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.