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## II. INTERNATIONAL REPORT

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### Health Care Financing Reform In New Zealand

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by Gordon K. MacLeod

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Radical restructuring of health care financing in New Zealand began almost immediately after the 1990 election of the National (conservative) Party. Even in such a small country, it took almost two years just to enact legislation to recast the future course for financing health care services. The new policy embraced a free-market approach. Quasi-governmental agencies would control costs by contracting competitively with doctors and with hospitals to provide publicly funded health care services.

Within months after enactment of New Zealand's health care financing law in August 1992, widespread opposition to the reforms had emerged, substantially affecting public support for change. As the mid-1993 start-up date for the reforms approached, negative news reports proliferated about the new government's efforts to reorganize health care financing. A crescendo of media criticism reached a climax during the first half of 1993. Both public and professional protests so frustrated the government that it failed to achieve many of its objectives for overhauling health care financing and contributed to almost defeating the incumbent party. New Zealand's experience with health care financing reform may well have international relevance.

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### New Health Care Financing Policy

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On 30 July 1991 the recently appointed minister of health introduced the new health care financing policy to the public in a monograph entitled *Your Health and the Public Health, Summary*.<sup>1</sup> In the official Summary document, concerns expressed by the New Zealand government were similar to

those expressed now by the US. government: "In the present climate, defining essential services is crucial. . . . Open-ended demand-driven reimbursement regimes are incompatible with the Government's need to constrain expenditure. This is all the more important given that demand for health-related expenditure will increase as the population ages. Rising consumer expectations and the escalating cost of technological advances also pose challenges."<sup>2</sup>

The new policy envisioned that (1) voluntary sector contracting with Regional Health Authorities (RHAs) would be ensured by government; (2) responsibility for managing funding would be placed in four RHAs; (3) "user-pays" part charges (copayments) would be extended to publicly supported hospital services and outpatient visits to specialists on a means-tested basis; (4) resource allocation would be less centralized and less politicized; (5) core health services, the services for which government assistance is available, would be explicitly defined by the government; (6) funding for the education and training of health professionals would be reviewed in line with wider reforms of education and training policy; (7) funding for clinical training would be separately contracted for with health service providers; (8) incentives would be created for monitoring the quality of care; (9) government funding for dental services and ambulance services would be transferred to the RHAs; (10) the Department of Health would be converted from an operational department to a policy advisory function; and (11) the government would set up a Public Health Commission to coordinate and contract for the provision of public health services, and a Public Health Agency to provide regionally based public health services.

If contracting for health care services succeeds in New Zealand, that country will join several others already moving' to separate payers from providers by the establishment of health services contracting. This trend was described by British economist Jeremy Hurst in a study of seven Organization for Economic Cooperation and Development

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(OECD) countries conducted in 1989.) Hurst concluded that "there are signs of convergence on the public contract model and increased reliance on market or quasi-market relationships that permit governments to regulate at arm's length." He further pointed out, "The public reimbursement model [for example, US. Medicare] is vulnerable to failures of cost containment. The public integrated model [for example, New Zealand's public hospitals] is vulnerable to failures of microeconomic efficiency. The contract model seems to have the potential for combining macroeconomic . . . with microeconomic efficiency." He went on to say that the contract model "is also the most suitable of these three models for promoting appropriate autonomy among providers and a measure of self-regulation."

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## Cross-National Considerations

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New Zealand and the United States have displayed an uncanny similarity in demographic and public health data, even though the two countries have had distinctly different developmental histories in social welfare and private-sector health care financing. Since 1938 general tax revenues in New Zealand have supported national health financing with universal coverage in the public hospital system. By contrast, the United States has used a pluralistic approach for financing health care, with a social insurance program for the elderly and some poor persons and private coverage for the rest of the population. Although New Zealand has many fewer people and is much less densely populated than the United States, it is similar in many other respects.

Health insurance. About 45 percent of New Zealanders carry some kind of private health insurance coverage, primarily to expedite access to elective medical and surgical procedures. Private health insurance is often an employment-based fringe benefit that pays for a small fraction (about 5.2 percent) of total health care expenditures.<sup>4</sup> New Zealand's largest health insurance company initially opposed the 1992 reforms, but later the chairman stated that "the release of such

a blueprint for the future was most welcome to those of us who had long recognized the shortcomings of the existing arrangements."<sup>5</sup> All New Zealanders have been eligible to receive inpatient and outpatient public hospital care at no charge. In addition, patients outside of the hospital have been subsidized for medical care, children's dental care, and prescription drugs in the private sector.

In the United States, about 60 percent of the population has employment-based private insurance, which typically covers most health care expenses by reimbursing the patient or provider or by paying for managed care through a health maintenance organization (HMO). The self-employed, the uninsured, and those eligible for government-funded health care under Medicare (serving the elderly) and Medicaid account for the remaining 40 percent of the population.

**Health status and demographics.** After more than fifty years of universal medical care coverage in New Zealand, health outcomes are no better than those in the United States, where at any given time during the year some 15-20 percent of its people are not covered by any health insurance.

Recent census data from both New Zealand and the United States reveal that approximately 12 percent of both populations are over age sixty-five.<sup>6</sup> In 1989 overall life expectancy at birth was almost identical in the two countries; New Zealand males have slightly longer life expectancies, while females can expect to live slightly shorter lives than their U.S. counterparts.<sup>7</sup>

The percentage distribution of minorities in New Zealand is 12 percent Maori, 6 percent South Pacific Islander, and about 2 percent Asian, approximately the same as the African American, Hispanic, and Asian/South Pacific Island populations in the United States, respectively. There are distressing similarities in social discrimination, health status, and health outcomes for minorities in both countries. Just before start-up of the reforms in New Zealand, the major Auckland newspaper reported that Maori men's death rates from potentially preventable disease such as tuberculosis are much higher than death rates among non-

Maori.<sup>8</sup> Indeed, a 1986 report showed tuberculosis death rates among the Auckland Maori to be seven times higher than those for the general population.<sup>9</sup> In the United States, deaths from tuberculosis have a far higher prevalence among African Americans and Hispanics than among other Americans.<sup>10</sup>

In 1987 the New Zealand Maori infant mortality rate was 60 percent higher than the non-Maori rate; for that same year, the U.S. black infant mortality rate was 100 percent higher than the overall infant death rate." Both U.S. and New Zealand infant mortality rankings among OECD countries have worsened over the past two decades: New Zealand's ranking declined from ninth in 1970 to twenty-first in 1989; the U.S. ranking declined from fifteenth to nineteenth during the same time period.<sup>12</sup>

In 1987 life expectancy in New Zealand was five years longer for non-Maori than for Maori, while in the United States whites expected to live almost six years longer than African Americans.<sup>13</sup>

**Physicians and hospitals.** Overall, physician-to-population ratios in the two countries also are comparable. In June 1991 New Zealand reported one doctor holding an annual practicing certificate per 490 people, while U.S. data showed one such physician per 500 people.<sup>14</sup> The 1991 public hospital occupancy rate in New Zealand was just below 60 percent.<sup>15</sup> That same year, the U.S. community hospital occupancy rate was just above 60 percent but dropping.<sup>16</sup> Approximately 35 percent of total health care expenditures are spent by the 12 percent age sixty-five and over in both New Zealand and the United States.<sup>17</sup>

**Differences.** Despite these similarities, several important differences exist between the health care systems of the two nations. First, New Zealand's very much smaller private health insurance industry influences health policy nowhere nearly so much as does the health insurance industry in the United States. Second, the percentage of gross domestic product (GDP) spent on health care in 1991 was 7.3 percent in New Zealand, compared with 12.1 percent in the United States, but both are rising. (GDP

estimates for 1994 are now 7.6 percent and 14 percent, respectively.) Third, the New Zealand government has budgetary authority over its public hospitals and strictly limits capital expenditures both for new facilities and for technological advances.

Fourth, further control over health care financing derives from the percentage of national health care expenditures paid from government revenues: about 80 percent in New Zealand, compared with just over 40 percent in the United States. Fifth, the percentage of primary care doctors in New Zealand is significantly higher than in the United States: 50 percent versus 35 percent, respectively. Sixth, 15 percent of the 18,000 elective surgery patients in New Zealand public hospitals waited at least a year for an operation in 1988, compared with a negligible number in the United States, mostly those waiting for transplants.<sup>18</sup>

Politically speaking, because of the difference in legislative structure between the two countries—a bicameral congress (two legislative chambers) in the United States and a unicameral parliament in New Zealand—it is inherently more difficult for the U.S. government to enact health care financing legislation than for New Zealand to do so.

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## Role Of The Media

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Throughout New Zealand, resistance to the health care financing reforms came from all quarters: individuals, citizens' groups, social welfare advocates, partisan politicians, organized medicine, the nurses' association, hospital managers, long-term care administrators, the health insurance industry, lobbyists, minorities, young conservatives, and pundits.

The news media also entered the fray, focusing attention on health care reform through a plethora of editorials, almost daily letters to the editor, and radio and television coverage. Commentary focused on common issues in both countries: core services, collecting data, contracts between providers and payers, free choice of doctors, rationing, means testing, alternative care plans, and profit-making health care enterprises. One

editorial indicated that concerns expressed by New Zealanders will be much the same for Americans and that New Zealanders are just as ambivalent about health care reform as Americans are.

The public and professional outcry was so strong that it actually drove the National Party then in power in Wellington to rescind most of the changes it had already activated as it prepared for implementation of the reforms on 1 July 1993. The furor is undoubtedly similar to what we can expect in the United States over the next several years if health care financing reform is enacted and implemented.

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### **Transitional Phase, 1991-1993**

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Although the opposition Labour Party strongly opposed many aspects of the reforms proposed by the National (conservative) Party from mid-1991 to mid-1993, both parties had recognized the need to restructure the financing of health care services since 1984.

The most controversial change in health care financing during the transitional period was the institution of a means-tested copayment for public hospital care, so-called user-pays reforms. No individual payments for public hospital care had been required under New Zealand's acclaimed Social Security program. The new charges were set at \$50 New Zealand (U.S. \$27) per night and were scheduled to top out at N.Z. \$500 per year for a maximum of ten nights in the hospital, including outpatient care. Each outpatient visit would be charged a copayment of N.Z. \$31.19. New Zealand's assessment of part charges for hospital-based care brought the total number of OECD countries engaged in the user-pays practice to twelve.

When user-pays part charges were introduced in New Zealand 1 February 1992, virtually every daily newspaper ran banner headlines signaling widespread opposition to the changes. Protesters held marches and demonstrations outside public hospitals throughout the country. Vigils were held outside Auckland's public hospitals in hopes of getting the minister of health to abolish

the newly imposed hospital charges.<sup>20</sup> In addition, medical specialists from the New Zealand Medical Association (NZMA) called upon the government to put the payment of part charges on hold.

Eventually, public pressure coerced the government to withdraw the inpatient part charges before the new program was implemented, but outpatient charges remained intact. Shortly thereafter, a physician acknowledged that he had admitted a patient to the hospital overnight free of charge to avoid having him pay the N.Z. \$31 (U.S. \$17) outpatient charge.<sup>21</sup>

Authorized increases in payments to doctors and charges for prescriptions through means testing were seemingly less troublesome to the public and to the opposition Labour Party. In a keynote address, the Labour Party health spokesperson (later to become the party leader) made no specific reference to eliminating means testing for primary care services if the party were to take over the reins of government in the upcoming elections.<sup>22</sup>

Despite government denials, some thought that the new health care financing policy threatened to reduce access to care because of its effect upon payment practices for public hospital care that had been in effect for more than half a century. Or, as one newspaper speculated, at the very least the government could introduce a two-tier system for hospital care.

As if in response to the newspaper article, the government openly announced its intention to establish an "innovative" two-tier payment system for care in public hospitals because of the hospitals' low occupancy rates. Two days later, the minister of health himself said, "Private patients in public hospitals could have better facilities than public patients but would receive the same [medical] care."<sup>23</sup> In his opinion, areas of public hospitals could be leased out for private patients once the reforms took effect 1 July 1993. Despite low occupancy rates in public hospitals, many new private hospitals were being built.

The medical profession speaks out. About half of New Zealand doctors are general practitioners (GPs), highly respected

throughout the country. Many GPs preferred the freedom to choose between negotiating a contract with the RHA and being reimbursed for each service under the entrenched social welfare system.

The NZMA, which represents all medical practitioners throughout the country, opposed the reforms; the NZMA chairman repeatedly stated that it wasn't necessary to fix a system that wasn't broken. Moreover, he claimed that no one had yet modeled the new arrangement, and so the government was unable to prove the effectiveness of the proposed changes. Also joining the rout of government were nursing home owners, many of whom were physicians.

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### **New Health Management Structure**

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The New Zealand government claimed that it had borrowed heavily from the private sector in its effort to design a quasi-private management structure for the new health care financing system.<sup>24</sup> In May 1993 it was announced that the new hospital managers would work under an incentive arrangement instead of straight salary, although by U.S. standards they would receive modest incomes averaging N.Z. \$121,000 (U.S. \$62,000) plus fringe benefits. With the newly introduced incentive, they could receive a 20 percent bonus. The highest-paid health manager in New Zealand—the administrator of the country's largest medical complex, which includes the four major teaching hospitals related to Auckland University—could then receive as much as N.Z. \$230,000 (U.S. \$120,000), including all fringe benefits and the full bonus for exceptional performance.<sup>25</sup>

In its crusade to convert health care financing from social insurance to managed competition, the government recruited the managing director of the Lion Liquor Retail Group to be the chief executive officer of the hospitals affiliated with the University of Auckland. The former brewery officer, without any health management experience whatsoever, now presides over more than 6,000 government employees on the four hospital staffs and administers an annual

budget of about N.Z. \$350 million. Upon his appointment, he remarked, "I am not being facetious when I say that one of my first jobs is to get to a speech therapist to help me to pronounce all those medical terms and go to the Oxford Dictionary after that to comprehend their meaning."<sup>26</sup>

The New Zealand Herald reported that another consequence of the financing reforms was the exodus of formerly employed hospital managers to Britain, Australia, and elsewhere, just when they were most needed in New Zealand.<sup>27</sup>

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### **Lessons For Other Countries**

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The travail of implementing health care reform legislation in New Zealand abounds with invaluable lessons for other countries interested in reforming their own health care financing systems. Many of the challenges faced by New Zealand may soon be braved by the United States, by other OECD countries, and perhaps by the newly sovereign East European nations.

The United States clearly stands to benefit from examining New Zealand's experience. Not unlike the United States, the New Zealand government had proposed to alter its health care financing system to require the use of substantial copayments along with a contract mechanism to pay providers of health services. Regrettably, the simplicity of the message surrendered to complexity and confusion, caused in part by the government itself.

The first lesson is that New Zealand's long history of a government-owned and -operated system for paying for public hospital care produced practically no difference in health outcomes when compared with data from the United States, where health care financing has had a more tangled history. Second, the New Zealand government failed to explain the new plan adequately both to its citizens and to special-interest groups. This is especially significant when one considers that the U.S. health care system, and thus U.S. health reform proposals, is far more complex than systems existing in New Zealand or any other Westernized society.

Third, any undertaking so personally intimate and vital as the delivery of health care services must be piloted first.

Finally, while it is too early to report results, the New Zealand reforms implemented 1 July 1993 are far from the model originally envisioned. One measure of success will be the number of doctors willing to enter into contracts with the RHAs; another will be the length of time patients must wait for an elective procedure to be performed in a public hospital.

A germane political consideration for the United States is the outcome of the 6 November 1993 parliamentary election in New Zealand. Obviously, an important issue in the election was health care reform. Despite overall improvement in economic conditions in New Zealand, the National Party lost its sixty-three to thirty-four vote majority in Parliament and ended up a single vote ahead, forty-nine to forty-eight.<sup>28</sup>

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#### NOTES

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