting of the new funding, and some GPs were concerned about the financial implications of the new model for their practices and perceived the government was
moving towards greater control of general practice. Establishment of new PHO structures had taken considerable time and money, but this phase was nearing completion and more focus would be going towards improving services and implementing new programmes. PHO boards had good community representation, but in some PHOs there was concern about medical dominance. Informants recognized that the strategy had increased the opportunities for an expanded nursing contribution in PHC, but practices differed greatly in how they were developing nursing roles, depending mainly on the preferences of GPs (who are largely the employers of practice nurses).

Later findings from the evaluation have highlighted the great diversity among PHOs, including their size, management support arrangements, governance, providers they work with and their views of their role (Barnett, Smith & Cumming, 2009; Smith & Cumming, 2009a). For example, PHOs ranged in enrolments from 1536 to 356 000 in July 2008 (Smith & Cumming, 2009a). Within general practice, there was clear support for the increase in funding for PHC and a greater role for nurses, but more muted support for other aspects of the PHCS such as the creation of PHOs, universal low-cost access, proactively approaching patients who do not present for care and the Care Plus programme for people with chronic conditions (Raymont & Cumming, 2009). Despite the PHCS’s focus on population health and the move to capitation-based funding, many PHC professionals are still working under fee-for-service incentives. A 2009 study found that from the outset of the strategy, patient fees have been a source of tension between the government and GPs, and the researchers believe one of the challenges moving forward is to shift the focus from infrastructure and fees to how the broader aims of the strategy can be achieved (Croxson, Smith & Cumming, 2009).

Other issues that need to be addressed include clarifying the roles of PHOs and DHBs; further development of clinical engagement and leadership within PHOs and strengthening the management and leadership of PHC more broadly; and integrated patient management information technology (IT) systems (Smith, 2009; Smith & Cumming, 2009b).

The role of nurses was emphasized in the PHCS, with teamwork among nurses, community outreach, and general practice replacing the previous concept of doctors being the principal providers of primary care (MOH, 2001d). The Strategy also asserted that “The concept of the PHC
nurse needs further development with clarification of the appropriate capabilities, responsibilities, areas of practice, educational and career frameworks and suitable employment arrangements” (King, 2001c). In response to this, the MOH established an Expert Advisory Group on Primary Health Care Nursing in 2001, which presented a framework for activating PHC nursing in New Zealand in 2003 [Expert Advisory Group on Primary Health Care Nursing, 2003]. The framework had five goals.

- Aligning nursing practice with community need: funding streams, employment arrangements and service delivery patterns will support nurses to adopt an integrated approach to practice, and incorporate population and personal health strategies into service delivery.
- Innovative models of nursing practice: new and innovative models of PHC nursing practice that improve access to PHC services, and contribute to improved health outcomes and reduced health inequalities for individuals, families/whānau and communities/iwi.
- Governance: PHC nurses will be equal partners alongside other professional groups and community representatives in governance of PHC organizations.
- Leadership: PHC nurses will have clear, accessible, integrated nursing leadership to encourage and promote change and facilitate the development of new roles and models of practice.
- Education and career development: postgraduate education will support all levels of PHC practice and be recognized in a national, standardized career pathway for PHC nurses.

The expert advisory group made a number of recommendations to the MOH, DHBs and PHOs for achieving these goals, including that the MOH should fund, monitor and evaluate innovative models of PHC nursing practice and disseminate examples of best practice to the wider sector (Expert Advisory Group on Primary Health Care Nursing, 2003). In response to this, the ministry allocated NZ$ 7 million to fund nursing innovations between July 2003 and July 2006. Eleven of 139 proposals were selected for funding, and were also independently evaluated. The evaluators found there were two broad models for the innovations, which they termed the ‘Leading Primary Health Care Nursing Development Model’ (focused on leading broad-based change involving PHC nurses across DHBs and/or PHOs) and the ‘Primary Health Care Nursing Practice Model’ (focused on the development of new, expanded or modified forms of nursing practice to deliver services to particular populations) (Primary Health Care Nurse Innovation Evaluation Team,
2007). The former was effective in developing the nursing workforce and enabling nurses to be involved in policy-making, practice development and the organization of PHC service delivery, while the latter could be effective in reaching population groups known to have difficulty accessing PHC and reduce inequalities, but needed good support from other PHC providers to be successful (Primary Health Care Nurse Innovation Evaluation Team, 2007).

A broad evaluation of the implementation and intermediate outcomes of the PHCS included assessment of developments in nursing between 2001 and 2007. This found that there had been significant development of nurses’ roles and capability within the PHO environment, particularly with regard to managing chronic conditions and working with people in underserved and vulnerable populations (Finlayson, Sheridan & Cumming, 2009). The two most important factors that influenced the expansion of nurses’ roles were having practices and PHOs that embraced the strategy’s intention to improve population health, and having additional funding for specific programmes. Further development of nursing roles would require consideration of the funding model for PHC services (currently tied to GPs); expanded nursing education; leadership, governance and mentoring by and for nurses; and addressing recruitment and retention issues (Finlayson, Sheridan & Cumming, 2009).

Refer to Figure 2.1 in Chapter 2 for the current organization of the New Zealand health system.

6.1.6 2009 onwards

Following elections in November 2008, a new government was elected, led by the National Party, with confidence and supply agreements with the ACT party, the Māori party and United Future. The National Party’s health policy expressed concern about increasing health expenditure, decreased productivity in the public health system (first specialist assessments and surgical discharges having shown little increase in relation to increased health expenditure) and growing elective surgery waiting lists (New Zealand National Party, 2007, 2008b; Treasury, 2005). While pledging to continue the growth in health spending which had been set out in the preceding Labour government’s budget, the National Party asserted it would spend the money “more wisely … as well as get more effective care from existing spending. We will deliver better, sooner, more convenient care and treatment for New Zealanders from the public’s investment
in health” (New Zealand National Party, 2008a, p. 2). They sought less bureaucracy and more frontline care for patients; increased clinical leadership by doctors and nurses; more collaboration between DHBs; increased devolution of hospital-based services to primary care settings; and smarter use of the private sector (New Zealand National Party, 2008a).

In January 2009, a Ministerial Review Group was established for six months to review the public health system and recommend how its quality and performance might be improved. The group’s report, Meeting the Challenge, was released in July 2009 (Ministerial Review Group, 2009). The report set out a proposed ‘way forward’, including the following:

- improved patient focus within the health system, shifting care ‘closer to home’, making greater use of primary and community care, and ensuring more continuity for patients accessing services across the health spectrum;
- stronger partnerships between clinical and management staff;
- improved patient safety and quality of care;
- strengthening the role of the National Health Committee to include assessing new services and procedures to determine which should be publicly funded and prioritizing them against existing interventions;
- better national and regional service configuration, with national services planned and funded by a National Health Board and delivered by DHBs; DHBs would also be required to produce Regional Service Plans and work more cooperatively;
- improved structures and processes for workforce, capital and IT planning and funding;
- shifting resources to the ‘frontline’ by creating a shared services organization to take over responsibility for common DHB ‘back office’ services;
- improved hospital productivity and reducing variation in clinical and financial performance within and between hospitals.

The review group aimed to have minimal structural change within the existing legislative framework. The major proposed change was the establishment of a National Health Board (NHB) (in place of the Crown Health Funding Agency), which would take over, from the MOH and DHBs, the function of planning and funding of national health services. Monitoring of DHBs would also shift to the NHB from the MOH. The focus of the MOH would be core policy and regulatory functions. The review
group argued that the separation of Ministry and NHB functions would “provide clearer separation between the development of health policy and its implementation ... and much clearer roles and accountabilities” (Ministerial Review Group, 2009, p. 33). Other proposed changes were the establishment of a National Shared Services Agency; additional roles for the NHC; an independent national quality agency to replace the existing Quality Improvement Committee; and a two thirds reduction in the number of health committees (Ministerial Review Group, 2009).

In response to the Ministerial Review Group’s report, the government established a National Health Board, although contrary to the Review Group’s recommendation, it was established within the MOH rather than as an independent agency. In addition, the New Zealand Public Health and Disability Amendment Act 2010 (NZPHDAA) legislated the establishment of a Health Quality and Safety Commission (HQSC). The HQSC’s role includes advising the Minister of Health and promoting quality and safety in health and disability support services. The NZPHDAA also directs DHBs to consider not only local but also regional and national health needs and “collaborate with relevant organizations to plan and co-ordinate at local, regional, and national levels for the most effective and efficient delivery of health services” (section 23(1)ba).

The shared services agency, Health Benefits Limited, delivers administrative, support and procurement services to all DHBs in an effort to reduce costs (MOH, 2012r).

The National Party-led government has also been interested in improving PHC. Their 2007 policy document, Better, Sooner, More Convenient, includes a chapter on primary care with a number of proposals, including moving some hospital services to Integrated Family Health Centres (such as minor surgery); having specially trained nurses as case managers for patients with chronic conditions and working across sectors with other government agencies; providing a wider range of care and support for patients within primary care and better coordination of their ongoing care; and more devolution of treatment and diagnostic services (with their funding) to primary care (New Zealand National Party, 2007).

In September 2009, the government announced a request for expression-of-interest proposals from PHC providers and/or organizations or networks that would “help deliver the Government’s priority intention for a more personalized primary health care system that provides
services closer to home, makes Kiwis healthier and reduces pressure on hospitals” (MOH, 2009g). More than 70 expressions of interest were received, of which nine (covering 60% of the population) were invited to develop detailed business cases, all of which were subsequently approved for implementation (Cumming, 2011; MOH, 2011g).

The MOH’s latest Statement of Intent sets out its five high-level priorities for the medium term:

- lifting health sector performance through greater clinical integration;
- shorted waiting times;
- ensuring that the health sector delivers on the health targets;
- improving the health of older people;
- Whānau Ora (MOH, 2012o).

6.2 Future developments

In the 2011 election campaign, the National Party campaigned on a number of health proposals (see http://www.national.org.nz/Policy.aspx) which are now the basis for the current National Party-led government’s health policy. These include:

- extend free GP care for children under six to include after-hours consultations;
- roll out a comprehensive after-hours telephone advice service with access to nurses, GPs and pharmacists;
- continue the development of Integrated Family Health Centres providing comprehensive primary care services;
- reduce waiting times for specialist appointments (to no more than four months by the end of 2014), reduce waiting time for elective surgery (to no more than four months by the end of 2014) and increase elective surgery by at least 4000 operations a year;
- introduce a new immunization target of 95% of eight-month-old children fully immunized by the end of 2014.
Chapter 7: Assessment of the health system

Chapter summary

The New Zealand Public Health and Disability Act (2000) sets the strategic direction and goals for the health and disability sector in New Zealand. The Act requires the responsible ministers to develop overall health and disability strategies for the country, which currently include The New Zealand Health Strategy (2000), The New Zealand Disability Strategy (2001), The Primary Health Care Strategy (2001), and He Korowai Oranga: Māori Health Strategy (2002). The current government (elected in 2011 for the 2011–2014 period) is focusing on six specific health targets, along with better public services, clinical integration, financial management and sustainability, and ensuring quality.

The Ministry of Health (MOH) reports annually on the state of public health in New Zealand. The 2012 report showed continuing improvement in life expectancy and health expectancy; decreases in the rates of death from cancer and cardiovascular disease; relatively stable levels of obesity in children, but a continuing rise in adult rates; increasing immunization rates; and a continuing reduction in smoking rates. However, in all cases, Māori (and, where reported, Pacific) outcomes were poorer than non-Māori. This inequality has been decreasing at least in life expectancy, but remains a focus for improvement throughout the New Zealand health system.

Overall, New Zealanders have very good coverage of their health care needs through public health services. User co-payments for primary health care (PHC) and pharmaceuticals have been regularly identified as a barrier to access in the past. These charges have been reduced by additional government funding made available since the introduction of The Primary Health Care Strategy, although cost is still a barrier to accessing PHC for some people.

New Zealand has a range of measures of people’s experiences with the health system. Available data (such as the Commonwealth Fund
surveys) show that the New Zealand public is somewhat satisfied with the public health system overall. The New Zealand Health Survey shows high levels of satisfaction with aspects of PHC services; however, Asian, Pacific and Māori adults and those in the most deprived areas were less likely to report positively about their treatment. More work is needed to systematize the available measures, however, and to better understand the basis for New Zealanders’ views on their health services.

New Zealand has been paying particular attention to better managing waiting lists and reducing waiting times since 1995. The focus for elective surgery is on balancing treatment with available resources and ensuring that those who can be treated are treated within six months of assessment (reducing to four months by the end of 2014), using priority-setting tools. However, there are major gaps in our understanding of access to elective services, including a lack of information about the number of people who are returned to their general practitioner (GP) for ongoing care as they do not reach the agreed thresholds for treatment; changes over time in the actual thresholds; and the actual times that people wait.

The Health and Disability Services (Safety) Act 2001 aims to promote the safe provision of health and disability services to the public. The Health Quality and Safety Commission New Zealand, established in December 2010, is responsible for assisting both public and private providers across the whole health and disability sector to improve service safety and quality, and therefore improve outcomes for all service users. Performance indicators are used in both primary and secondary care to assess primary health organisation (PHO) and District Health Authority (DHB) performance against set targets. The results of DHB performance targets and PHO Performance Programme targets are publicly available on the MOH web site. Generally, performance is improving over time, but significant differences in performance are evident.

7.1 **Stated objectives of the health system**

The New Zealand Public Health and Disability Act [2000] sets the strategic direction and goals for the health and disability sector in New Zealand. Key goals are:

- improving health and disability outcomes for all New Zealanders;
- reducing disparities by improving the health of Māori and other population groups;
• providing a community voice in personal health, public health, and disability support services;
• facilitating access to, and the dissemination of information for, the delivery of health and disability services in New Zealand (New Zealand Government, 2000).

The Act requires the responsible ministers to develop overall health and disability strategies for the country. Four strategies are currently in place:

• The New Zealand Health Strategy (King, 2000);
• The New Zealand Disability Strategy (Minister for Disability Issues, 2001);
• He Korowai Oranga: Māori Health Strategy (King & Turia, 2002);
• The Primary Health Care Strategy (King, 2001c).

The New Zealand Health Strategy identifies seven fundamental principles that the government believed should be reflected across the health sector.

• Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi.
• Good health and well-being for all New Zealanders throughout their lives.
• An improvement in health status of those currently disadvantaged.
• Collaborative health promotion and disease and injury prevention by all sectors.
• Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.
• A high-performing system in which people have confidence.
• Active involvement of consumers and communities at all levels (King, 2000, p. 7).

The strategy sets out 10 key goals and 61 objectives, of which 13 population health objectives were chosen as the focus for implementation in the short to medium term. Two factors supporting their selection were the degree to which they could improve the health status of the population, and their potential for reducing health inequalities.

The vision of The New Zealand Disability Strategy is one of a fully inclusive society. According to the strategy, New Zealand will be inclusive when people with impairments can say they live in “A society that highly values our lives and continually enhances our full participation” (Minister for Disability Issues, 2001). Fifteen objectives were set out to advance this vision, supported by actions.
The Māori Health Strategy, He Korowai Oranga, advocates the concept of Whanau Ora: healthy Māori families supported to achieve their maximum health and well-being (King & Turia, 2002, p. 1). To achieve this, four pathways have been identified: Pathway one, the development of whānau, hapu, iwi (families, clans and tribes) and Māori communities; Pathway two, Māori participation in the health and disability sector; Pathway three, effective health and disability services; Pathway four, working across sectors. Accompanying He Korowai Oranga was Whakatataka – Māori Health Action Plan 2002–2005 (MOH, 2002e). This has been built on by the subsequent Whakatataka Tuarua: Māori Health Action Plan 2006–2011, which sets objectives for Māori health over the next five years. Whakatataka Tuarua provides a framework for the Ministry of Health (MOH), DHBs and key stakeholders to take a leadership role in improving Māori health outcomes (Minister of Health & Associate Minister of Health, 2006).

The Primary Health Care Strategy was released in 2001. Its release followed concerns over poor access to primary health care (PHC) services (in part due to costs arising from the co-payments charged to patients), and recognition that better PHC in New Zealand may improve health, reduce inequalities in health, and reduce pressure on hospitals (King, 2001c; NHC, 2000). The strategy’s vision is that: “People will be part of local PHC services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. PHC services will focus on better health for the population, and actively work to reduce health inequalities between different groups” (King, 2001c, p. vii). The strategy envisages a greater focus on population health and prevention; greater community orientation; and increasing teamwork.

The current government has had a strong emphasis on setting a small number of specific health targets and monitoring performance against them. The targets are reviewed annually to ensure they align with government health priorities (MOH, 2011i). There are six current targets: shorter stays in hospital emergency departments; improved access to elective surgery; shorter waits for cancer treatment; increased immunization; better diabetes and cardiovascular services/more heart and diabetes checks; and better help for smokers to quit. Information about each target is available on the MOH web site, along with quarterly DHB performance data (MOH, 2013l, 2013e).
The six health targets are also the focus of the Minister of Health’s latest annual report on implementing the New Zealand Health Strategy, along with other priority areas of better public services, clinical integration, financial management and sustainability, and ensuring quality (Minister of Health, 2012). These priority areas are described as being “consistent with the broad goals of the New Zealand Health Strategy”, but seem to have narrowed the strategy’s broader public health approach reflected in the original population-health objectives.

The MOH reports annually on the state of public health in New Zealand in its annual reports. The most recent of which reports continuing improvement in life expectancy and health expectancy; decreases in the rates of death from cancer and cardiovascular disease; relatively stable levels of obesity in children, but a continuing rise in adult rates; increasing immunization rates; and a continuing reduction in smoking rates (MOH, 2012b). However, in all cases, Māori (and, where reported, Pacific) outcomes are poorer than non-Māori. This inequality has been decreasing at least in life expectancy, but remains a focus for improvement throughout the New Zealand health system.

The Minister for Disability Issues reports to Parliament annually on the implementation of the New Zealand Disability Strategy by reporting on key activities across government. In 2010, the government established a Ministerial Committee on Disability Issues “to provide visible leadership and accountability for implementing the New Zealand Disability Strategy and the United Nations Convention on the Rights of Persons with Disabilities, and to set a coherent direction for disability issues across government” (Office for Disability Issues, 2011, p. 17). Work under the plan currently focuses on supports for living, mobility and access, and paid employment for disabled people (ODI, 2011).

Disability surveys have been conducted in New Zealand following the censuses in 1996, 2001 and 2006. Information is collected on the prevalence, nature and cause of disabilities among New Zealanders living in households and adults (aged 15 and older) living in residential facilities, and the barriers people with disability encountered in daily life (Statistics New Zealand, Undated-b). The 2006 survey estimated that 17% of the total population had a disability, significantly lower than the 20% reported in the earlier surveys (Statistics New Zealand, 2007a). This apparent decline was noted in all age groups, but was more marked in the older age groups. No specific contributing factors to account for this change.
could be identified, but were thought likely to include minor statistical factors, changes in people’s perceptions of disability, as well as possible real-world changes (Statistics New Zealand, 2007a). Apart from this apparent decline in the disability rate, the results of the 2006 survey were largely consistent with the two earlier surveys.

7.2 Financial protection and equity in financing

7.2.1 Financial protection

The New Zealand health system is largely (83.2%) financed through progressive taxation (the remainder being private user payments [10.5%] and health insurance [4.9%]). Nonresidents, however, must purchase private health insurance while in New Zealand or pay out of pocket. It is not known how many people living in New Zealand are therefore ineligible for publicly funded care.

Overall, New Zealanders have very good coverage of their health care needs. User co-payments for PHC and pharmaceuticals have been regularly identified as a barrier to access in the past (Raymont, 2004), but these charges have been reduced by additional government funding made available since the introduction of The Primary Health Care Strategy. However, the 2011–2012 New Zealand Health Survey found that in the previous 12 months, 14% of adults and 5% of children did not attend a GP due to the cost, and cost was also a barrier to collecting prescriptions for 8% of adults and 7% of children (MOH, 2012q, 2012f). Other key gaps in coverage include potentially limited access to elective procedures, long waiting times for mental health (including alcohol and drug services), limited coverage for adult dental care and optometry services, increasing concern over access to residential support services, and concern over family-carer funding. Differences in coverage between the government-funded health sector and Accident Compensation Corporation (ACC) raise significant equity issues in New Zealand.

7.2.2 Equity in financing

New Zealand’s health care system is funded through a range of taxes that are paid into a central consolidated fund, with funding for health then allocated each year. Hence there are no financing arrangements in New Zealand that are specific to the health sector.
7.3 User experience and equity of access to health care

7.3.1 User experience

New Zealand has a range of measures of people’s experiences with the health system, but more work is needed to systematize the available measures and to better understand the basis for New Zealanders’ views on their health services.

Available data show the New Zealand public is somewhat satisfied with the public health system. Commonwealth Fund data show that in 2010, some 37% of New Zealanders felt the health care system worked well, while 51% felt major change was needed, and 11% felt that the system needed to be completely rebuilt. The public’s views on the health system have improved in recent years, but these surveys do not allow us to understand the basis for these views.

The State Services Commission (SSC) administers a continuous survey, Kiwis Count, measuring New Zealanders’ satisfaction with frequently used public services (SSC, 2012). Satisfaction scores for those receiving four specific health services are shown in Table 7.1.

Table 7.1 Kiwis Count health service quality scores

<table>
<thead>
<tr>
<th>Service</th>
<th>Service quality scores (maximum score: 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
</tr>
<tr>
<td>Received outpatient services from a public hospital</td>
<td>69</td>
</tr>
<tr>
<td>(includes ED)</td>
<td></td>
</tr>
<tr>
<td>Stayed in a public hospital</td>
<td>68</td>
</tr>
<tr>
<td>Obtaining family services or counselling</td>
<td>68</td>
</tr>
<tr>
<td>Used an 0800 number for health information</td>
<td>67</td>
</tr>
<tr>
<td>Overall</td>
<td>68</td>
</tr>
</tbody>
</table>

Source: DHBSS (2012a).

The 2006–2007 New Zealand Health Survey showed high levels of satisfaction with aspects of PHC services – e.g. that people were treated with respect and dignity (85–90% agreement), were listened to carefully (65–85%), and had adequate discussion of health care by a PHC professional (65–85%). However, Asians, Pacific and Māori adults and those in the most deprived areas were less likely to report being treated
with respect and dignity ‘all of the time’; men aged 25–34 years and women aged 15–34, Māori women, and those in the most deprived areas were less likely to report they were listened to carefully ‘all the time’; men aged 25–34 and women aged 15–34, Māori and Pacific adults and those in the most deprived areas were less likely to report they had adequate discussion ‘all of the time’ (MOH, 2008a, p. 245). Regular satisfaction surveys of hospital patients also show high levels of satisfaction; but these surveys are reported to have low response rates, are not always in use, and are under review.

New Zealand has been paying particular attention to better managing waiting lists and reducing waiting times since 1998. The focus for elective surgery is on balancing treatment with available resources and ensuring that those who can be treated are treated within six months of assessment. Thus, patient need and ability to benefit are assessed using priority tools and those meeting a particular threshold (set with available resources in mind) are now mostly treated within six months of assessment. By the end of 2014, this will reduce to within four months of assessment.

However, there are major gaps in our understanding of access to elective services, including a lack of information about the number of people who are returned to their general practitioner (GP) for ongoing care as they do not reach the agreed thresholds for treatment; changes over time in the actual thresholds; and the actual times that people wait (Cumming, 2013).

[See also section 2.9.]

7.3.2 Equity of access to health care

The health inequalities between Māori/Pacific and non-Māori/non-Pacific people are a major health issue in New Zealand (see also section 1.4). People of Māori and Pacific ethnicity and those with low socioeconomic status (income, education, occupation, housing) have consistently poorer health outcomes in comparison with the rest of the population (MOH, 2007d). The MOH aims to reduce inequalities through policy, funding decisions and service provisions.

The New Zealand Public Health and Disability Act was enacted in 2000. The provisions under the Act require that District Health Boards: have Māori representation on the boards and their committees; involve Māori
in decision-making and in the delivery of health and disability services; improve Māori health outcomes and thereby reduce disparities between Māori and other New Zealanders; and build the capacity of Māori to participate in the health and disability sector and to ensure that it responds to the needs of Māori. The 2000 legislation began the process to reduce health inequalities between Māori and non-Māori, but does not offer preferential access to services or Māori control over their own separate health care system (Pere et al., 2007). There is, however, no evidence on how well such initiatives work to improve Māori health.

The New Zealand Health Strategy has a strong focus on the need to reduce inequalities in health, as does the later Primary Health Care Strategy. In 2002, the MOH released ‘Reducing Inequalities in Health’, a framework which identifies the need for action to target:

- social, economic, cultural and historical factors contributing to inequalities in health;
- pathways through which these factors influence health, for example, health-related behaviours and environmental conditions;
- health and disability services;
- the impact of poor health and disability on economic and social well-being (MOH, 2002d, p. 3).

The Māori Health Strategy, He Korowai Oranga, advocates the concept of Whanau Ora: healthy Māori families supported to achieve their maximum health and well-being (King & Turia, 2002, p. 1). Whakatātaka Tuarua 2006–2011, the second Māori Health Action Plan, set objectives for Māori health. Whakatātaka Tuarua provides a framework for the MOH, DHBs and key stakeholders to take a leadership role in improving Māori health outcomes (Minister of Health & Associate Minister of Health, 2006).

People from the Pacific islands make considerable use of mainstream health services, especially for secondary care. They have high rates of hospitalization for a number of communicable diseases and for accidents and injury, as well as for other conditions such as asthma, diabetes and pneumonia (MOH, 1999c). More priority, therefore, is being directed at earlier preventive and primary care for the Pacific population. Three Pacific-focused strategic frameworks were created between 2002 and 2006 with the overall aim of improving health outcomes for Pacific peoples and reducing inequalities between Pacific peoples and other New Zealanders.
Pacific Health and Disability Action Plan highlights six priority areas where improvements can be made to health and disability support services for Pacific people (King, 2002b). A number of papers have been published as part of this work, covering Pacific child health, youth health and mental health; Pacific people’s experience of disability; how to improve quality of care for Pacific people; and a literature review of Pacific cultural competencies (MOH, 2008g, 2008l, 2008n; Tiatia, 2008). The action plan has recently been superseded by ‘Ala Mo’ui, which sets out priority outcomes and actions for Pacific health for 2010–2014 (Minister of Health & Minister of Pacific island Affairs, 2010).

The Pacific Health and Disability Workforce Development Plan provides a framework for health and education organizations to positively influence the pathways for Pacific peoples’ participation in the health workforce (MOH, 2004b).

The Pacific Provider Development Fund Purchasing Strategy 2005/06 to 2007/08 guides funding and purchasing decisions for the MOH and DHBs on issues relating to Pacific people. This has since been updated to 2008–2009 (MOH, 2005b, 2008m).

Life expectancy and other measures of health status are similar for rural and urban populations overall, but a number of factors may impede people’s access to health and disability services in rural areas, including socioeconomic deprivation, geographical barriers and distance, transport, telecommunications, the cost of accessing services, and service acceptability (Fraser, 2006; NHC, 2010). A National Health Committee report on rural health concluded that better rural health service delivery would require comprehensive PHC, supportive technology, visiting services and transport support for patients who need to travel, increased scopes of practice, and flexible, sustainable and efficient contract and funding arrangements (NHC, 2010, p. xi).

7.4 Health outcomes, health service outcomes and quality of care

7.4.1 Population health

As noted earlier, New Zealand continues to show improvement in many population health indicators, but with notably poorer outcomes for Māori and Pacific peoples (MOH, 2011b) (see also section 1.4 and Tables 1.1, 1.3, 1.4 and 1.7). What proportion of these improvements should be
attributed to the health system is uncertain, but one measure of health service performance is amenable mortality, defined as “deaths from those conditions for which variation in mortality rates [over time or across populations] reflects variation in the coverage and quality of health care” (MOH, 2010c). A report on amenable mortality for people aged under 75 in New Zealand for the decade 1996–2006 found:

- both amenable and nonamenable mortality fell steadily over the decade (amenable mortality by approximately 30% for both males and females, and nonamenable mortality by 18% for males and 12% for females);
- in 2006, some 47% of deaths of people aged under 75 were classified as amenable;
- adjusting for age, males have higher risk of both amenable and nonamenable mortality than females;
- in 2006, Māori mortality, adjusted for age, was approximately three times higher than non-Māori rate for amenable mortality and twice as high for nonamenable mortality for both sexes;
- in 2006, Pacific mortality, adjusted for age, was approximately twice the non-Pacific rate for amenable mortality and 1.5 times as high for nonamenable mortality;
- in 2006, after adjusting for age and ethnic mix, people living in areas of highest deprivation (New Zealand Deprivation index quintile 5) had amenable mortality 1.9 times (males) and 1.7 times (females) higher than those living in areas of lowest deprivation (NZDep quintile 1) and 1.5 times (males) and 1.4 times (females) higher nonamenable mortality (MOH, 2010c).

An analysis of mortality amenable to health care in 19 Organisation for Economic Co-operation and Development (OECD) countries ranked New Zealand 15th (Nolte & McKee, 2003). This was based on 1998 standardized death rates per 100 000 for ages 0–74 (mortality amenable to health care of 74.29). The ranking improved one place although amenable mortality increased to 109.03 when 50% of ischaemic heart disease deaths were included. Compared to other high-income countries in the OECD, New Zealand performed substantially worse than first-ranked Sweden (amenable mortality rate of 50.55) and Australia (60.81), but better than the United States (80.66) and the United Kingdom (91.10).

Public health efforts contribute to New Zealand’s declining smoking rates which positively affects a number of major causes of mortality, including cancer, coronary health disease, lung disease and cerebrovascular
disease. In common with many other countries, New Zealand is experiencing an obesity epidemic. As part of health efforts to address this, a Healthy Eating – Healthy Action strategy was developed in 2003 (MOH, 2003b) and an independent evaluation of the strategy began (Mann et al., 2009; McLean et al., 2009), but the National Party-led government made major changes to the implementation of the strategy in 2009 (reducing funding and programmes) and the evaluation did not continue. An important aspect of the strategy and its implementation plan, however, is the recognition that many sectors other than health have a role to play and that coordination and collaboration are essential if change is to be achieved.

7.4.2 Health service outcomes and quality of care

The Health Quality and Safety Commission New Zealand was established in December 2010 under the New Zealand Public Health and Disability Amendment Act 2010. It is responsible for assisting both public and private providers across the whole health and disability sector to improve service safety and quality and therefore improve outcomes for all service users.

The Health and Disability Services (Safety) Act 2001 aims to promote the safe provision of health and disability services to the public; enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely; encourage providers of health and disability services to take responsibility for providing those services to the public safely; and encourage providers of health and disability services to the public to continuously improve the quality of those services (section 3). For example, residential care facilities for the aged must achieve Certification under the Act and comply with the Health and Disability Sector Standards 2008 in order to receive DHB funding (MOH, 2012m).

Performance indicators are used in both primary and secondary care to assess Primary Health Organisation (PHO) and District Health Board (DHB) performance against set targets. The results are publicly available (at DHB-level in the case of PHO performance) on the MOH and District Health Boards Shared Services web sites (DHBSS, Undated-a; MOH, 2012g). The 2011–2012 health targets for DHBs are shorter stays in emergency departments (95% of patients admitted, discharged or transferred from the emergency department within six hours); improved
access to elective surgery (increased average volume of annual discharges); shorter waits for cancer treatment (everyone needing radiation treatment will have this within four weeks of first specialist radiation oncology assessment); increased immunization rates (95% of two-year olds fully immunized by July 2012); better diabetes and cardiovascular services (90% of eligible adult population will have had a cardiovascular disease risk assessment in the last five years); increased percentage of people with diabetes attend free annual checks and have satisfactory or better diabetes management). Generally, performance is improving over time but significant differences in DHB performance are evident (MOH, 2012q).

Current PHO performance indicators are breast screening coverage, cervical cancer screening coverage, ischaemic heart diseases coding, cardiovascular disease risk assessment, diabetes detection and follow up, influenza vaccination coverage for those over 65 years old, vaccination status of two-year olds, recording of smoking status, and brief smoking advice and cessation support. Here too, performance is improving over time but significant differences in PHO performance are evident (DHBNZ, 2012).

Mechanisms to ensure the competence of individual practitioners in 16 health professions are set out in the Health Practitioners Competence Assurance Act 2003, and may include continuing professional development activities and quality assurance evaluations of performance. These operate on an individual level; the Royal New Zealand College of General Practitioners has also developed a quality improvement and assurance programme for general practices known as CORNERSTONE (Royal New Zealand College of General Practitioners, 2010).

Patient rights are clearly set out in the Code of Health and Disability Services Consumers’ Rights, monitored and upheld through the Office of the Health and Disability Commissioner (see section 2.9.3). Complaints about patient care can also be addressed by provider organizations (e.g. a DHB) or practitioners’ professional bodies. Where a patient suffers an injury in the course of their care, they are eligible for compensation through ACC, which removes the right to sue for damages.

### 7.4.3 Equity of outcomes

A number of studies have identified differences in the health of Māori and non-Māori New Zealanders. Māori have higher rates of illness and hospitalization and poorer health outcomes (including higher morbidity
rates), as well as lower rates of health service utilization and higher reports of unmet need (Ajwani et al., 2003; Crengle et al., 2005; MOH, 2006c; Robson & Harris, 2007; Westbrooke, 2001). Explanations for these inequalities include differences in access (cost, location, transport), attitudes of doctors and acceptability of the service to its users (MOH, 2006c; Pomare et al., 1995).

Pacific peoples in New Zealand also experience inequalities. For example, they have shorter life expectancy at birth than the New Zealand average (4.8 years shorter for males and 4.4 years shorter for females); higher rates of avoidable mortality than the all New Zealand benchmark (approximately 50% excess risk); high rates of ambulatory sensitive hospitalization relative to the all New Zealand benchmark (approximately 60% excess); an infant mortality rate 40% higher than the all New Zealand average; significantly higher rates of cardiovascular disease and diabetes; and high rates of overweight and obesity among both children and adults (MOH, 2005e).

Reducing inequalities is a continuing focus of the health sector, and there are some indications of improvements in trends (MOH & Minister of Health, 2008). Provisional estimates of life expectancy at birth in 2006 were 82.8 years for non-Māori females compared to 75.8 years for Māori females, and 78.8 years for non-Māori males compared to 71.2 years for Māori males, the differences are statistically significant (MOH, 2008d). However, life expectancy had been improving faster for Māori than non-Māori since 1995, with the gap narrowing from 9.8 years in 1995–1997 to 7.3 years in 2000–2002 and 7 years in 2006. Pacific peoples’ provisional estimates for life expectancy in 2008 were 73.9 years from birth for males and 78.9 years for females. Mortality by ethnicity also continues to show marked ethnic differences, but between 1996–1999 and 2001–2004, absolute inequality in all-cause mortality among 0–74 year olds decreased for all population groups, more so for Māori than Pacific ethnic groups (MOH & Minister of Health, 2008). Māori and Pacific ethnic groups also have higher infant mortality rates than the total population, with rates declining for all groups, but more quickly among Māori (from a rate of 11.5 per 1000 in 1996 to 6.69 per 1000 in 2006, a drop of 42% compared with a 28% drop in the total population to 5.1 per 1000) [MOH & Minister of Health, 2008].

Māori and Pacific peoples are proportionately under-represented in the health workforce, although numbers employed have been increasing
since 1996. In 2008, some 3.2% of doctors identified as Māori and 1.7% as Pacific (compared with 15% of the population being Māori and 6% Pacific) (Davis et al., 2005; Medical Council of New Zealand, 2008; MOH & Minister of Health, 2008; MOH & Ministry of Pacific island Affairs, 2004).

7.5 Health system efficiency

7.5.1 Allocative efficiency

Since July 2003, DHBs have been funded through a population-based funding formula (PBFF), the aim of which is “to fairly distribute available funding between DHBs according to the relative needs of their populations and the cost of providing health services to meet those needs” (MOH, 2004c).

The MOH has annual Crown Funding Agreements with each DHB which set out the funding the government will supply and the services the DHB is required to provide and requirements it must meet in return. However, within the limits of the Minister of Health’s directions and national health strategies, and their own prioritization processes, DHBs have freedom to configure their services to their population’s needs. Therefore there can be regional differences in the type and level of services offered. Research on the DHB health reforms found considerable variety in how DHBs undertook their planning and priority setting, and that their strategic and annual plans were only indirectly related to the specific resource allocation and purchasing decisions made by the DHBs (Mays, Cumming & Tenbensel, 2007). In addition, prioritization was only considered realistic for new or additional funding, with DHB board members and managers reporting that government opposition and community resistance constrained disinvestment from existing services or contracts (Tenbensel, 2007).

Prior to the development of The Primary Health Care Strategy in 2001, GPs were funded on a fee-for-service basis. PHOs are now funded on a capitation basis, with rates determined by the number and characteristics of a PHO’s enrolled population. The Primary Health Care Strategy was also accompanied by a significant amount of new government funding, in the order of NZ$2.2 billion over seven years (Hodgson, 2005).

The government made it clear that the increased funding should result in lower patient fees, and this has generally been the case, along with increased consultation rates (Cumming & Gribben, 2007). However,
97% of PHOs reported disbursing all first-contact funding to practices, with almost no use of this funding to leverage change in general practices’ clinical practice or service provision (Smith & Cumming, 2009a). Nevertheless, 92% of PHOs were using the MOH’s weighted capitation formula (rather than measures related to practice activity) to determine how first-contact funding should be allocated to practices, although within practices, there are a variety of payment methods, with at least some income still being paid on a fee-for-service basis (Smith & Cumming, 2009a). Thus, while PHC in New Zealand is now funded overall on a capitation basis, there remains a strong fee-for-service culture and concerns by GPs about having the government involved in their fee-setting, which provides challenges to the strategy’s aims of changes in PHC service provision (Croxson, Smith & Cumming, 2009).

The bulk of New Zealand health services remain focused on treatment rather than prevention, with 54% of total expenditure on health in 2005–2006 being used for services of curative and rehabilitative care, and only 6% on prevention and public health services (MOH, 2008e).

Most health care personnel groups show increasing numbers per 1000 population since 1990 (see section 4.2.1), but New Zealand has fewer doctors, dentists and pharmacist than many OECD countries, though a similar proportion of nurses to comparable countries. There are some areas of shortage (particularly mental health workers) and rural areas generally find it more difficult to attract staff than urban areas.

### 7.5.2 Technical efficiency

The MOH’s annual report provides some measures of hospital efficiency, showing a decline in DHB deficits since 2008–2009, a small increase in the average rate of day-case procedures from 2001 to 2010 (from 53 to 57%), and a small increase (0.7%) in doctor and nurse productivity between 2009–2010 and 2010–2011 following a 7% decline in the preceding six years (MOH, 2012b). An earlier Treasury report suggested that hospital efficiency (comparing real hospital expenditure with measured hospital outputs) had increased by 1.1% per annum over the three years 1997–1998 to 2000–2001, then fell by 2.6% per annum over the following three years (2000–2001 to 2003–2004) (Treasury, 2005).

The move to capitation funding in PHOs should create incentives for doctors to focus more on preventive care to keep patients well. However,
a fee-for-service component remains in general practice, which may reduce the potential efficiency of a capitation system. However, fee-for-service systems have advantages in terms of responsiveness of providers to users.

A small proportion of PHO funding is now tied to quality improvement through the performance management programme, with payment made according to whether or not targets are met for the performance indicators (see section 6.1.5).

The Pharmaceutical Management Agency (PHARMAC) is a monopsony purchaser and has been successful in controlling both community and hospital pharmaceutical costs, largely through supply-side controls, including reference pricing, targeting through restrictions (e.g. specialist-only prescribing), expenditure caps and tendering (Braae, McNee & Moore, 1999; Tordoff, Norris & Reith, 2008).

7.6 Transparency and accountability

Although there is a significant amount of information collected and reported about the New Zealand health system, inevitably there are significant gaps in our understanding of how the system performs. In addition, there can be long delays in data being reported.

Comprehensive information is available on expenditure trends in New Zealand. The most recent published data covers the decade 2000–2010 (MOH, 2012e). Significant amounts of information are routinely published on health status, including differences in health status across different groups in the population. The MOH also now routinely undertakes surveys on key topics in health care in New Zealand, including self-reported health, diagnoses with key chronic conditions, and risk factors, along with modules on specific topics such as health services, mental health, and tobacco use. Hospital discharge data are also routinely reported, and a new Health and Quality Safety Commission is likely to focus on releases of quality-of-care data in the future. However, key gaps in our understanding of the performance of the health system include PHC service use, use of services and quality of care in community services, and all aspects of service user experiences. These are all very poorly researched in New Zealand.
Chapter 8: Conclusions

Key findings

Overall, New Zealanders experience a high health status by international comparisons and good access to health services through a predominantly publicly funded, universal coverage system. However, Māori and Pacific populations, despite improvements since the mid-1990s, continue to have significantly lower health status than other New Zealanders and reducing these inequities is a major challenge for the New Zealand health system. The development of new ‘whānau ora’ services – including intersectoral services – is a key strategy for reducing inequalities.

New Zealand’s health expenditure as a percentage of gross domestic product (GDP) is slightly more than the Organisation for Economic Co-operation and Development (OECD) average and has been tracking upwards since 1990. Recent annual increases in health expenditures have been higher than increases in GDP; restraining health expenditure growth is a key focus at present.

Responsibility for purchasing and providing most health and disability services (guided by national strategies) is devolved to 20 District Health Boards (DHBs), funded through a population-based funding formula. DHBs are increasingly working together to reduce transaction costs and improve coordination of services.

Since 2002, primary health care (PHC) services have been provided through Primary Health Organisations (PHOs), funded on the basis of their enrolled population (with most patients paying additional fees for service). There has been significant additional government funding for PHC in this period, resulting in reduced fees for most patients, increases in consultation rates and reduced reporting of unmet need to see a general practitioner (GP). However, fees tend to rise quite quickly and if gains in access to services are to be maintained, continued attention to patient fees is needed.
The Accident Compensation Corporation (ACC) established in 1974 provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors injured in New Zealand. The scheme continues to be highly supported by New Zealanders.

Clinical Priority Assessment Criteria (CPAC) tools are used to assess access to specialist services and elective surgery, but inconsistencies in their use and differing treatment thresholds create inequalities between DHB regions. The introduction of performance targets of a maximum six months wait for first specialist assessment and maximum six months wait for elective surgery for patients meeting a treatment threshold (both to decrease to four months by the end of 2014) has increased certainty for these patients. However, there are no national data about what happens to patients below the threshold who are referred back to their GP for care. A new national patient data collection is currently at the business case stage and, if approved, would collect this information in the future.

The Crown Pharmaceutical Management Agency (PHARMAC) is responsible for managing the pharmaceutical schedule and purchasing medicines. As sole pharmaceutical purchaser of publicly subsidized medicines, PHARMAC has been very successful in negotiating costs and controlling supply-side expenditure. PHARMAC operates under a capped budget and the relative cost-effectiveness of medicines is a key component of its decision-making about what to publicly fund. PHARMAC is now tasked with advising on medical devices. The National Health Committee has also been recently revamped to better oversee the introduction of new technologies and services in New Zealand. The work of PHARMAC and the National Health Committee will play a key role in health expenditure trends and health services delivery in future years.

Lessons learnt from health system changes

New Zealand has had five significant health system reforms since the 1980s. Perhaps the most important lesson from these reforms is that they take considerable time, effort and money, diverting attention from ongoing health system issues.

The business and competitive model of the 1997–1999 Crown Health Enterprises was not favoured by many professionals and promised efficiency gains did not eventuate. However, successes from this period include the establishment of PHARMAC to manage the national
pharmaceutical budget and the growth of Māori and Pacific health providers.

DHBs are allocated funding to improve, promote and protect the population of their district (moving towards a greater focus on population health and away from hospital management only). They are also to cooperate with other DHBs in providing services and, under the current government, there is an increased emphasis on collaboration in planning and shared back-office functions. DHBs have majority publicly elected boards and must ensure community participation in their planning. Evaluation has found widespread support for the DHB model. Researchers have concluded that since the reforms, the public health system has shown some signs of greater equity of access to services; better financial performance in terms of deficit reduction; no obvious sign of efficiency improvements and possible reductions in some areas; some signs of an improvement in responsiveness in high-profile areas such as elective surgery; and a higher level of public acceptability, all occurring against a background of substantial real-terms expenditure increases. Little is known, however, about the impact of the late-2000s changes establishing a National Health Board, increasing collaboration across DHBs, and establishing more shared back-office support.

The Primary Health Care Strategy, enacted through the development of PHOs with population-based funding, is also increasing the focus on population health and preventive care. However, many PHC professionals still work under fee-for-service incentives, while the likely ongoing increases in patient fees may well create future access problems once again. While broad guidelines rather than rigid rules fostered the development of PHOs, it also resulted in great diversity of structures, including their size, governance and management arrangements. There remains a need to: clarify the roles of DHBs and PHOs; further develop clinical engagement and leadership within PHOs; further develop the role of nurses and other health professionals in PHC; and better integrate patient management information technology (IT) systems. Most important is the need to more clearly understand whether and how health care providers are working to better integrate care, and to evaluate the impact of changes on how professionals work, patient care, patient outcomes, and the overall costs of the New Zealand health system.
Remaining challenges and future prospects

- The global international recession and the costs of rebuilding Christchurch following two major earthquakes continue to impact on the New Zealand economy, with flow-on effects to health, including social impacts such as unemployment and overcrowded housing, as well as budgetary constraints on all government spending.
- As with the rest of the developed world, managing the growing burden of noncommunicable diseases and chronic conditions, and addressing their underlying causes is a major challenge for the health system, along with an ageing population.
- Significant inequalities continue, and reducing these by improving the health of Māori and Pacific islanders is an essential focus.
- The development of Integrated Family Health Centres in PHC is currently under way. Further integration and coordination of services within and between primary and secondary care is needed to improve care for patients.
- Greater consistency is needed in the use of prioritization tools for accessing secondary services.
- New Zealand does not have an agreed core of publicly funded health services and differing levels of service are provided through the 20 DHBs.
- Health workforce planning has some challenges in addressing shortages of professionals in some areas (such as mental health and rural regions), the high mobility of New Zealand professionals leaving to work overseas, the high numbers of overseas-trained staff who must become culturally competent within this health system, and an ageing health workforce.
- The recently reorganized National Health Committee faces the challenge of prioritizing and advising the Minister of Health on existing and new health interventions.
Chapter 9: Appendices

9.1 References


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9.2 Further reading

Government review documents on the New Zealand health system


Additional reading

• Morgan G, Simmons G (2009) Health cheque: the truth we should all know about New Zealand’s public health system. Morgan Family Charitable Trust.

9.3 Useful web sites
Accident Compensation Corporation: http://www.acc.co.nz/

DHB Shared Services: http://www.dhbsharedservices.health.nz/

Ministry of Social Development: http://www.msd.govt.nz/

National Health Board: http://www.nationalhealthboard.govt.nz/

New Zealand Ministry of Health: http://www.health.govt.nz/


9.4 Health Systems in Transition methodology and production process
Health Systems in Transition (HiT) reports are produced by country experts in collaboration with an external editor and the Secretariat of the Asia Pacific Observatory based in the WHO Regional Office for the Western Pacific in Manila, the Philippines, or the European Observatory based in Brussels, Belgium (depending upon the country / region). HiTs are based on a template developed by the European Observatory on Health Systems and Policies that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.
Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Data are drawn from information collected by national statistical bureaus and health ministries. Furthermore, international data sources may be incorporated, such as the World Development Indicators of the World Bank.

In addition to the information and data provided by the country experts, WHO supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the Western Pacific Country Health Information Profiles (CHIPs) and the WHO Statistical Information System (WHOSIS). HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are subject to wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following:

• A rigorous review process consisting of three stages. Initially, the text of the HiT is checked, reviewed and approved by the Observatory Secretariat. It is then sent for review to at least two independent experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant Ministry of Health, or appropriate authority, and policy-makers within those bodies to check for factual errors within the HiT.

• There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.

• HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and, in close consultation with the authors, ensures that all stages of the process are taken forward as effectively as possible.

9.5 About the authors

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The Asia Pacific Observatory on Health Systems and Policies is a collaborative partnership which supports and promotes evidence-based health policy making in the Asia Pacific Region. Based in WHO’s Regional Office for the Western Pacific it brings together governments, international agencies, foundations, civil society and the research community with the aim of linking systematic and scientific analysis of health systems in the Asia Pacific Region with the decision-makers who shape policy and practice.