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New Zealand Health System Reforms

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SUMMARY

- ▶ **Between 1938 and 1983 the New Zealand health system developed as a dual system of public and private provision.**

Social Security Act 1938.

- ▶ **1983-1993 Gradual establishment of 14 Area Health Boards (AHBs) funded by a population-based formula.**

Area Health Boards Act 1983.

- ▶ **1993 Four Regional Health Authorities (RHAs) were established. Purchasing and provision of health services were separated. The 14 Area Health Boards were reconfigured into 23 Crown Health Enterprises (CHEs) structured as for-profit organisations and subject to ordinary company law. Public health services were unbundled and a separate public health purchasing agency, the Public Health Commission, was established.**

Health and Disability Services Act 1993

- ▶ **1997 The National-New Zealand First Coalition Government, through the Coalition Agreement on health, reformed the structure of the health system. In 1998, 4 RHAs were combined into one national purchasing agency, the Health Funding Authority (HFA). The 23 CHEs were reconfigured as 24 not-for-profit Crown-owned companies and renamed Hospital and Health Services (HHSs).**

Health and Disability Services Amendment Act 1998.

- ▶ **2000 The Labour-Alliance Coalition Government initiated a health system reform. In 2001, 21 District Health Boards (DHBs) were formed. Primary Health Organisation (PHOs) were developed in 2002 to manage primary care, including general practitioners and their services.**

New Zealand Public Health and Disability Act 2000

Introduction

Since 1983 the New Zealand public health sector has undergone four structural transformations. With each change there was a new set of organisations to fund and deliver health services: 1983-1993 Area Health Boards (AHBs); 1993-1997 Regional Health Authorities (RHAs) and Crown Health Enterprises (CHEs); 1998-2001 Health Funding Authority (HFA) and Hospital and Health Services (HHSs); and 2001 District Health Boards (DHBs). These changes were designed to improve health outcomes, increase accountability and efficiency and to reduce escalating health expenditure. New Zealand was not alone in change, a health reform movement developed around the world focused by the needs of an aging population, increased medical technology and growing public expectations of health systems. This paper discusses the development and structures of the New Zealand health system over each of the four change periods. The health sector before 1983 is discussed first to contextualise the later reforms.

New Zealand health system prior to 1983

Overview

New Zealand, like other advanced industrial countries, has experienced dramatic changes in health and health care over the last century.¹ The leading causes of death have changed from infectious diseases such as cholera and smallpox to chronic conditions such as heart disease, cancer and strokes.² The number of older people, who suffer most from these conditions, has steadily increased. The focus of health services shifted from community primary care and disease prevention to the modern hospital equipped with the latest medical technology aimed at curing the new diseases.³

A free health system, with hospital and other health services universally available to all New Zealanders was the vision behind the Social Security Act 1938.⁴ This was never fully realised due to ongoing disputes between the medical profession and the Government.⁵ Health services evolved as a dual system of public and private health care subsidised through a series of arrangements known as the General Medical Service (GMS) benefits established in 1941.⁶

The escalating expenditure on health and the inequity of health provision became a source of concern for governments and the health sector. These issues were highlighted by a series of reviews: *The Barrowclough Committee* 1953, *The Department of Health review* 1969, *The Royal Commission on social security* 1972 and *A health service for New Zealand* 1975.

Governance

The State was the main contributor to the provision and organisation of health care in New Zealand. The centralisation of control and funding of the New Zealand health system put overall power in the hands of the Minister of Health advised by the Board of Health and the

¹ OECD. 'New Zealand'. *The reform of health care systems: a review of seventeen OECD countries*. Health Policy Studies No. 5. OECD, Paris, 1994.

² Blank, R. F. *New Zealand health policy: a comparative study*, Oxford University Press, Auckland, 1994.

³ Davis, P. *Health and health care in New Zealand*, Longman Paul, Auckland, 1981, pp. 5-7.

⁴ Hyslop, J., Dowland, J., & Hickling J. *Health facts New Zealand*, Department of Health, 1983, p. 9.

⁵ Gauld, R. *Revolving doors: New Zealand's health reforms*, Institute of Policy Studies and Health Services Research Centre, Wellington, 2001, p. 18.

⁶ Minister of Health. *A health service for New Zealand*, Appendices to the Journals of the House of Representatives, 1975, H-23 and OECD, 1994, p. 227.

Hospitals Advisory Council. The Board of Health's principle function, as set out in the Health Act 1956, was to advise the Minister of Health on general health policy including the prevention, promotion, and effective treatment of diseases. The Board also had mandatory powers over Territorial Local Authorities in regard to environmental health services.⁷ The Hospitals Advisory Council, under the Hospitals Act 1957, advised the Minister on matters relating to the provision, control, and management of the Hospital Boards.⁸

The Department of Health had the combined responsibility for policy, purchasing, and the provision of health services. Health care was structured around 18 District Health Offices and 29 locally elected Hospital Boards that provided hospitals and hospital services as well as a range of community services, such as district nursing and domiciliary care. The Hospital Boards were also charged with encouraging the provision and maintenance of private hospitals. A hospital board of 8 to 14 members was elected every three years for each hospital district.⁹ Some 230 Territorial Local Authorities had basic responsibility for environmental health and town planning.¹⁰

High priority was given to increasing health funding after 1938. Expenditure on health continued to grow through the 1970s. From the 1980s onwards, governments have made a determined effort to decentralise the control of health and restrict expenditure.¹¹

Secondary care

As modern scientific medicine developed (through the 1950s and 1960s) health care became oriented towards the search for cures to disease rather than the prevention of illness. Hospitals made large investments in technology and specialist medical staff. By the 1980s they had become the centre point of health care, utilising complex technologies and dispensing sophisticated and up-to-date medical treatment.¹² In 1980 there were 186 public hospitals with 26,345 hospital beds and 163 private hospitals with 5,139 hospital beds.¹³

Since April 1958 the cost of hospital treatment in public hospitals, pharmaceuticals, and laboratory diagnostic services¹⁴ has been fully funded by the State out of general tax revenue.¹⁵ Private health care was funded largely through health insurance premiums with government subsidies.¹⁶

During the 1970s and early 1980s long public hospital waiting lists for particular surgical procedures, especially for some kinds of non-urgent surgery, developed into a problem.¹⁷ Consumers facing waiting times could alternatively pay for private hospital services which offered no waiting times.

⁷ Minister of Health. 1975, p. 63.

⁸ Minister of Health. 1975, pp. 64-65.

⁹ *New Zealand official year book*, Department of Statistics, Wellington, 1981, p. 137.

¹⁰ OECD, 1994, p. 228.

¹¹ Gauld, 2001.

¹² Davis, 1981, pp. 1-6.

¹³ *New Zealand official year book*, 1981, p. 137.

¹⁴ OECD, 1994, p. 228.

¹⁵ Lang, H. G. 'Health policy formulation in New Zealand', *International Journal of Health Planning and Management*, vol. 2, 1987, pp.143-160.

¹⁶ Gauld, 2001, p. 18-19 and *New Zealand official year book* 1981, p. 137.

¹⁷ Fougere, G. M. 'From market to welfare state? State interventions in medical care delivery in New Zealand', *In the public interest: health, work and housing in New Zealand* eds C. Wilkes and I. Shirley, Benton Ross Ltd, Auckland, 1984, p.81.

An extensive range of voluntary health and social care organisations has developed in New Zealand. These organisations, such as the Salvation Army, Plunket Society, the Intellectually Handicapped Children's Association, and St. John Ambulance, were dependent on government support. Many are now taking on a health provider role, seen by the state as a way of increasing choice and competition.¹⁸ Small community health groups developed in reaction to dissatisfaction with health services and, influenced by new social movements, formed the beginnings of health consumerism.¹⁹

Primary care

Primary care includes services provided by general practitioners (GPs), laboratories and radiology and the dispensing of pharmaceuticals.²⁰ In contrast to the publicly funded hospital sector, primary care was dominated by GPs and other medical specialists who received payment for services through state subsidies (GSM benefits) and a 'fee for service' charged to the patients. GSM benefit subsidies failed to keep up with inflation and over time the patient charges increased disproportionately, creating inequalities in health care based on the patient's ability to pay.²¹

ACC

The Accident Compensation Corporation (ACC) scheme introduced in 1974, supplied 'no fault' accident insurance coverage which compensated people for medical bills and loss of wages. The scheme was intended to be self-funding from a range of levies.²²

¹⁸ Ovretveit, J. 'The Kiwi way: lessons from New Zealand', *British Medical Journal*, 312, 1996, p.645.

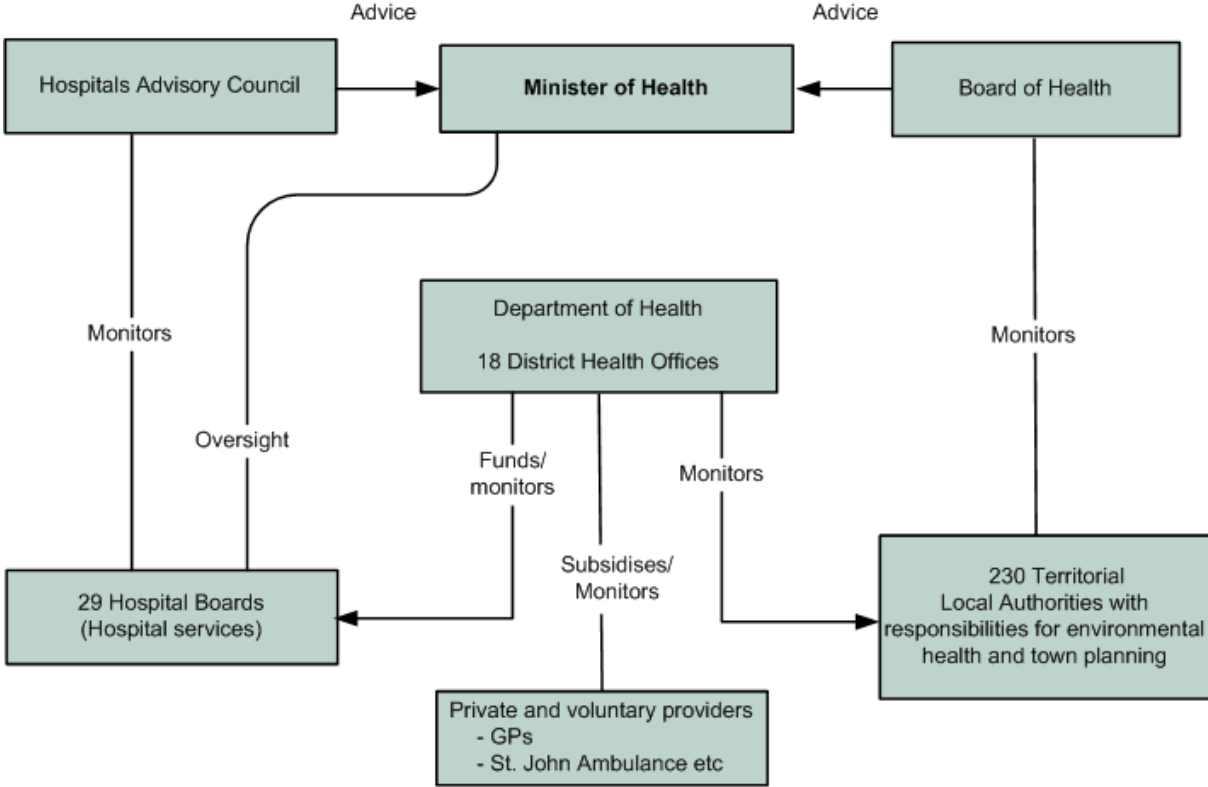
¹⁹ OECD, 1994, p. 228.

²⁰ Malcolm, L. 'Primary-care reform in New Zealand: key contrasts with Australia', *Health reform in Australia and New Zealand*, ed A. Bloom, Oxford University Press, Melbourne, 2000, p. 184.

²¹ Gauld, 2001, p. 19.

²² St John, S. 'Accident compensation in New Zealand: a fairer system' *Redesigning the welfare state in New Zealand: problems, policies, prospects*, eds J. Boston, P. Dalziel, & S. St John, Oxford University Press, Auckland, 1999, p.156. Also see *History of ACC in New Zealand* at <http://www.acc.co.nz/index.htm>

Figure 1. The structure of New Zealand’s health system, 1980



Source: Based on Figure 16.1 OECD. 'New Zealand'. *The reform of health care systems: a review of seventeen OECD countries*. Health Policy Studies No. 5 OECD, Paris, 1994, p227.

Area Health Boards 1983-1993

Overview

Inconsistencies in health care quality and unequal access to health care services caused public and political concern.²³ A white paper, issued by the 1972 to 1975 Labour Government, entitled *A health service for New Zealand*²⁴ listed the problems of the existing structure and provided a template for health reform. There was some unease among stakeholders, including medical practitioners who disagreed with aspects of these reforms.²⁵

Nevertheless, reform of the health system progressed slowly through the 1970s and 1980s. The newly elected 1975 National Government took a pragmatic approach to health reform by working with stakeholders in the Special Advisory Committee on Health Services Organisation (SACHSO).²⁶ The Committee’s recommendations were similar to those of the 1975 White Paper: the establishment of fourteen regional, locally elected Area Health Boards (AHBs)

²³ Gauld, 2001, pp. 31-32.

²⁴ Also available as Department of Health, *A health service for New Zealand*, Government Printers, 1975 and Minister of Health, *A health service for New Zealand*, Appendices to the Journal of the House of Representatives, H-23, 1975.

²⁵ Gauld, 2001, pp. 32-34.

²⁶ Special Advisory Committee on Health Services Organisation (SACHSO), *Proposed Northland pilot scheme: a framework for discussion*. Department of Health, unpublished paper, 1977.

combining both the curative functions of the Hospital Boards with the preventative functions of the Department of Health's District Health Offices.²⁷

Cautiously, the Government chose to pilot the AHB scheme in the Wellington and Northland regions.²⁸ With the trial proving successful, the Area Health Boards Act 1983 was passed. Again change was not swift, as the Act did not make the development of AHBs compulsory.

The Fourth Labour Government came to power after the snap election of 1984.²⁹ Significant state sector reforms followed a market driven framework. Certain advisers recommended a commercial approach for health, but the Government chose to continue with the AHB system. This system was fully formed after the Local Government Act 1989 reformed local government and abolished Hospital Boards.³⁰

Summary of significant changes

- 14 Area Health Boards formed between 1983 and 1989 with locally elected and appointed board members
- Early version of population based funding for AHBs
- Decentralisation of the Department of Health's responsibilities to AHBs
- Move from curative to preventive health services
- Emphasis on management and accountability structures for AHBs
- National health goals and targets – strategic health delivery

Significant policy documents

- Department of Health, *A health service for New Zealand*, 1975
- Department of Health, *Health services reorganisation: a discussion document*, 1982

Governance

While major reform was slow, it was still a time of considerable uncertainty in the health sector. From 1987 to 1990 there were three ministers of health each with a different outlook and style.³¹ Robin Gauld (2001:64) says that “[w]ith each of the new Labour ministers, there was a change in direction of a magnitude normally expected of a change in government”.

A major provision of the Area Health Boards Act 1983 was the decentralisation of power away from the Department of Health. Once the AHB system was fully functioning the Department released its operational and public health responsibilities to the regional AHBs.³² Working under budgetary constraints and with a ceiling on staff numbers, the Department of Health undertook a fundamental restructuring, moving primarily towards policy formulation, advice to the Minister of Health,³³ the development of health targets and budgets to guide the AHBs, and the monitoring and evaluation of their performance against national requirements.³⁴ As part of the restructuring the Department was organised into six new management blocks: Corporate

²⁷ Gauld, 2001, p. 35.

²⁸ Department of Health, *Health services reorganisation: a discussion document*, Department of Health, 1982.

²⁹ Gauld, 2001, p. 40.

³⁰ Gauld, 2001, p. 37.

³¹ Michael Bassett commissioned the Gibbs report, David Caygill issued his own policy document *Health: a prescription for change*, 1988 while Helen Clark detached the Department of Health from the policy circuitry (Gauld, 2001, p. 65) see Clark, H. (1989) *A New Relationship: introducing the new interface between the government and the public health sector*, Wellington, Minister of Health.

³² Blank, 1994, p. 124.

³³ Department of Health, *General briefing notes for the Minister of Health*, 1984, p.5.

³⁴ Department of Health, *Report of the Department of Health for the year ended 31 March 1989*, 1987-1990, VII, Appendices to the Journals of the House of Representatives, E10, p.4

Secondary care

The Area Health Boards Act 1983 saw the merger of Hospital Boards and Health Development Units (District Public Health Units of the Department of Health). The first AHBs were formed in 1985 in Northland, Nelson and Wanganui and by the end of 1989 the restructuring of 27 Hospital Boards as 14 AHBs was completed.³⁶ The AHBs' responsibilities included hospital services, health promotion, health protection, and environmental health.³⁷ Each AHB was required to sign a performance oriented accountability agreement with the Minister of Health³⁸ based on the health goals and targets described by The New Zealand Health Charter 1989.³⁹ This brought the health system into line with the management reforms reflected in the State Sector Act 1988 and the Public Finance Act 1989. Previous to this, no clear requirements for health outputs existed and hospitals were taken to be fulfilling government expectations if they remained within their budgets.⁴⁰

AHB populations varied in size from 35,000 to 900,000 people. Until 1991, board members were elected for a three year term in the same way and at the same time as local bodies. The Minister of Health had the power to appoint four additional board members to supplement perceived deficiencies in a board, for example business management skills or a Maori perspective.⁴¹ In 1991, in preparation for the Government's intended reforms, (see next section) all 14 Boards were replaced by Commissioners appointed by the Minister of Health.⁴²

A major turning point in health policy was the introduction in 1983 of a population-based funding (PBF) formula⁴³ for allocating resources to Hospital Boards and later AHBs.⁴⁴ The capping of hospital budgets was an attempt to contain government spending in relation to rising demand and expectation for health services.⁴⁵ Hospitals dominated health expenditure, with approximately 70 percent of the health vote spent on hospital services in 1989.⁴⁶

In 1987 there were a total of 344 hospitals in New Zealand with 30,645 beds. One hundred and seventy one of these were public hospitals with 24,488 hospital beds available. The remaining 173 hospitals were privately owned and had 6,157 beds.⁴⁷

³⁵ Department of Health, *Report of the Department of Health for the year ended 31 March 1987, 1987-1990*, VII, Appendices to the Journals of the House of Representatives, E10, p.8

³⁶ OECD, 1994, p. 230.

³⁷ Department of Health, *Briefing notes for the Minister of Health*, 1989, p. 2

³⁸ Blank, 1994, p. 126

³⁹ Department of Health, *The New Zealand health charter*, Wellington, Department of Health, 1989. The *New Zealand Health Charter* broadly describes the operations and goals for the operation of a nationwide publicly funded health system.

⁴⁰ OECD, 1994, p. 231

⁴¹ OECD, 1994, p. 228

⁴² OECD, 1994, p. 230

⁴³ The population based funding (PBF) system was revised in 1990 for Area Health Boards. 1993-1997 PBF occurred at a regional level and the four Regional Health Authorities funded the 23 Crown Health Enterprises (providers) on a contractual price-volume basis. 1998-2000 the Health Funding Authority maintained this approach. PBF was introduced on 1 July 2003 for DHBs. Previously, DHBs were funded to provide hospital services and to administer contracts for providers who were based in their districts.

⁴⁴ Blank, 1994, p. 124.

⁴⁵ Blank, 1994, p. 124 and Department of Health, *Funding for health: an allocation formula*, special report, series No. 58, 1981.

⁴⁶ Department of Health, 1989, p. 1.

⁴⁷ *New Zealand official year book*, Department of Statistics, Wellington, 1988/89, p316.

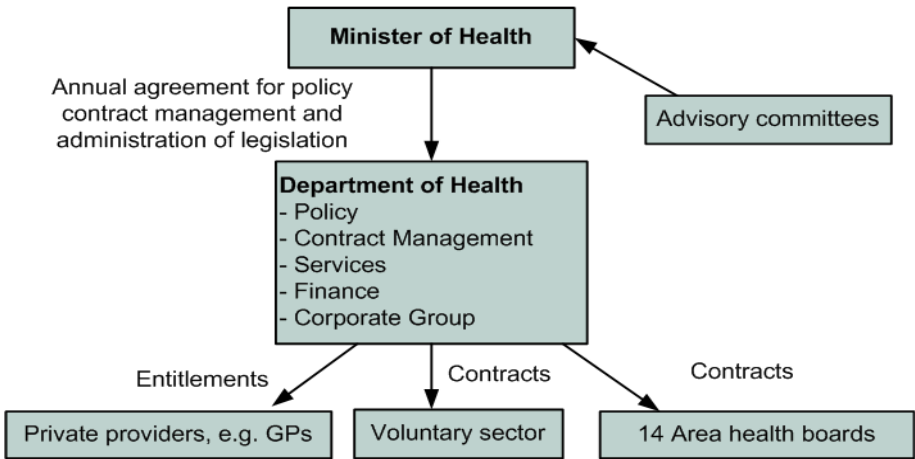
User charges

In February 1992 user charges were introduced for services provided by public hospitals. These were dropped in 1993. The rationale for their introduction was to discourage free hospital use over primary care, to reduce health expenditure, to improve equity of primary care by making higher income people pay more and to encourage healthy living.⁴⁸ The scheme proved costly in terms of negative publicity and financially cost the AHBs \$8.012 million.⁴⁹

Primary health

In the 1980s General Practitioners were essentially independent providers with no direct contract with the government. Under the General Medical Services scheme of 1941 GP visits were subsidised by the government. GPs supplemented these low subsidies with user co-payments (these varied); approximately \$31 (NZ) per adult consultation in 1991.⁵⁰ These user charges were monitored by the New Zealand Medical Association, with an informal agreement to keep payments at a reasonable level.⁵¹ As GP user charges increased, people opted to use the free public hospital system for primary care. In order to remove some of the pressure (and expense) from the hospital system, and make primary care more accessible, the newly appointed Minister of Health (the Hon. Dr. Michael Bassett) tried to cap patient fees and increase the subsidy to GPs.⁵² There was strong opposition by GPs to this proposal and it was dropped.

Figure 2. The structure of New Zealand’s health system, 1992



Source: Courtesy of Ministry of Health

⁴⁸ Ashton, T. 'User charges for hospital services: will they achieve their stated aims?', *NZ Nursing Forum*, vol 20, No.1, 1992, p. 6.
⁴⁹ Gauld, 2001, p. 96.
⁵⁰ OECD, 1994, p. 230.
⁵¹ OECD, 1994, p. 230.
⁵² Gauld, 2001, pp. 54-55.

Regional Health Authorities and Crown Health Enterprises 1993-1997

Overview

In 1991 the newly elected National Government embarked on a comprehensive restructuring of the health sector. Early that year a Ministerial Taskforce chaired by Roderick Carr commenced work on plans to address perceived deficiencies in the system.⁵³ The Taskforce's recommendations were launched on Budget night July 1991 in a paper entitled *Your health and the public health*. The paper borrowed heavily from the 1988 Gibbs report⁵⁴ (*Unshackling the hospitals*) and the 1986 *Choices for health care: report of the Health Benefits Review*⁵⁵ both published during the 1980s.

Your health and the public health recommended the separation of the purchaser and provider roles of the Area Health Boards and the establishment of a competitive, quasi-market approach to the provision of health services.⁵⁶ Four Regional Health Authorities (RHAs) were designed to purchase services from a range of providers in a competitive health market. Area Health Boards were transformed into 23 Crown Health Enterprises (CHEs) which were to be run on a commercial basis with boards of government appointees.⁵⁷ A new Ministry of Health was to replace the existing Department of Health.⁵⁸

Implementation was scheduled for 1 July 1993 allowing two years for consultation, development and implementation of a new health infrastructure. Work began immediately with Area Health Board members replaced by Government appointed commissioners to lead the change-over. The implementation process was managed by the Government through the Health Reform Directorate (HRD) located within the Department of the Prime Minister and Cabinet (DPMC) and not the Department of Health. In turn, the HRD oversaw the work of the National Interim Provider Board (NIPB) set up shortly after July 1991. The NIPB, chaired by Sir Ronald Trotter, was set the task of managing the transition from 14 Area Health Boards to 23 Crown Health Enterprises (all but one based on major acute hospitals).⁵⁹

Another substantial change was the relocation, in 1993, of the 'disability support budget' to the new Regional Health Authorities. This was an attempt to unify funding and delivery of services which had been fragmented between Vote Health and Vote Social Welfare.⁶⁰

Summary of significant changes

- Four RHAs established and 23 CHEs established.
- The Public Health Commission (PHC) established as a Crown agency.
- Department of Health (1900 to 1993) becomes the Ministry of Health.
- Separation of the provision of public hospital services from purchasing functions.
- Purchasers free to purchase from public or private sector providers.
- CHEs accountable to shareholding ministers and monitored by Crown Company Monitoring Advisory Unit (CCMAU).

⁵³ Gauld, R.' Introduction'. *Continuity amid chaos: health care management and delivery in New Zealand*, Oxford University Press, Dunedin 2005, p. 17.

⁵⁴ Gibbs, A., Fraser, D. and Scott, J. *Unshackling the hospitals* 1988, Government Print, Wellington, 1988.

⁵⁵ Scott, C., Fougere, G. and Marwick, J. *Choices for health care: report of the Health Benefits Review*. Government Print, Wellington, 1986.

⁵⁶ Blank 1994, p.128.

⁵⁷ Gauld, R. 'Beyond New Zealand's dual health reforms', *Social Policy & Administration* Vol. 33, No. 5, 1999, p. 569.

⁵⁸ Gauld, 2001, pp. 84-85.

⁵⁹ Gauld, 2001, p. 87.

⁶⁰ OECD, 1994, p. 237.

- Public hospitals corporatised and granted operational autonomy.
- Public hospitals paid in relation to volume and quality of services according to legally binding contracts negotiated with purchasers.

Significant policy documents

- Scott, C. et al, *Choices for health care: report of the Health Benefits Review*, 1986.
- Gibbs, A. et al, *Unshackling the hospitals*, 1988.
- Upton, S. *Your health and the public health*, 1991.

Governance

The Ministry of Health (MOH) was established on 1 July 1993 as a streamlined version of the Department of Health.⁶¹ The MOH was given the task of monitoring the performance of the Regional Health Authorities and the newly established Public Health Commission (PHC) against their funding agreements with the Crown. It also took up a regulatory role for all purchasers and providers, assessed and interpreted broad trends and influences in the health sector, serviced the national advisory committees, such as the National Advisory Committee on Core Health Services, provided some national specialist services and administered health legislation, including public health regulations.⁶² The reforms provided for two ministers, a Minister of Health and a Minister of Crown Health Enterprises.

The Public Health Commission (PHC)

The Public Health Commission (PHC) was established as a Crown agency, independent of the Ministry of Health, with the task of advising the Minister of Health on public health policy, health monitoring, consultation and the purchase of public health services.⁶³ The PHC entered into contracts with CHEs and other service providers for the provision of public health services.⁶⁴ The PHC was decommissioned in 1995 because the government saw an unnecessarily complex public health structure developing, and according to Gauld (2001:125), because it produced advice that clashed with other government policy.⁶⁵ See Figures 3 and 4 below for the structure of the health system in 1994, including the PHC, and then in 1996 after it had been decommissioned.

Core services

Central to the health reforms was the need to control expenditure.⁶⁶ The National Advisory Committee on Core Health Services, known as the National Health Committee, was established to rank health services and advise the Minister on which *core* personal health services RHAs should purchase and which services would no longer be offered. Defining core health was complex and a list of 'core services' was never developed.

Regional Health Authorities

With the introduction of the Health and Disability Services Act 1993 four Regional Health Authorities were established as purchasers of health care and 23 Crown Health Enterprises as providers. Regional Health Authorities had the responsibility of monitoring the health needs of

⁶¹ Gauld, 2001, p. 113.

⁶² OECD, 1994, p. 239.

⁶³ Blank, 1994, p. 128.

⁶⁴ Bloom, 2000, p. 35.

⁶⁵ Gauld, 2001, p. 125.

⁶⁶ Gauld, 2001, pp. 96-97.

their populations, purchasing the appropriate health and disability services⁶⁷ and monitoring the performance of providers with whom the RHAs entered purchase agreements.⁶⁸ The four RHAs were: Northern, Midland, Central and Southern each with a legislative responsibility for the health needs of between 750,000 to 1000,000 people and financial responsibility for purchasing primary, secondary and continuing care and accident related services from both Crown owned and privately owned providers.⁶⁹

Regional Health Authorities were funded by the MOH according to a population-based formula.⁷⁰ RHA budgets were capped to promote macroeconomic efficiency. Locally elected Area Health Boards were replaced by non-elected government appointed boards of directors for both RHAs and CHEs.⁷¹ The appointments of directors, largely from outside the health sector and with predominately business backgrounds, was seen as a way of reducing provider vested interests and achieving more rational decision-making.⁷² RHAs were accountable to the Minister of Health and to Parliament.⁷³ The purchaser/provider split also meant that the public hospitals no longer had privileged access to public funding over similar private providers.⁷⁴ When the RHAs were fully established, the intention was to introduce competition between public and private purchasers by giving people the choice of obtaining their health care through RHAs or through other (non-government) health care plans using a public voucher. However, this plan was not implemented.⁷⁵

Pharmac was initially set up under the Health and Disability Services Act 1993 with the specific purpose of improving the management of government expenditure on pharmaceuticals. Subsidised medicines and related products (the pharmaceutical schedule) were formerly managed by the Department of Health, but the worldwide growth in pharmaceutical expenditure led the four RHAs to form the joint venture Pharmac, the Pharmaceutical Management Agency of New Zealand, to manage the pharmaceutical schedule on their behalf.⁷⁶

Secondary care

Crown Health Enterprises were designed to make hospital care more efficient. They were created as autonomous, publicly owned business units and typically included a single metropolitan hospital or a group of hospitals and related services.⁷⁷ CHEs were established along the lines of the state-owned enterprise (SOE) model and were able to contract with staff, raise capital and operate independently under the Companies Act 1993 as limited liability companies and were subject to commercial legislation.⁷⁸ RHAs funded CHEs on a contractual

⁶⁷ Bloom, A., 'Context and lead-up to health reform' in Abbey Bloom (ed) *Health reform in Australia and New Zealand*, Oxford University Press, Melbourne, 2000, p. 35.

⁶⁸ *New Zealand official year book*, Statistics New Zealand, Wellington, 1997, p.179.

⁶⁹ Coster, G. and McAvoy, P., 'Editorial: Health reforms: a New Zealand perspective', *British Journal of General Practice*, July 1996, pp.391-392.

⁷⁰ Blank, 1994, p. 128.

⁷¹ Barnett, P. and Barnett, R., 'Reform and change in health service provision' in Kevin Dew and Peter Davis (eds) *Health and society Aotearoa New Zealand*, Oxford University Press, Australia, 2000, p. 225.

⁷² Barnett, and Barnett, 2000, p. 225.

⁷³ OECD, 1994, p.238.

⁷⁴ Easton, 2002, 'The New Zealand health reforms in context', June 28, 2002, accessed June 2008-06-04. <http://www.eastonbh.ac.nz/?p=35>

⁷⁵ Ashton, T., Mays, N. and Devlin, N. 2005, Continuity through change: The rhetoric and reality of health reforms in New Zealand, *Social Science and Medicine*, vol 61, No. 2, p253-262, p.254.

⁷⁶ Gauld, 2001, pp. 125-127.

⁷⁷ OECD, 1994, p. 238.

⁷⁸ OECD, 1994, p. 238.

price volume basis. Directors of the CHEs were appointed by the shareholding ministers. The Crown Company Monitoring Advisory Unit (CCMAU) was established to ensure that the CHE directors and boards met their financial targets.

In 1994 there were a total of 330 hospitals in New Zealand with 24,120 beds. One hundred and twenty six of these were public hospitals with 16,468 hospital beds available. The remaining 204 hospitals were privately owned and had 7,652 beds.⁷⁹

Community trusts

Not all Area Health Board facilities were transferred to CHEs. Some facilities were established as community trusts. The majority of community trusts consisted of facilities and services designed to serve local communities. The trusts, like CHEs, were private or independent providers, who owned their facilities and could contract to the RHAs.⁸⁰

Primary care

Apart from relatively small changes to subsidy levels, the organisation of primary care had not changed for decades.⁸¹ During the 1990s however, primary health sector reform made significant moves towards capitated funding⁸² and increased accountability. Regional Health Authorities were given the responsibility for purchasing primary care. This devolved the function from the Ministry of Health and integrated it within the secondary care environment.⁸³ The decentralisation of funding meant that for the first time GPs could negotiate new initiatives, including budget holding.⁸⁴ GPs formed Independent Practitioner Associations (IPAs) which were networks of (30-40) doctors conducting contract negotiations with RHAs for the delivery of primary health care services, including general medical services, maternity services and immunisation.⁸⁵ About 30 IPAs existed in 1996, the largest, ProCare Health in Auckland had 340 GP members.

⁷⁹ *New Zealand official year book*, Statistics New Zealand, Wellington, 1996, p169.

⁸⁰ OECD, 1994, p. 239.

⁸¹ Malcolm, 2000, p. 186.

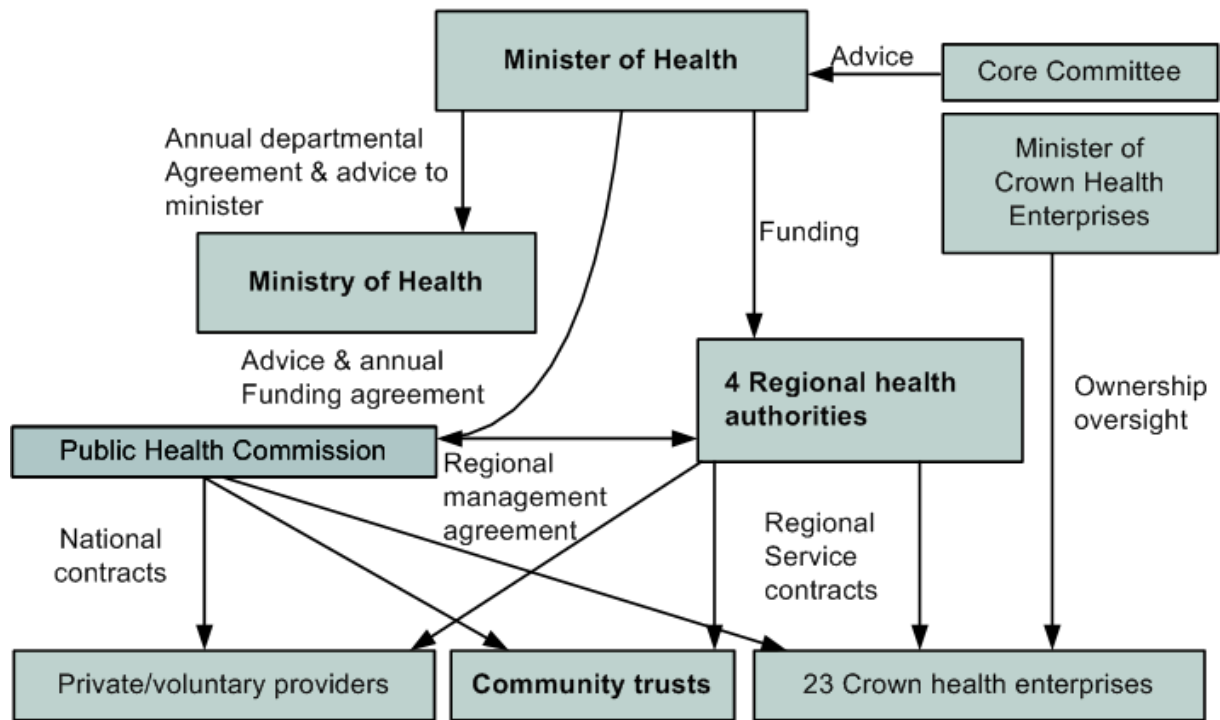
⁸² A capitation based payment system is based on a payment per capita (per head) of population not per visit to the general practitioner.

⁸³ Blank, 1994, p. 128.

⁸⁴ Malcolm, 2000, p. 188.

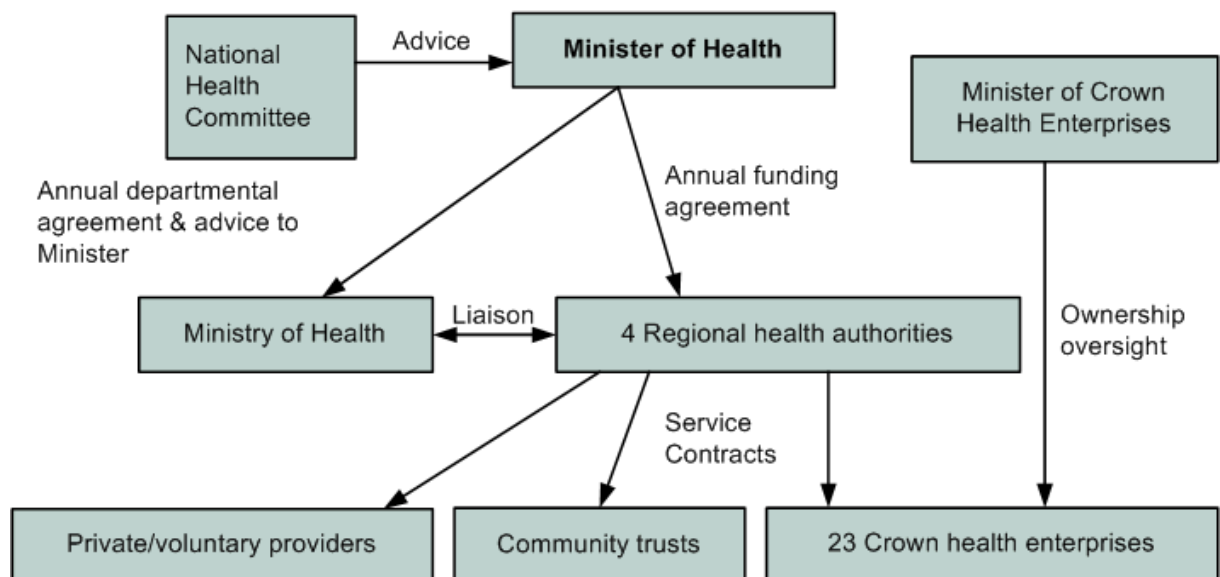
⁸⁵ Coster, and McAvoy, 1996, pp. 391-392.

Figure 3. The structure of New Zealand's health system after enactment of 1993 reforms



Source: Courtesy of Ministry of Health

Figure 4. The structure of New Zealand's health system, 1996



Source: Courtesy of Ministry of Health

The Health Funding Authority and Hospital and Health Services 1998-2001

Overview

The 1996 general election was the first under the new MMP electoral system. A National – New Zealand First Government formed around the Coalition Agreement. The Coalition Agreement on health was the result of negotiations between the two political parties with briefing advice from Treasury, MOH and CCMAU.⁸⁶ The agreement on health policy signalled a shift from the market model towards a more cooperative system.⁸⁷ Key changes indicated in the agreement were: The Minister of Health to combine the portfolios of Health and Crown Health Enterprises; one independent funding body (instead of four RHAs) with a focus on developing good collaborative relationships with providers; CHEs to be renamed Hospital and Health Services; health provision to be ‘business like’ not ‘for-profit’; increased health funding; reduced elective surgery waiting times; boosted child and mental health services; support for Maori health developments; and free doctors visits and prescription medicine for children five years and under.⁸⁸

Advice on the implementation of the Coalition Agreement on health came from the Steering Group chaired by the Director General of Health Karen Poutasi.⁸⁹ Disagreement developed over the Coalition Government’s health policies and the Steering Group’s recommendations. Gauld (2001:147) says that only “elements of the coalition policies were promoted; other changes indicated attempts to repackage ideas introduced in 1993.”⁹⁰ The following 18 months included uncertainty as restructuring proceeded. The coalition partnership eventually broke down in August 1998⁹¹ leaving a minority National Government.⁹² From 1999 the focus was on consolidating the changes, working towards nationally consistent purchasing and service delivery frameworks and stabilising the health sector.⁹³

Summary of significant changes

- Four RHAs become centralised into one Health Funding Authority (HFA)
- CHEs become Hospital Health Services (HHS)
- Centralisation of health funding
- More emphasis on collaboration
- Hospitals to be less commercially focused with some community representation on the hospital boards

Significant policy documents

- New Zealand Government, *Coalition Agreement: health*, 1997

⁸⁶ Gauld, 2001, pp. 144-145.

⁸⁷ Ashton, T. ‘Implementing the Coalition health policy: the baby and the bath water’, *Health Manager*, vol 5, no. 1, 1997 p. 5.

⁸⁸ Gauld, 2001, p. 145 and Martin, J. ‘Health structures and the Coalition’, *Health Manager*, vol 4, no. 2, 1997 p. 3.

⁸⁹ Gauld, 2001, p. 147. and Steering Group to Oversee Health and Disability Changes. *Implementing the coalition agreement on health*, The report of the Steering Group to oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health, Steering Group, Wellington, 1997.

⁹⁰ Gauld, 2001, p. 147 and Laugesen, R. ‘NZ First health imprint getting fainter by day’, *Sunday Star Times*, 7 September, 1997, p. A:2 .

⁹¹ The immediate cause of the breach was a disagreement over the decision to sell the government’s 66% shareholding in Wellington Airport. See Boston, J., S. Church & H. Pearce, ‘Explaining the demise of the National-New Zealand first Coalition’, *Australian Journal of Political Science*, Vol. 39, no. 3, pp585-603.

⁹² Gauld, 2001, p. 143.

⁹³ Gauld, 2001, p. 142.

Governance

While the New Zealand First Party was the primary driver in the Coalition Agreement on health the changes also allowed the Government to remedy some of the problems from the 1993 reforms.⁹⁴ The Coalition Government contained the Minister of Health, Hon Bill English from the National Party and the Associate Minister of Health, Hon Neil Kirton from the New Zealand First Party who differed on many issues and principles.⁹⁵

The Ministry of Health and the Health Funding Authority (HFA) came under increased scrutiny because of the conflict and duplication of work being done. The two bodies encountered difficulty in building a good relationship. The MOH was the principal statutory body charged with monitoring the performance of the HFA. In practice however the HFA had direct access to the political executives which allowed it to circumvent the hierarchy and undermine the policy and relationship building work of the Ministry.⁹⁶ In 1998, the MOH issued a five year strategic business plan for 1997 to 2002 in which it concentrated on its leadership role and focused closely on three core functions: strategic policy advice, performance management of the HFA, and ministerial servicing. It shed a number of its traditional operational responsibilities to the HFA and other yet to be established agencies. These included public health policy and regulation, the licensing of public and private hospitals and rest homes, regulating therapeutic medicines and equipment, acting as secretariat of health occupational registration boards, and the operation of the New Zealand Health Information Service.⁹⁷

Health Funding Authority

Soon after the general election of 1996, work started on the integration of the four RHAs into one central purchasing agency, the Health Funding Authority. In mid 1997 the Transitional Health Authority (THA) was created to assess the problems of the previous purchasing system and to oversee the amalgamation of the four RHAs. Following the Health and Disability Services Amendment Act 1998, the Health Funding Authority replaced the THA and assumed legal responsibility for the purchase and monitoring of health and disability services for the public.⁹⁸ While the primary functions of the HFA were the same as those of the RHAs (see previous section), the rationale for a single funder was to reduce cost shifting among different agencies and service levels.⁹⁹

The HFA reviewed the organisation of purchasing and developed a new national structure to replace the four RHAs. *Transformation 98* (T98), as it became known, had a major effect on the sector; 520 staff were made redundant and 370 new posts created.¹⁰⁰ 1998 was a year of some uncertainty for both purchaser and providers of health as both became acquainted with Government expectations and awaited completion of the new institutions arrangements.¹⁰¹ From 1999 however, collaborative relationships between purchasers and providers began to develop.¹⁰²

⁹⁴ Gauld, 2001, p.142.

⁹⁵ Gauld, 2001, p.143.

⁹⁶ Gauld, 2001, p. 153.

⁹⁷ Gauld, 2001, pp. 156-157.

⁹⁸ Gauld, 2001, p. 149.

⁹⁹ Bloom, 2000, p. 35.

¹⁰⁰ Gauld, 2001, p. 151.

¹⁰¹ Gauld, 2001, p. 152.

¹⁰² Gauld, 2001, p. 152.

In 1998 the National Advisory Committee on Health and Disability Services (commonly known as the National Health Committee (NHC) and formerly the National Advisory Committee on Core Health and Disability Services (1992) (see Core Services in last section)) was set up to provide a second opinion on the range, mix and quality of services the HFA was purchasing, as well as continuing with its existing work programme. The National Guidelines Group was launched under NHC sponsorship and was subsequently funded by the HFA (presently by the MOH) to give evidence based health advice.¹⁰³

Secondary care

The 23 CHEs became Hospital and Health Services (HHS) through the Health and Disability Services Amendment Act 1998. The underlying structures and governance stayed the same.¹⁰⁴ Despite the legislative changes, new policy directions and funding increases, the hospital sector continued to downsize and reconfigure. The mandate to be profit driven was replaced with the requirement to be business like, which still meant that HHSs continued to search for ways to live within their budgets. The Health Funding Authority imposed capped funding growth levels from mid 1997. This meant substantial change in the services delivered by the hospitals. There was a reduction in financially unviable hospital beds. Some services were considered to be non-core business, such as midwifery services, sexual health services, and mental health staff training and a reduction in the provision of services in provincial hospitals occurred. Some of these services were taken over by other HHS or community providers.¹⁰⁵

In 1998 there were a total of 387 hospitals in New Zealand with 30,282 beds. One hundred and nine of these were public hospitals with 14,298 hospital beds available. The remaining 278 were privately owned hospitals with 15, 984 beds.¹⁰⁶

Elective surgery, the national booking system

Long waiting lists for publicly funded, non-urgent surgical and medical procedures are considered to be an indicator of poor hospital performance and a significant political issue.¹⁰⁷ Treatment for patients on waiting lists was traditionally based on list position and not on need. After 1 July 1998, under the guidance of the HFA, all hospitals were required to have booking systems in place.¹⁰⁸ The new booking system saw patients scored against a predetermined series of medical and social criteria, including the level of severity or disability, the capacity to benefit from the treatment, and the ability to work and maintain independence. Patients would gather points until they had enough to obtain an appointment for surgery on a specific date.¹⁰⁹ Those without enough points went back to their GP for treatment or paid for an operation in the private sector. Further changes were made in 2000 when the HFA announced the introduction of a new pilot integrated scoring system in which sub-specialities would be ranked in order of

¹⁰³ Gauld, 2001, pp. 157-159.

¹⁰⁴ Gauld, 2001, p. 159.

¹⁰⁵ Gauld, 2001, p.160.

¹⁰⁶ *New Zealand official year book*, Statistics New Zealand, Wellington, 2000, p192.

¹⁰⁷ See Gibbs, A., Fraser, D. and Scott, J., *Unshackling the hospitals: report of the hospital and related services taskforce*, Hospital and Related Services Taskforce, Wellington,1988. (aka the Gibbs Report), Upton, S. *Your health and the public health: a statement of government health policy*, government printer, Wellington (aka Green and White Paper) and Fraser, G., Alley, P., and Morris, R., *Waiting lists and waiting times: their nature and management*, Core Services Committee, Wellington, 1993.

¹⁰⁸ Gauld, 2001, p. 170.

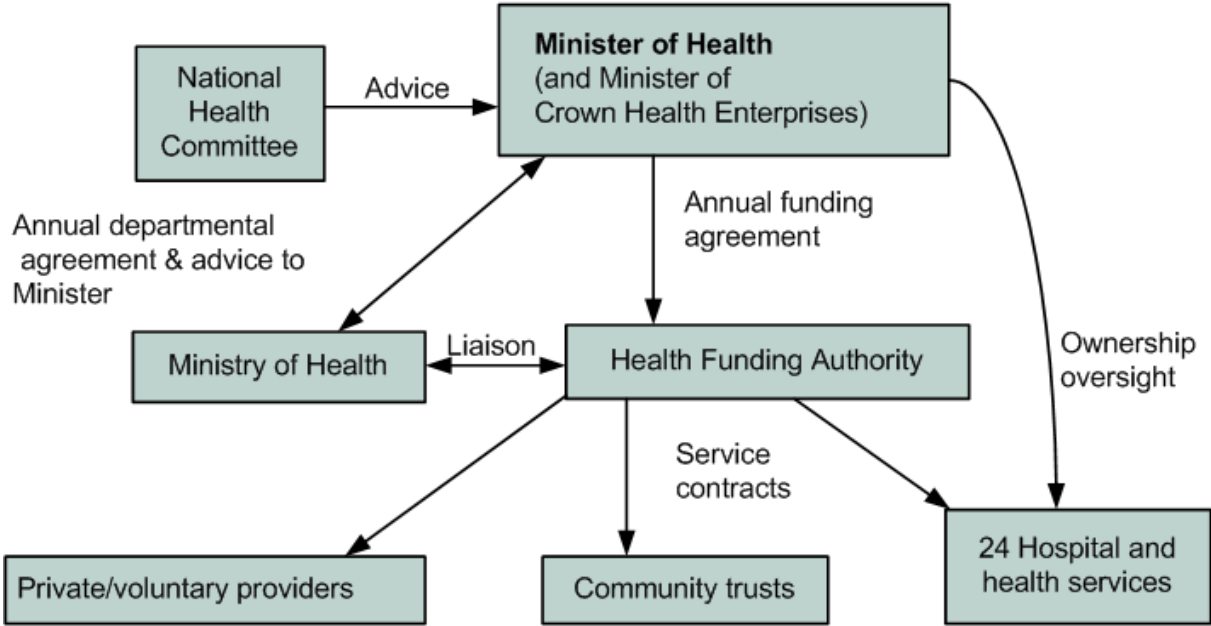
¹⁰⁹ Gauld, 2001, p. 169.

their relative clinical importance.¹¹⁰ New Zealand has been seen as a world leader in the development of scoring and booking systems.¹¹¹

Primary care

Independent Practitioners Associations (IPAs) led the primary care sector during this period and set the scene for a more integrated approach to health with the later introduction of the Primary Health Organisations (PHOs) in 2002. IPAs were a GP-initiated move to increase sector bargaining power while remaining independent. Malcolm (2000:199-200) says that IPAs have made a number of key achievements with improved information systems being an important move in professional accountability. Nearly all IPA practices have computerised age-sex registers leading to the extension of the National Health Index (NHI) to practice registers. The National Health Index number is a unique number assigned to identify patient use of health and disability services and all health care expenditure. At the time of publication, several IPAs were still operating providing management infrastructure and support services for Primary Health Organisations (PHOs).

Figure 5. The structure of New Zealand’s health system, 1999



Source: Courtesy of Ministry of Health

¹¹⁰ Gauld, 2001, p. 172.

¹¹¹ Gauld, 2001, p. 173 and British Medical Association, *Waiting list prioritisation scoring systems: a discussion paper*, 1999. <http://www.bma.org.uk/ap.nsf/Content/Waiting+list+prioritisation+scoring+systems>

District Health Boards 2001

Overview

The release of Labour's 1999 health policy reinforced its pre-election pledge to restructure the health system.¹¹² *Focus on patients: Labour on health* became the basis for the Coalition Government's new District Health Board system. Labour considered the previous Health Funding Authority system to be overly competitive, low in community input, and lacking adequate efficiency and accountability.

Through the *New Zealand health strategy 2000* the Labour – Alliance Coalition Government set about change. With the introduction of the New Zealand Public Health and Disability Act 2000 the Ministry of Health became the principal agency responsible for policy advice, funding and monitoring the health and disability sector; the Health Funding Authority was abolished, with its functions transferred to the newly restructured Ministry of Health; 21 District Health Boards (DHBs) replaced the Hospital Health Services and took responsibility for the purchase and provision of health services. The Primary Health Care Strategy 2001 guided the reorganisation of GPs and IPAs into Primary Health Organisations (PHOs).

Summary of significant changes

- 21 DHBs were established
- Centralisation of health funding with MOH
- Hospitals less commercially focused
- DHB governance by mostly locally elected boards
- Emphasis on preventative health services
- National health goals and targets
- PHOs were established in July 2002 and are funded by DHBs

Significant policy documents

- Ministry of Health, *The New Zealand health strategy*, 2000
- Ministry of Health, *The Primary health care strategy*, 2001

Governance

Soon after the 1999 election the newly elected Labour-Alliance Coalition Government began to restructure the health system. The Health Funding Authority was slowly phased out, with its operations absorbed by the newly restructured Ministry of Health. The Ministry's new role involved national policy development, the purchase of health services, and monitoring DHB performance.¹¹³ District Health Boards New Zealand (DHBNZ) developed out of the old hospital representative body, the Crown Health Association (CHA), to assist the Ministry in its new role.¹¹⁴ DHBNZ represents the DHBs' interests by overseeing and coordinating workforce development, benchmarking and efficiency-related projects, and the development of nationally consistent funding contracts.

Secondary care

In 2001, 21 District Health Boards were established through the New Zealand Public Health and Disability Act 2000. DHBs are Crown entities that are responsible to the Minister of Health and

¹¹² Gauld, 2001, p. 179. Also see New Zealand Labour Party, *Focus on patients: Labour on health*, 1999.

¹¹³ Gauld, 2001, pp.191-192.

¹¹⁴ Gauld, 2001, p. 191.

funded via a population-based formula by the Ministry of Health. District Health Boards are responsible for planning, funding and ensuring the provision of health and disability services to a geographically defined population¹¹⁵, thus removing the funder / provider split, dominant in the previous reforms of 1993-2001. DHBs are required to focus on reducing inequalities among their populations, prioritising health services within budget and providing access to disability support, mental health services and primary health care.¹¹⁶ District Health Boards range in population size from about 30,000 at smallest to nearly 500,000 for the largest.¹¹⁷

DHBs are governed by an 11 member committee; seven locally elected, and up to four ministerial appointees, including the Chair. Each Board must have at least two Maori members (they are appointed if not elected). DHB elections are timed to coincide with local body elections. Under the New Zealand Public Health and Disability Act 2000, DHBs are required to develop partnerships with Maori by developing formal iwi relationships in their regions.

The Crown Entities Act 2004 requires District Health Boards to produce a statement of intent and an annual report to Parliament. Monitoring and accountability of individual DHBs is achieved through Crown funding agreements with the Minister, a district strategic plan and a district annual plan.¹¹⁸ Population based funding was introduced on 1 July 2003. Previously, DHBs were funded to provide hospital services and to administer contracts for providers who were based in their districts.¹¹⁹

In 2002 there were 445 hospitals in New Zealand with 23,825 beds. Eighty five of these were publicly funded and had a total of 12,484 hospital beds available. The remaining 360 were privately owned hospitals with 11,341 hospital beds.¹²⁰ Public health services are split between the 12 Ministry of Health funded (but DHB owned) Public Health Units and some 200 non-governmental organisations (NGOs).¹²¹

Primary care

Since July 2002, the Government's primary healthcare strategy has been to reform the primary health system by encouraging GPs to join non-profit, community-based Primary Health Organisations (PHOs). PHOs comprise doctors, nurses and other health professionals in the community (such as Maori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives). Their role is to serve the health needs of their enrolled populations. PHOs contract to DHBs on a per capita basis to provide primary health care services, including preventative services. The funding is based on the demographic details of the people enrolled with them. Before July 2007 there were two types of PHO, interim and access PHO (high needs populations), each catering to a different demographic population and each with a different funding system.¹²² From July 2007, PHOs with similar demographics and special needs now receive similar funding. In October 2007, very low cost practices were introduced, these practices receive extra government subsidies provided they offer free services for children under six and a range of lower charges for other patients. There are currently 82

¹¹⁵ Ministry of Health. *Annual report 2005/06* including 'The health and independence report'. Ministry of Health, Wellington, 2006. p. 14.

¹¹⁶ Gauld, 2001, p. 190-192, and Gauld, R. 'Health policy and the health system' in Raymond Miller's (ed) *New Zealand Government and Politics*, 4th editions, Oxford University Press, Auckland, 2006.

¹¹⁷ Ministry of Health, *New Zealand health and disability support sector: the organisations, Advice to the Incoming Minister of Health 2005*, p 10. <http://www.moh.govt.nz/moh.nsf/pagesmh/2840?Open>

¹¹⁸ Ministry of Health, *2005*, p 12.

¹¹⁹ Ministry of Health, *Population based funding*, 2008. <http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/262d2106244fe595cc257093000ac48e?OpenDocument>

¹²⁰ *New Zealand official year book*, Statistics New Zealand, Wellington, 2004, p146.

¹²¹ Ministry of Health, 2006. p. 16.

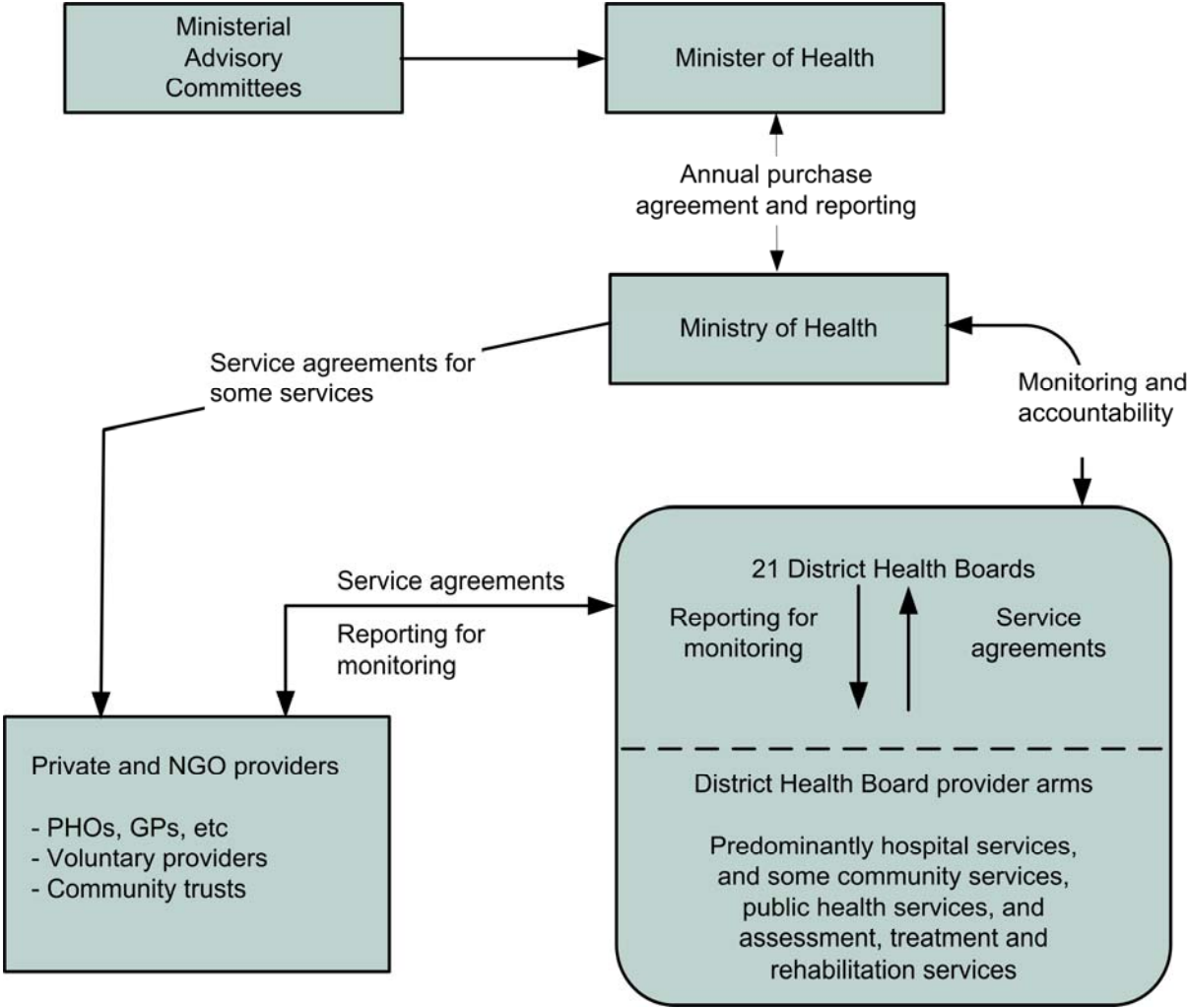
¹²² Hutton, C. 'GPs' fees: survey', *Consumer*, 469, 2007, pp. 16-18.

PHOs around the country with more than 4 million enrollees.¹²³ GPs' fees vary between practices and PHOs, and are monitored by DHBs and an independent Fee Review Committee.¹²⁴ General Practitioners fees are now displayed in GP practices and published on DHB and PHO websites.

Non-government organisations (NGOs)

Many health and disability support services are delivered by NGOs. They include independent community and iwi/Māori organisations operating on a not-for-profit basis. Some organisations identify more closely with other categories, for example third sector organisations, voluntary organisations, community organisation etc, rather than under an NGO category.¹²⁵

Figure 6. The structure of New Zealand's health system, 2008



Source: Diagram based on the Ministry of Health *Structure of the New Zealand health and disability sector*. www.moh.govt.nz

¹²³ Ministry of Health, *Enrolment demographics*, <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-pho-enrolment#demographics>
¹²⁴ Gauld, R. and N. Mays, 'Reforming primary care: are New Zealand's new primary health organisations fit for purpose?' *British Medical Journal*, Vol. 333, 2006, pp. 1216-1218.
¹²⁵ Ministry of Health, *Health and disability non-government organisations*, <http://www.moh.govt.nz/ngo>

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