Your Health

A Statement of Government Health Policy

by the

Hon. Simon Upton

Minister of Health

1991
Your Health & the Public Health

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A Message from
the Minister of Health

Reform of our health system is worth doing only if the outcome is a better system with benefits for all New Zealanders. We must be quite clear about the goals we set ourselves and realistic about what can in fact be achieved.

The primary objective of this reform process must be to secure, for everyone, access to an acceptable level of health care. Low income should not create a barrier to quality care.

We need a health system that is flexible enough to respond to rapidly changing medical technologies, treatments and practices and to relate to changing contemporary lifestyles. New Zealand is well behind the rest of the world in making greater use of day surgery, moving to shorter hospital stays, and embracing treatment options in the community outside of hospital settings.

To make the most of these possibilities, we need a less centralised and less politicised way of allocating resources. The present system of funding health care services paralyses major decision-making at area health board level. Boards are supposed to reflect the needs of the community they serve. Their funding, however, is determined by the Government. When boards attempt strategic change, they frequently face intense public pressure to stick with the status quo. Faced with cost constraints, but prevented from changing to effective alternative ways of delivering care, boards have little option but to cut services.

Financial constraints also mean that priorities must be addressed. Demand for health care will always outstrip the resources available. It is more honest to define which services will be made available to all, rather than to continue to place patients on waiting lists where they may stay for years without treatment. In the present climate, defining essential services is crucial. Countries much richer than ours are having to face these issues. As a heavily indebted nation, New Zealand cannot avoid facing the limitations that its income imposes on it.

Similarly, the Government can no longer afford to commit itself to providing social services without being able to limit its liability. Open-ended, demand-driven reimbursement regimes are incompatible with the Government’s need to constrain its 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.

Finally, sufficient resources must be set aside for effective health promotion and disease prevention campaigns. Public health programmes are essential
long-term investments in health for the whole population. These activities need to be more visible to the public, with their funding specifically defined and protected.

When I asked the Health Services Taskforce to examine possible future options for health care in New Zealand, I was acutely conscious that numerous reports on the health system had been produced in recent years, with indifferent results.

The time has come for action. We must confront the fact that the system is in trouble, and face up to the magnitude of the problem. Having done so, we must start building a revitalised system, which is both strong and flexible enough to serve all New Zealanders better in future. I have issued a Statement of Government Health Policy—Your Health and the Public Health—which sets out the foundations of that new structure.

It proposes extensive reform of the public health system. But it is still a public health system. The reform is, expressly, not ideologically driven. It is a long overdue reorganisation of a publicly funded system. For that reason, I am hopeful that a wide range of groups will be prepared to assist the Government in seeing that implementation of the reforms is given the very best chance.

By leaving the question of financing open for public debate, the Government has acknowledged the need to build a system that is widely supported, thereby securing a measure of stability in the medium term.

The Hon. Simon Upton
Minister of Health
Executive Summary

• A new structure for the provision of publicly-funded health care services will be introduced to:

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

• Commissioners will be appointed to take over existing area health board functions as a first step towards the introduction of a new structure for the administration of publicly-funded health services.

• The purchasing and provision roles currently performed by area health boards will be separated.

• Four Regional Health Authorities (RHAs) will be established to manage the purchasing of, and contracting for, health services throughout New Zealand.

• The RHAs will take over responsibility for funding both primary care, provided by general practitioners and others in the community, and hospital-based care.

• Unlike area health boards, the RHAs will not own any hospitals or other facilities, so they will feel no obligation to concentrate funding on their own hospital-based services.

• The RHAs will purchase services from the public, private or voluntary sectors.
EXECUTIVE SUMMARY

- Most big public hospitals will be established on more business-like lines as Crown Health Enterprises (CHEs), with appointed boards of directors drawing on business as well as health sector expertise.

- A Minister of Crown Health Enterprises will be appointed to represent the Crown's interest as the owner of public hospitals and associated services.

- Many smaller communities will be given the opportunity to take over their local hospitals and run them as community trusts.

- People will be given the choice of obtaining their health care through RHAs or through other (non-Government) health care plans.

- The Government will explicitly define core health services, the services for which Government assistance is available.

- The Government will appoint a National Advisory Committee on Core Health Services to establish a process of public consultation about core health services.

- The current system of user part-charges will be rationalised.

- User part-charges will be extended to some aspects of hospital services and outpatient visits to specialists for people on middle and upper incomes.

- Services currently provided by area health boards will continue to be free of charge to beneficiaries and people on low incomes.

- Accident compensation levies will be adjusted to cover more of the costs of health care for work-related accidents and motor vehicle accidents.

- A system for managing the transition to the new structure has been designed.

- Public comment will be sought before major decisions are made to determine:

  - how we should determine the limits to core health services, the services for which Government assistance is available;

  - the option to be adopted for financing health services

  - from taxes, as at present; or

  - from a new system of health premiums.
• A new, separate system for the promotion and protection of public health, through activities such as the monitoring of hygiene standards and publicity campaigns promoting healthy lifestyles, will be established.

• A timetable for the implementation of all key decisions by the 1993/94 financial year has been established.

• The elements of the new health sector are set out in the following diagram.
The New Health Sector

Key
- Contracts
- Regulatory Oversight
- Advice
- Monitoring

Private and Voluntary
Government
INTRODUCTION

For many decades up to the 1960s, New Zealand’s health system was regarded as one of the best in the world, envied and praised by other countries. Even today, when there is a widespread feeling that the health system is failing, many strengths remain. New Zealand has a highly trained, professional workforce, providing good-quality primary and secondary care. Those who suffer life-threatening illnesses or injuries can expect to get prompt and high-quality treatment. Area health boards have made some gains in efficiency, largely as a result of budget pressures and the introduction of general management reforms.

However, morale in the health services is low and there is increasing public concern about the way in which health care is delivered. Public hospital waiting lists for many conditions are unacceptably long. Queues for surgery vary in length across the country. A person may wait years for an operation in one place and yet be able to have it performed within months, or even weeks, in another centre. Some low-income people are having difficulty paying for primary services such as doctors’ visits and prescriptions.

Dissatisfaction with health services is not unique to New Zealand. At the moment 18 out of the 24 member countries of the Organisation for Economic Co-operation and Development (OECD) are either planning or implementing health reforms. Like New Zealand, they are grappling with the problem of ever-increasing demand for health services as a result of an ageing population; new technologies and higher consumer expectations.

Pressures will increase in the next few decades, particularly as a result of demographic changes. In New Zealand, people aged 60 and over currently consume an estimated 44 per cent of Vote: Health. The number of people aged 60 and over is projected to increase by almost 70,000 over the next 10 years, and the system must be able to cope with their growing health care needs.

New Zealand’s deteriorating economic position has exacerbated its problems. Over the past two decades the New Zealand economy has been growing more slowly than other OECD countries. As a result we have not been able to afford the same level of improvements in health and other social services as other countries, though for too long we have attempted to have what we cannot afford.

Expenditure on health in New Zealand is largely funded by the Government. It contributes nearly 80 per cent of health spending, largely through the Department of Health. Between 1980 and 1991 the Department of Health’s budget
increased from $1.1 billion to $3.8 billion, an increase of some 27 per cent more
than the increase in consumer prices over that period.

Despite increasing expenditure on health, the 1980s were marked by mounting
dissatisfaction with the way in which health services were delivered in New
Zealand. Numerous reports were produced which identified public concerns
about health care and reflected a growing desire for community involvement in
the resolution of these issues.

Two widely publicised reports which provided clear diagnoses of the ills of the
primary and secondary systems respectively, and proposed reforms, were the
Health Benefits Review, *Choices for Health Care* (1986)<sup>1</sup>, and the Hospital and
Related Services Taskforce, *Unshackling the Hospitals* (1988)<sup>2</sup>. The recom-
mendations of these two reports were largely ignored.

By the end of 1990, concern about health care had reached an unprecedented
level, with fresh evidence coming to light almost daily of failures in the system.
Against a background of continuing fiscal crisis, the Government decided it
must address the problem of how health care services are to be funded and
provided in the future.

**Why Change is Needed**

The structure of New Zealand’s health system dates back to the 1930s. Only ad
hoc changes have been made since, so some fundamental features have
remained unchanged for more than 50 years. Given the changes in population,
expectations and technology, the present system is unsustainable in the medium
to long term. Even with current funding levels, it can continue to operate
adequately for only a few more years.

There are already signs of physical decay. Hospital buildings are deteriorating
because many area health boards have neglected maintenance. The Health
Services Taskforce heard of one hospital which alone required over $1 million
of maintenance work. All the work had been deferred because no funds had
been set aside. Ageing equipment is not being replaced, even though in some
hospitals it is decades old. This running down of resources cannot go on for
much longer. There will soon be an urgent need for massive reinvestment in

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<sup>1</sup> *Choices for Health Care*, Report of the Health Benefits Review, chaired by Professor Claudia Scott,
Wellington, 1986.

capital stock. It is doubtful whether, in the current structure, area health boards are able to adequately confront this problem.

Area health boards have been trying hard to cope in difficult circumstances. Many have improved the way they manage their resources. However, when boards attempt to make major strategic decisions, they are hampered by the politicisation of the decision-making process.

For example, a board may develop a strategic plan which it considers is appropriate for the region as a whole. However, announcement of any strategy is sure to bring vehement protests from numerous interest groups, and public campaigns against change. Often this sort of response effectively paralyses boards' ability to take decisions.

This makes it very difficult for boards to change basic ways of doing things, even when they can see the clear advantages of doing so. One of the problems with the present system is that too much money is tied up in staffing and running big institutions. The trend worldwide is away from monolithic structures, which tend to be both unwieldy and unresponsive, and towards day-stay units, multi-speciality practices, and other more personal and “user-friendly” services. Such services offer choice and diversity and encourage greater individual responsibility for health. Often they offer better value for money.

At present, when a board decides, for instance, to move resources out into the community and close part or all of a big hospital, it is almost sure to face public opposition and hostility. Until the system itself changes, there is little chance of opportunities opening up for a diverse new range of health services.

A further concern is that public health activities, such as immunisation and other disease prevention programmes, fare poorly under the present system, even though they are essential for the long-term health of the population. Much lip-service is paid to the importance of public health functions, but when money gets tight, disease prevention and health promotion programmes frequently fall victim to area health board cost-saving drives.

It is clear that the present system will not be able to deliver accessible and affordable care to New Zealanders in the future. Simply injecting more money into the system is not, by itself, the answer; it would not guarantee more and better health services, because the system is structurally flawed.

The Government is well aware of the magnitude of the task it has set itself in reforming the financing and delivery of health services. The health system is huge and cannot be changed overnight. It contains many interest groups,
including powerful professional organisations, which have always been protective of their territory. However, the difficulty and complexity of reform cannot be a reason for paralysis on the Government's part. All over the world health care is changing. The Government cannot sit back and watch New Zealand's health system stagnate.

The Role of the Taskforce

The Government recognises that the public, and many of those employed in the health sector, are tired of endless reports and want action to rectify what is wrong with the health system. At the beginning of this year the Minister of Health set up a small Taskforce. Members were drawn from the health and business sectors. The Minister made it clear that he did not want the Taskforce to "reinvent the wheel". Rather, its brief was to analyse all the reports and research already done on health sector problems and solutions. That would include looking at experience overseas. However, the Taskforce was to advise the Government on how to achieve a New Zealand solution—one which was appropriate to our unique history and social fabric. As well as examining previous reports, the Taskforce received over 120 submissions from organisations and individuals interested in health care and its delivery.

The Taskforce was given a set of objectives to guide its thinking. These emphasised the need for recognising and fostering individual responsibility for health, and for appropriate disease prevention and health promotion activities. These contribute to the objective of ensuring that health costs are shared fairly between the Government, private funders, health providers and consumers.

The Taskforce was instructed to develop a model in which everyone, regardless of income, had access to an acceptable level of health care; in which the right mix of services was delivered with maximum efficiency; and in which, where possible, consumers had a choice of services.

The Taskforce presented its findings to the Government in a number of briefings and papers. The Government considered its advice and recommendations before identifying key issues and formulating its own strategy. This Statement outlines the Government's diagnosis of the system and its strategy for the future delivery of health care in New Zealand. It sets out the decisions the Government has made and gives a timetable for implementation. It also

3 See Annex 2 for Taskforce membership.
4 See Annex 1 for Taskforce terms of reference.
identifies some issues on which further consultation is sought, including options on how health care should be financed.

Problems with the Current System

Analysis of the many reports produced over the last decade identifies a number of problems with the health system.

Public Hospital Waiting Times Are Too Long

Waiting lists are too long. Many people wait more than a year, often for pain-relieving surgery for conditions which seriously affect their lives and often their livelihood. This can result in considerable personal, social and economic cost.

In one case outlined to the Taskforce, a 56-year-old Auckland man was placed on a hospital waiting list after he was diagnosed as having cataracts in both eyes. Treatment is through simple surgery which can be done without overnight hospital admission. During the 18 months he waited for surgery, his eyesight deteriorated, he lost his job, and was placed on a sickness benefit. After his operation he was unable to find work and so remained on the sickness benefit, until moving to Guaranteed Retirement Income when he turned 60.

A general practitioner (GP) told the Taskforce: “I have a patient languishing on the orthopaedic waiting list for a hip replacement who has suffered almost complete destruction of his lifestyle, his occupation and his mental state because of severe disabling pain in his hip. Despite repeated requests from myself and others his operation is still months and months away.”

A list of waiting times for operations, prepared in May 1991 by a large area health board, lists the waiting time for urgent hip replacements as one to three years. It gives the waiting time for “routine” hip replacements as two to four years, but notes that “very little routine surgery is being done at the moment due to cutbacks”.

Several factors lead to long waiting lists. Within the present structure, often the easiest way for boards to respond to funding constraints is to cut services. Instead they should be looking at how to make efficiency gains. This can often be achieved by using alternative and more cost-effective services. For instance, a board might be able to increase throughput by closing an inpatient ward and using the money to purchase the services of a day surgery unit. However, boards have little incentive to search for more efficient and innovative ways of delivering services. This will continue until the purchasing and provision roles of area health boards are separated.
Waiting lists are not always well managed. A recent investigation into the waiting time for ear, nose and throat (ENT) surgery in one of the larger boards revealed that 15 per cent of those on the list no longer required surgery. The eligibility of several hundred others was in question as they were waiting to have their noses straightened. The clinicians were sure the operations were necessary and appropriate, but others expressed doubt about whether this was the case.

Meanwhile many people who want and need ENT surgery have been waiting for years. The parents of a boy who has been waiting more than four years to have troublesome tonsils and adenoids removed sent the Taskforce a copy of a letter they received in February this year, which stated: “I am writing to inform you that the management has cut our operating time by 50 per cent. This unfortunately means that an already long waiting list will become longer still. The same situation pertains in other surgical departments.”

The investigation into ENT waiting lists also revealed that those who had their initial consultation as private, paying patients could see a consultant within weeks and get on to the public hospital operating waiting list. However, those who had their initial consultation as public outpatients had to wait almost a year for an appointment, thereby adding a year to their wait for surgery.

Another factor affecting waiting lists is the lack of adequate rehabilitation or long-stay facilities into which people can be moved once their conditions improve. This means that people who no longer need “acute” care stay on in “acute” beds simply because there is nowhere else for them to go. A surgeon working in a hospital in a large city cited three such cases, all collected within a week:

- A 20-year-old man had been occupying a bed in an acute ward for a month because there was no other accommodation for him during his recuperation and rehabilitation.

- A teenage boy with head injuries had occupied a bed in an acute ward for three weeks, because there was no other accommodation available for him during his rehabilitation.

- An 80-year-old woman with a fractured hip was occupying a bed in an acute ward because of the lack of an available bed in a geriatric unit.

Problems with lengthening queues are compounded by the lack of any explicit definition of fundamental or “core” treatments which public funds should be used to provide. This means patients do not know what services they are entitled to, because it has never been defined. One example, referred to earlier, is the debate over whether nose-straightening operations should be performed in
public hospitals when the waiting times for other ear, nose and throat surgery are already so long. An explicit list setting out core health services can be used to define the “ceiling” on the Government’s obligations to assist people’s access to health care. By doing so, it protects priority health services.

**Conflict in the Roles of Area Health Boards**

Area health boards not only purchase, but also provide, services. Much recent criticism of area health boards relates to the perceived conflict between those roles. There are incentives for boards to buy their own services rather than contract with the most cost-effective and appropriate supplier. Boards are concerned that contracting out could result in board staff losing jobs and board facilities lying empty.

Overall, people lose out because the system is geared to what existing facilities can most conveniently provide, rather than responding to people’s needs. The balance of funding is heavily weighted in favour of hospitals and secondary care, with the bulk of resources locked up in large institutions. There is little incentive to move to community, day-stay or outpatient care, even where this would serve patients better and offer greater value for money.

Lines of responsibility between boards, the communities they serve and the Minister of Health are blurred and confused. Elected board members are presumably responsible to the communities which elected them, but have no responsibility for raising the money boards receive. The Government does that, and it is very easy to blame the Government for spending too little. The Minister is responsible for allocating funds to boards. The control he has over how those funds are spent is minimal.

**Constraints on Area Health Boards**

Legislative constraints on boards make it difficult for them to lease out unused space to the private sector to raise revenue which could be used to improve health services, or to deliver additional health services. It is even difficult for boards to enter into joint ventures with private medical agencies.

Other problems relating to the environment in which boards operate include: scarcity of management skills; clinical data bases and information on costs and benefits of services are only just emerging; lack of adequate systems for monitoring the quality of services; lack of control of hospital employment conditions; and lack of a coherent, rational system of funding continuing care for the physically, intellectually and psychologically disabled and the frail elderly.
Integration between public and private sectors is poor, leading to some duplication of expensive technology and facilities, and their subsequent under-utilisation.

**Funding of the System Is Fragmented**

Fragmentation of funding for health care is a major problem. Different parts of the health system are funded in completely different ways.

Funding for secondary care is distributed on an adjusted population basis to area health boards. Each board gets a limited amount of money each year, and has to decide (subject to some national guidelines) what to spend it on.

Primary care is funded through a bizarre mixture of subsidies. Subsidies are set at widely varying levels, between zero and 100 per cent, and there are no limits on the number of services for which the subsidy can be paid, so the spending is open-ended.

Some accident-related health services are funded by the Accident Compensation Corporation (ACC) on a more generous basis than funding for sickness-related care.

Funding of continuing care for the intellectually, physically and psychologically disabled and frail elderly is based on arbitrary and inconsistent policy, with responsibility and funding split along unclear lines between the Department of Social Welfare, area health boards, the Department of Health and other agencies.

Fragmentation of funding contributes to problems of poor patient management, poor access, inappropriate allocation of resources, and cost-shifting. The latter occurs when treatment decisions are based largely on what will cost the least to the client or agency involved, rather than on which treatment is most appropriate and cost-effective overall.

There is little opportunity for GPs and area health boards to work closely together to ensure that their patients get the most appropriate and effective treatment. Patients run the risk of being shunted between systems with no guarantee of proper, managed, personal care. An Auckland GP told the Taskforce: "A typical patient admitted to a public hospital undergoes a minimum of three physical examinations, carried out by three different medical practitioners. The first will be done by the patient’s GP, the second by the admitting house surgeon, the third, and sometimes a fourth, by the registrar or consultant. Often uncomfortable procedures such as vaginal or rectal examinations are duplicated, or triplicated."
Separate funding systems discourage health professionals from co-operating with one another, and so discourage them from broadening and diversifying their approach to service delivery.

Access to services is also affected by fragmentation. As some services cost patients less than others, those services may be used even when they do not represent the most appropriate care or offer the best value for money. For instance, a person with a minor ailment may go to a hospital accident and emergency department rather than to a GP because the service will be free to them. It will, however, probably cost the country, and thus the tax-payer, more.

Fragmentation encourages cost-shifting, which can result in inefficient provision of services and increased costs to the tax-payer. Cost-shifting operates in a variety of directions. A GP who knows that a patient needs an X-ray but cannot afford to pay may refer the patient as an acute admission to hospital, where the X-ray will be done free to the patient but at considerable cost to the tax-payer.

A Wellington GP said there were plenty of ways of “subverting the system” to help patients. Examples included classifying patients as “chronically ill”, which could take up to $10 off prescription fees and $17 off the cost of doctors’ visits. Another common practice was to treat children, who visited doctors with their parents, as the principal patient; this reduced the charge. He said he was well aware that some doctors charged full fees to patients with medical insurance, because they would be largely refunded. Income from such visits could then be used to subsidise non-insured patients.

In other cases, costs may be shifted on to the ACC where patient charges are minimal or zero. One indication of how much this happens is that the proportion of GP visits classified as accident-related has risen from 15 per cent in 1981/82 to 22 per cent in 1989/90.

Problems of Access to Services

There is anecdotal evidence that some people on low incomes are not going to the doctor when they are sick because they cannot afford the charges. Sometimes patients end up in hospital because the delays in treating the initial complaint have led to serious complications. A Northland GP wrote: “I recently saw a four-year-old boy who had been unwell for four days with a prolific discharging ear and high fever. His parents were unemployed and, as is so often the case, they had delayed coming to see me due to lack of money.”

The doctor said it was not only the consultation charge but also the prescription costs which prevented the parents seeking help sooner. Although he subsequently got free medical care and free medication, the boy did poorly and was admitted to hospital.
Geographical access to services can also be a problem. Distribution of GPs across the country is uneven. Larger cities, especially in their affluent areas, are generally regarded as being relatively over-serviced, while smaller towns and rural or disadvantaged areas often have difficulties attracting a GP.

Submissions received by the Taskforce reflected some of the problems experienced by small or isolated communities in attracting and retaining health professionals. The Hokianga Community Health Committee stated: "...if any new health system emerges it has to provide geographic, socio-economic and cultural equity of access. Rural areas have already been greatly affected by other services cuts ...."

When the tiny township of Matata in the Bay of Plenty set up a community health committee, it had no visiting doctor, no Plunket or public health nurse, and restricted access to the district nurse. A doctor now holds a once-weekly clinic there, but the Matata Community Health Committee feels that the community's needs would best be met by a community clinic staffed by an independent community practice nurse. "We feel that the nurse should be available to the community generally and there should be no tie to a particular doctor." At present, subsidies are paid for practice nurses but only where they are employed by a doctor.

Barriers to hospital treatment are also a problem for some people. There are strong incentives for the ACC to move people off generous earnings-related compensation (ERC). Thus accident compensation funding for private hospital treatment is available for those disabled by accident, where it is necessary to get them back to work and off ERC. However, the same criteria do not apply to sick people. They often have to wait years for public hospital treatment, unless they have private medical insurance which covers the procedures required.

**Little Assistance for Doctors in Making Choices**

Primary medical benefits are set at varying levels. Differences between benefit levels make no sense. Some primary services such as laboratory tests are virtually 100 per cent subsidised so the individual pays nothing. Other services, like visits to the doctor and X-rays, attract a far lower level of subsidy.

Most working people pay exactly the same for prescriptions and doctors' visits, regardless of their income. Only the elderly, the young, the chronically ill and beneficiaries receive higher subsidies and pay lower charges, and some members of these groups may be on higher incomes than those who receive no subsidy. In effect, some children of high-income parents are being subsidised by low-income workers.
There are no limits on the quantity of services that attract subsidies. Those services which attract the highest subsidies, therefore, are most likely to be over-used. The system fails entirely to assist or encourage doctors to choose the most appropriate and cost-effective treatments. As a result, costs are pushed up. The Government paid out approximately $945 million in primary care benefits in 1990/91, but had no way of monitoring whether this funding was used effectively, or of directing it to those most in need.

User part-charges are limited to a small range of primary services and not related to ability to pay. In the secondary sector there have traditionally been no user charges. Thus the current regime contains no direct financial incentives for people to choose the most effective and affordable health services. Indeed, the financial incentives are perverse, encouraging the use of high-cost “free” hospital services at the expense of alternatives.

**Lack of Consumer Control**

People want more say in how their health care is delivered. There is a feeling that there is too little consultation and too little opportunity for local involvement in the delivery of health services. Some communities, rural communities in particular, have made large commitments in time and money to their hospitals and related health care infrastructure. They would welcome the chance to take control of these facilities, and of the funding and provision of their health services.

Health services are not sufficiently responsive to consumers’ changing needs. This is reflected in submissions to the Health Benefits Review and the Hospital and Related Services Taskforce which variously describe health structures as male-oriented, monocultural and dominated by medical models. Few services are designed to meet the needs of particular groups, like Maori and women. The system ties subsidies to particular providers and services, and offers few incentives for innovative health care. There is a strong desire among many consumers, and among some health providers, for greater diversity of services.

Maori groups in particular want greater flexibility in delivery of health care. The report Rapuora: Health and Maori Women (1984) argues that Maori should be able to choose health provision arrangements appropriate for their needs. A recent review of asthma among Maori people concluded that there is strong support for more innovative approaches to health care, including culturally

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appropriate marae-based health services. A discussion paper recently prepared by the Department of Health's Maori policy unit has examined the feasibility of health maintenance organisations run by Maori authorities. This type of structure would allow Maori groups to have their health services provided through an organisation run by their iwi authority, and thus geared to meet their particular needs.

Some union groups already run union health clinics designed to meet the needs of people on low incomes who require access to basic primary health care services.

**Fairness**

Underlying all the problems in the health system is the issue of fairness. The system must treat people fairly. It must guarantee all New Zealanders reasonable access to an adequate and affordable range, level and quality of services.

Inconsistencies in the existing system stand in the way of achieving this objective. There are inconsistencies in the way we fund health care, in subsidies for services, and in criteria for public and private hospital treatment.

Some sections of the population start out with poorer health. This is associated with many factors including income, education, housing and lifestyle as well as health care. There are disparities in the health status of the Maori and non-Maori populations. The vulnerability of Maori people was highlighted in the *Hauora: Maori Standards of Health, 1970-1984* report, and further work since its release has strengthened those findings.

Those with lower health status often face difficulties of access to treatment services. Barriers may be related to education, culture, gender or income. Some people face multiple barriers.

Some regions believe they have special problems which are not adequately recognised by the present system. This view is reflected in a submission to the Taskforce from the Bay of Plenty Area Health Board. Referring to the Eastern Bay of Plenty as significantly different from New Zealand as a whole, the board said: “It has a very large population of Maori with their unique health perceptions and problems. It has high unemployment and low incomes. The health status of the population and the Maori population in particular is poor.

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These differences have resulted in considerable hardships and an inequality of access to the health system. Special attention is urgently required to overcome these problems and help promote a level of health that most New Zealanders expect as of right."

Many other areas also believe they have special problems associated with isolation or the low socio-economic status of their population.

The Government must ensure that the health system is able to deliver the range, level and quality of services necessary to ensure that all users are treated fairly.

**Approach**

The Government considered several options for addressing the problems identified in the health system. One option was to retain the existing system. The Government acknowledges that there have been some improvements in recent years, both in management practices and in provision for greater community involvement in decision-making.

The system, however, generally remains centralised, rigid and unresponsive to change. Attempts by area health board management to make strategic decisions which allow greater choice and flexibility in health services inevitably run into resistance from various interest groups which resist the proposed changes. There must be a clear distinction between those moral issues into which the community must have an input, for instance defining "core" services, and those management issues which are less amenable to public consultation, and are best left to those who are expert in the area.

After considering all the alternatives, the Government decided that fundamental reform of the system was essential. It decided to move to a system which would reflect the choices of groups and individuals about the health services they want, and how they would like these services to be delivered. The system should allow both users of the health system and health providers to experiment with new styles of health care particularly appropriate for New Zealand consumers.

The Government realises that a more flexible system will be more complex to administer, particularly in the transitional stages. However, it believes that New Zealanders are prepared to accept this, in return for the opportunity to have much more control over what sort of health services are available. It believes that there is a widespread feeling that a uniform approach to the delivery of health services is no longer appropriate or desirable.
THE ROLE OF PURCHASERS AND PROVIDERS

Key Points

- The conflicting purchasing and provision roles of area health boards hamper the quest for better value for money in the health system, and make it impossible to reward the most effective health care providers. The two roles should be split. The resources currently locked up in public hospital and other services boards deliver, must be used to buy the health services people need most from the best available sources, so that we get more and better health care for our money.

- The Government has therefore decided to separate the purchasing and provision roles currently performed by area health boards by:

  — establishing four Regional Health Authorities (RHAs), to buy health services for people. Their sole task will be to purchase the health services that best meet the needs of their communities;

  — establishing most area health board services as Crown Health Enterprises (CHEs), which will be run in a business-like way. The larger public hospitals and related services, especially those in the larger centres, are likely to become CHEs;

  — offering some area health board facilities to communities to establish as community trusts, giving them control over their own health services. The smaller community hospitals and other local health services are likely to become community trusts;

  — establishing a new Ministerial portfolio, the Minister of Crown Health Enterprises, responsible for the Crown’s interests as owner of public hospitals and other services.

- These reforms will build upon the important changes in area health boards in the last three years, in particular the recent move to create a unified management structure for boards.

- Users of the system will benefit because they will be able to choose between different types of health care, with more services provided in the
The role of purchasers and providers

Community. RHAs may contract with public hospitals, private hospitals, community-based day clinics and so on to provide health services for their communities. Those providing services will become more aware of, and responsive to, the needs of their clients as a result of this change. Waiting times for operations will get shorter.

- Health professionals and effective managers will find the new environment gives them opportunities to work with greater autonomy, and be recognised and rewarded for delivering better health care. Service providers who perform well will be rewarded by winning more RHA funds, with which they can expand their services. Managers will have greater freedom to reward staff who contribute to the success of the organisation.

Introduction

Three years ago, the Hospital and Related Services Taskforce, established by the Government of the day, released a report, *Unshackling the Hospitals*, which diagnosed major problems in the health system and offered a prescription for reform. The essence of that prescription was:

- the task of running hospitals and other health services should be separated from the task of purchasing health services for the community, and given to separate organisations;

- the organisations responsible for purchasing health services should be able to buy services from whichever provider offers the best service for the price paid, whether that provider is in the public, private or voluntary sector;

- large hospitals and other major health services are complicated enterprises, which must be well managed in a business-like way.

Since that report was issued, significant changes have occurred in the health sector. Area health boards, with broader responsibilities for the health of their regions, have now been established in all regions to replace the old system of hospital boards. General managers have been appointed to manage boards, instead of the old "troika" system which divided management responsibility among a chief executive, a medical superintendent and a chief nurse. The Minister of Health has developed contracts with boards, which set out more clearly their obligations to provide services.

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There is evidence that these changes have improved our health system. They were necessary first steps for what the Government intends to do. Many of the reforms which have been progressively implemented over the last three years will continue to be implemented over the next two to three years. Health Boards New Zealand Inc, in their submission to the Health Services Taskforce, made the point that it will take two to three years for the full benefits of some of these changes to be realised. The Government will ensure that these changes continue, and that they provide a foundation on which further reform can build.

However, deep-rooted problems in our health system remain. The Government believes that the essential prescription of Unshackling the Hospitals is appropriate, although it offered only a partial remedy: it did not address important issues in primary health care, and in disease prevention, health protection and health promotion. The Government does not accept many of the detailed recommendations of that report. However, its basic advice about reform of the system of public hospitals and related services stands the test of time. Several other countries have adopted the approach it recommends in reforming their health systems.

This chapter argues that there remain problems in our health services which cannot be addressed effectively in the current system. Separation of the purchaser and provider roles of area health boards will help to deal with these problems.

**Problems Faced by Area Health Boards**

The key problem facing area health boards is that they are expected to be both purchaser and provider of services. These roles conflict, making it difficult for boards to carry out either role effectively. This leads to other problems which are more visible to the public, such as long waiting times for hospital care and lack of responsiveness to individuals' needs. Some of the problems confronting area health boards are discussed below.

**Problems with Purchasing Services**

Boards have a budget allocated by the Government. Their job is to use that budget to buy health services for the people in their region, with the goal of doing the best they can with the money they have to improve health status. Sound purchasing decisions resulting in better value for money in health care are crucial to achieving that objective. That could mean purchasing a day surgery service, a clinic tailored to the needs of Maori people, or private long-
stay geriatric services. Good purchasing practices allow the most services to be delivered to the population, within current spending.

Area health boards face obstacles to achieving the mix of services which is most effective and best suited to people's needs. The reasons for this include:

- lack of information on the costs of area health board services, so boards do not know whether alternatives are indeed better value for money;
- reluctance to seek alternatives because this could result in board facilities lying empty and boards having to face the costs associated with closing down their own facilities and reducing their own staffing levels;
- concentration on hospital-based treatment services, which reduces the likelihood of boards developing community services, and health promotion, protection and disease prevention services, which might result in reductions in spending on hospital services;
- obstacles to developing contracts with service providers which would encourage them to choose more cost-effective care;
- inability of boards to set even modest user part-charges to encourage users and providers to consider the cost of health care;
- a tendency by boards to neglect primary care because traditionally this has not been their "patch". While they have no control over Government subsidies for primary care services, this should not have stopped them investing in their own primary care services where this would prevent use of expensive hospital care in the future.

The result is that New Zealand, like a number of other countries, has a higher level of expenditure on hospital-based services than is desirable. Hospital-based services tend to be expensive, with greater centralisation and specialisation. The result is high-cost services, often delivered at some distance from where people live.

Submissions to the Health Services Taskforce noted that more could and should be spent on day surgery, outpatient programmes and community services. Many countries are seeking ways to reduce expenditure on hospital services, citing the better quality care and lower overall costs that can be achieved through alternative forms of provision. This is associated with a greater emphasis on primary care (see Chapter 3).

Lack of Rewards

Frustration with working conditions has led to serious morale problems in the public health and hospital system. Staff feel hampered by the inflexibility of the system, difficulties in getting access to resources, lack of funds to replace ageing equipment, and rigid staffing arrangements. At the same time they are under pressure from the public, who are often vociferous in their complaints about the system. Health professionals want the opportunity to deliver services in more flexible ways, but this is often denied them in the current system.

Why Boards Are Not More Efficient

A number of reports in recent years have argued that there is scope for boards to be more efficient. This would allow them to treat more people while maintaining present quality standards and current funding levels.

The Arthur Andersen report, *Public Hospital Performance Assessment (1987)*, argued that there were significant efficiency gains to be made in the management of hospitals. Although this report was criticised for some aspects of its methodology, commentators at the time acknowledged that considerable efficiency gains could be made, particularly from better management and greater contracting out.

The Audit Office report, *Management of Public Hospital Surgical Workloads (1989)*, also found that better management could improve efficiency. It argued that more effective use of hospital outpatient clinics, better management of waiting lists, more effective use of available bed space and staffing, better management of operating theatre sessions and more use of day surgery, could increase the numbers of people able to undergo treatment, within current spending.

Some efficiency gains have been made since these two reports were produced, but submissions to the Taskforce, and discussions with those who work in area health boards, suggest there is room for further efficiencies.

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The problem is that boards have weak incentives to be efficient. Boards receive funding regardless of their performance. If an area health board fails in some way, there are few ways of making it do better, except through the Minister of Health directing the board or replacing the board members with a Commissioner. A board that is failing to provide adequate services is likely to continue to receive funding, and may even receive more if services are under threat. However, a board that does manage to provide services efficiently cannot be rewarded for doing so.

Similarly, those working in hospitals are not always rewarded for efficiency. For instance, one unit within a hospital may treat only a small number of people in order to remain within budget. But another unit may treat far more people, at much lower cost per head, and run the risk of being penalised for exceeding its budget. Those who work harder thus get penalised.

Elected members facing local elections may also argue for more funds from the Government instead of seeking out efficiency gains, since the latter may involve decisions which are unpopular with vocal interest groups.

**Lack of Choice of Health Services**

The current system provides little choice for people. There is little incentive for boards to respond to people’s needs.

Earlier reports have noted the lack of choice and responsiveness, especially for women and Maori. *The Report of the Cervical Cancer Inquiry* (1988)\(^5\) questioned the attitude of some health professionals towards patients and noted that the community expects more of professionals in their clinical behaviour and in the control they maintain over their colleagues. *Rapuora: Health and Maori Women* (1984)\(^6\) noted that Maori health policy needs to reflect the Maori view of health, allowing full consultation and access to resources so that Maori can choose their preferred provision arrangements.

Another common concern is that people are often not given the information they require to allow them to make choices about their health care.

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Some efforts are being made to address these concerns. The Government is considering establishing the Office of the Health Commissioner. The Office would investigate complaints against health professionals and bodies, and establish a code of consumer rights and a consumer advocacy service. Some area health boards are working towards better consultation with their communities, particularly with Maori communities, over the services needed and how they should be provided. Community Health Committees were intended to be a vehicle for ensuring that people have a say in the sort of health services they want in their area.

However, health care services generally must be made more responsive to diverse and changing consumer needs. There must be greater opportunities for change and variety in the system.

**Problems with Waiting Lists and Times**

While accident victims and those with acute conditions get prompt treatment, those who have less acute conditions usually have to wait. There are two major concerns with waiting lists: the way they are managed; and the numbers of people on the lists and the time they must wait for treatment.

The management of waiting lists is of great concern. The Audit Office report *Management of Public Hospital Surgical Workloads* (1989) found that lists are often not accurate. They do not indicate the total number of people needing treatment nor the resources required to provide services. Patients are not always allocated to surgeons with the smallest workloads.

The Taskforce was told of waiting times being manipulated to allow some people to obtain their operations early. It appears it is not always those with the greatest medical need who are seen first: the more articulate may be able to move up waiting lists faster than those who are less articulate or don’t complain.

The number of people on waiting lists and the time they must wait for treatment are imposing significant costs on the community and pain and suffering on people.

People must first wait for an outpatient appointment to determine whether or not they need treatment. Outpatient waiting times vary around the country and by speciality. Waiting times for general surgery outpatient appointments vary from one week to six months. Those for ear, nose and throat surgery can be up to 12 months for non-urgent cases. People who can afford to pay for an initial appointment with a private specialist can avoid the wait for an outpatient appointment and instead go directly onto a waiting list for surgery.
There are an estimated 62,000 people on waiting lists (although the accuracy of the data is in doubt). Table 2.1 shows the increases in the numbers on surgical waiting lists over the past nine years. Between 1981 and 1991, the number of people waiting for surgery increased from about 38,000 to about 62,000, an increase of 61 per cent.

**Table 2.1: National Surgical Waiting Lists**  
(percentage change between 1981 and 1991)

<table>
<thead>
<tr>
<th></th>
<th>No. as at 31 March 1981</th>
<th>No. as at 31 March 1991</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>7872</td>
<td>13401</td>
<td>70.2</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>8318</td>
<td>14141</td>
<td>70.0</td>
</tr>
<tr>
<td>Ear, Nose and Throat Surgery</td>
<td>8482</td>
<td>9035</td>
<td>6.5</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1896</td>
<td>7510</td>
<td>296.1</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>5653</td>
<td>6754</td>
<td>19.5</td>
</tr>
<tr>
<td>Urology</td>
<td>1484</td>
<td>5062</td>
<td>241.1</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>3921</td>
<td>3628</td>
<td>-7.5</td>
</tr>
<tr>
<td>Dental Surgery</td>
<td>166</td>
<td>882</td>
<td>431.3</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>620</td>
<td>958</td>
<td>54.5</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>89</td>
<td>304</td>
<td>241.6</td>
</tr>
<tr>
<td>Other</td>
<td>—</td>
<td>360</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>38501</td>
<td>62035</td>
<td>61.1</td>
</tr>
</tbody>
</table>


*Note: All figures should be treated as indicative only as historically, waiting list data have not been overly robust.*

The problem is not so much the number of people on waiting lists as the time spent waiting for surgery. Figure 2.1 shows the percentage of those on waiting lists in 1988 who had to wait less than six months, between six months and one year, between one and two years, and longer than two years, for their treatment. For example, 63 per cent of those on neurological waiting lists are treated in less than six months, while 19 per cent must wait over a year. Twenty-three per cent of those waiting for cardiothoracic surgery must wait more than two years.

On average, in 1988, 45 per cent of those on waiting lists had to wait less than six months for treatment, while 15 per cent had to wait longer than two years.
If these percentages apply today (and there is no information as to whether they do), about 28,000 people on waiting lists now would wait less than six months, 13,600 between six months and one year, 11,000 between one and two years, and almost 3,000 longer than two years, for their operation.

**Figure 2.1: Length of Waiting by Speciality, 1988**  
*(expressed as percentages)*

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**Key**
- Over 2 years
- 1 to 2 years
- 6 months to 1 year
- Less than 6 months

**Source:** Absolute values taken from Hospital Management Data year ended 31 March 1988, National Health Statistics Centre, Department of Health, 1988, Table 5A and converted into percentages.

**Note:** All figures should be treated as indicative only as, historically, waiting list data have not been overly robust.
Making Sure Boards Do a Good Job

Boards are contracted by the Minister of Health to provide certain services, and their performance is monitored annually. However, ensuring boards are actually meeting service and efficiency objectives remains a problem because:

- there is a dearth of management, financial and clinical information with which to compare boards’ performances;

- boards are responsible for services but not for raising funds, so they can easily argue for more money rather than seek efficiency gains;

- one of the requirements on boards is that they “promote, protect and conserve the public health”. It is impossible to hold them responsible for such broad objectives when many other factors, such as income, housing and education, all play a part in determining people’s health status. In addition, boards have no control over Government subsidies for general practitioners and other primary care providers;

- the only tools available to force efficiency gains out of boards can cause longer-term problems. The main tool available is funding reductions. These are likely to lead to service reductions rather than efficiency gains.

Lack of Integration of the Public and Private Sectors

All New Zealanders have access to public secondary health services, although quite often people have to wait for treatment. The private sector also provides secondary services, but only to those who can afford to pay private fees or who have medical insurance, or who, as a result of an accident, can claim private treatment costs from the Accident Compensation Corporation. Private fees and health insurance are more affordable for those on high incomes. New Zealand is gradually developing a two-tier health system: one for those who can afford private treatment, and one for those who must wait on a public sector waiting list.

Even for those who have private insurance, there are restrictions on the treatment available in private hospitals. For example, many private insurance companies do not cover maternity services or high-cost intensive treatment. This leaves little room for people to choose appropriate providers and means that no one organisation is responsible for managing total care. These issues are discussed in Chapters 3 and 4.
In addition, there is little integration between the public and private sectors. Area health boards cannot easily lease out any spare capacity to the private sector, nor can they easily undertake joint ventures with the private sector. The result is that there is a lot of under-used space and equipment.

The lack of co-ordination between the two sectors also means that sometimes public and private sectors buy the same expensive technology, resulting in both duplication of resources and under-utilisation of those resources. For example, CT scanners have been bought by both sectors in the Waikato. This technology, a sophisticated, computerised X-ray, is very expensive and it is difficult to see how both machines will be used to capacity.

A New Health Structure for New Zealand

The Government believes that these problems must be addressed. This will ensure that in future all New Zealanders have access to an acceptable level of health care services, delivered with maximum efficiency and flexibility. The Government has therefore decided to:

- separate the purchasing and provision roles currently performed by area health boards;
- establish four Regional Health Authorities (RHAs), giving them the role of purchasers of health services for their communities;
- establish most area health board services as Crown Health Enterprises (CHEs). These are likely to include the larger hospitals and related services, especially in the larger centres;
- offer some board facilities to communities to establish as community trusts. These are likely to include the smaller community hospitals and other local services.

The proposed new structure is depicted in the Executive Summary (page 6). The form and main functions of the different agencies are described below.

Regional Health Authorities

Four RHAs will be established, each responsible for purchasing health services for the population in its area. Figure 2.2 shows the new boundaries, which will
be established by amalgamating the current board areas. Table 2.2 shows the population size of each region.

RHAs will be established as independent Crown agencies. Each RHA will have a board of directors, of between five and eight people. Directors will have health management and business expertise.

Table 2.2:  Indicative Regional Health Authority Populations

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>127,230</td>
</tr>
<tr>
<td>Auckland</td>
<td>935,370</td>
</tr>
<tr>
<td></td>
<td><strong>1,062,600</strong></td>
</tr>
<tr>
<td>Waikato</td>
<td>324,200</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>204,030</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>44,720</td>
</tr>
<tr>
<td>Taranaki</td>
<td>109,650</td>
</tr>
<tr>
<td></td>
<td><strong>682,600</strong></td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>140,020</td>
</tr>
<tr>
<td>Manawatu-Wanganui</td>
<td>218,500</td>
</tr>
<tr>
<td>Wellington</td>
<td>388,550</td>
</tr>
<tr>
<td>Nelson/Marlborough</td>
<td>104,350</td>
</tr>
<tr>
<td></td>
<td><strong>851,420</strong></td>
</tr>
<tr>
<td>West Coast</td>
<td>32,740</td>
</tr>
<tr>
<td>Canterbury</td>
<td>433,360</td>
</tr>
<tr>
<td>Otago</td>
<td>172,680</td>
</tr>
<tr>
<td>Southland</td>
<td>108,160</td>
</tr>
<tr>
<td></td>
<td><strong>746,940</strong></td>
</tr>
<tr>
<td>Total</td>
<td><strong>3,343,560</strong></td>
</tr>
</tbody>
</table>

*Source:* Based on estimate of area health board populations at 31 March 1990 (Department of Statistics).
Figure 2.2: Health Authority Boundaries
RHAs will consult with health and policy professionals about the most efficient and effective forms of health services, to help guide their purchase decisions. They will also consult with their communities over the services each community requires and how it would like those services delivered.

RHAs will focus on purchasing personal health services for their populations. They will contract for some health promotion and disease prevention services that can be delivered to individuals, such as screening, immunisation, advice on diet and smoking. Public health activities that focus on populations (e.g., national media campaigns on nutrition and exercise, policies relating to food poisoning or measles outbreaks, policies on waste disposal) will be the responsibility of a new Public Health Commission (see Chapter 7).

Each RHA will seek out appropriate providers of services—public, private and voluntary—and contract with the providers that offer the best value for money. The contracts will also cover the quality of services provided. Through their monitoring of providers' compliance with contracts, RHAs will play an important role in ensuring the efficiency and quality of health services.

RHAs will receive funding based on the size and characteristics of the populations they serve. They will be monitored by Government to ensure they have contracted to provide a comprehensive range, level and quality of services and to ensure they consult with the communities they serve.

Good purchasing practices will be crucial to the success of the new system. The RHAs must encourage providers to come up with innovative ways in which services can be delivered. In addition, contracts will need to encourage efficiency. New Zealand does not want to go the way of the United States, where health insurers in the past simply reimbursed hospitals on the basis of cost. This has, in part, contributed to the rising health care costs faced by Americans. It has also led to over-investment in expensive technologies as well as some of the highest rates of medical intervention in the world.

RHAs will receive capped budgets, which will encourage careful contracting with providers.

RHAs will have to employ staff skilled in contracting. They will also need to employ people to advise on and research what health services the community needs and the mix, level and location of these services.

Crown Health Enterprises (CHEs)

Running large hospitals and other major health services requires all the skills involved in running a large business as well as the talents and skills of health
professionals. Establishing hospitals and other major area health board services on a business-like basis will allow managers to get on with the job of running hospitals and other services efficiently, and will allow health professionals to work in a better-organised, more professional environment. Providers which attract more clients by providing quality, value-for-money services will be rewarded, and will then be able to expand their services. RHAs can use incentives to get improvements in efficiency and cost-effectiveness, rather than using the bludgeon of cutting budgets.

The Government therefore intends to establish the larger units and those in the larger centres as Crown Health Enterprises (CHEs), owned by the Government on behalf of the community. It is not intended that each hospital or service be a stand-alone enterprise. Some enterprises may include groups or chains of hospitals and other service facilities.

Management boards will be appointed by the Government to run these enterprises. Boards will include people with a mixture of skills, including health sector, management and financial skills. Boards will appoint managers to run the enterprises.

CHEs will contract with RHAs (and later with health care plans: see Chapter 4) to provide services. RHAs will monitor enterprises carefully to ensure that services are provided as required by contracts, that services are of an appropriate quality, and that people are treated with respect.

CHEs will also be monitored by the Government to ensure they make adequate provision in their pricing to make a return on assets, that they are not engaging in monopoly behaviour, that they make prudent investment decisions and that they manage their assets wisely.

A new Ministerial portfolio will be established, the Minister of Crown Health Enterprises. The Minister will be responsible for the Crown's interests as the owner of public hospitals and other services.

**Community Trusts**

The Government recognises the value many communities place on local community hospitals and other local facilities. Where it is not appropriate to set these up as CHEs, communities will be offered the opportunity to take over the control and management of such facilities. The Government will identify those facilities suitable for setting up as trusts, in consultation with local communities.
Trusts will be free to contract with RHAs (and later with health care plans) to provide certain services to the local community. Trusts might even become part of a health care plan at some future date (see Chapter 4).

The establishment of trusts will enable local communities to become more involved in running their health services. Communities will be able to decide on the range of services the trusts provide. Because they have control over trusts, communities may want to contribute local resources to their trusts. Once primary care funding is devolved to RHAs and allocated to providers, even greater flexibility in the use of resources will become possible. Community trusts could be used to deliver primary and community care as well as secondary services.

**Community Consultation**

Area health boards are required to consult with their communities. Many boards have established Community Health Committees to provide community input into the health services that are provided and the ways in which they are provided. The role of these Committees has grown in different ways across the country. For example, there are only four Community Health Committees in Auckland but 17 in Canterbury. There is wide variation in how far Committees can claim to be representative of or accessible to their communities.

Community input will play a vital role in some of the new institutions established by these reforms. RHAs will be required to consult with their communities over the level and mix of services to be purchased. Community trusts will want to explore ways in which to obtain community input. Health care plans, discussed in Chapter 4, are also likely to have an interest in seeking input from their clients into planning health services. The Public Health Commission, discussed in Chapter 7, will consult the public about the population-based health strategies it will be responsible for.

There is no one way to ensure community input into planning health services. The present Community Health Committees have the opportunity to play a vital role in exploring how this might be done. They can be pro-active in writing submissions to the Government on the new health system, and in approaching RHAs, community trusts (and, eventually, health care plans) about how consultation with consumers will be made in the future. The Government hopes that many will take this opportunity to explore how better consumer representation can be developed and to seek new ways for helping communities have a say in their future health services.
How Will People Benefit from these Reforms?

Some important benefits are expected to result from these reforms.

Waiting times for operations will get shorter. Improved efficiency will free up resources which can be used to treat more people. Both RHAs and the providers they contract with will be keen to see waiting times reduced. Providers could lose contracts if waiting times are too long. In the longer term, RHAs could lose clients if people thought they might get a better deal from an alternative health care plan (see Chapter 4).

People in larger centres will have greater choice of hospital or other provider, and therefore choice of the sort of health care services best suited to their needs. At present the only real choice is for those who can afford private insurance or to pay private fees. This is limited to some services only, and can be quite restrictive. As RHAs will contract with public, private and voluntary providers, the range of choices will increase for most people, and will expand further as RHAs look for alternative ways of providing health care, for example more use of day clinics.

Local communities will be able to establish community trusts and control their own health services. These communities will have more say about how services are delivered.

Longer-term benefits will include greater efficiency as a result of innovative ways of delivering care and less reliance on hospital services. More people will be treated with the same or better quality of service, for the same amount of money.

The reforms should unlock resources from big hospitals, since RHAs will find it easier than area health boards to consider alternative ways of providing services.

More information will become available about the costs, prices and quality of different services. This will improve the efficiency with which services are provided by publicly-owned hospitals. The monitoring of services by RHAs will also allow better planning and decision-making than at present.

The reforms will make it easier to integrate the funding for primary and secondary care. Integration would be difficult under the existing system because of fears that area health boards would divert primary care funding to problems in their hospitals. Integrating primary and secondary care will
encourage co-operation between GPs and hospitals, and better-managed and more personal care of people. It will also mean that the total health care needs of people will be managed by one agency. These issues are further discussed in Chapter 3.

**Costs of Change**

As with all reforms, some costs will be incurred. These include:

- costs associated with the implementation of the reforms (see Chapter 9);
- costs associated with completing and fine-tuning the information systems which boards have been developing in recent years;
- costs associated with developing and negotiating contracts.

The Government is confident that the benefits from these reforms will outweigh these costs, especially in the longer term, as waiting times for operations get shorter, and more outpatient and community care becomes available.

**Is So Much Change Really Necessary?**

The Government considered several options for reform, including that of simply giving area health boards more money. That option was rejected because there is no guarantee that it would lead to more and better health services.

The Government also examined the option of internally splitting boards into a purchasing agency and a provision agency. Some boards have already made moves towards this, and have made some improvements in management and efficiency as a result. The Government, however, believes that 14 purchasing agencies would be far too many for a country the size of New Zealand. The purchasing role is critical and requires a range of skills which are in short supply in New Zealand. Purchasing decisions need to cover a wide geographical area to avoid expensive duplication of resources. Creating 14 new bureaucracies would also be an unjustifiable use of scarce health resources. In addition, the potential for efficiency gains would be reduced, because the purchasers would be likely to continue to favour the providers with which they had been associated in the past. Integration of primary and secondary sectors would be difficult.
Summary of Decisions

The Government has decided to:

- separate the purchasing and provision roles currently performed by area health boards;
- establish four Regional Health Authorities (RHAs), giving them the role of purchasers of health services for their communities;
- establish most current area health board hospitals and services as Crown Health Enterprises (CHEs). These will incorporate the larger services, especially those in larger centres;
- establish a new Ministerial portfolio, the Minister of Crown Health Enterprises. The Minister will be responsible for the Crown’s interests as the owner of public hospitals and other services;
- offer to local communities health service facilities for establishment as community trusts. Smaller community hospitals and services are the most likely to become trusts.
Key Points

- Within the health system a more integrated approach must be taken to managing total care for individuals and families, to address the problems arising from the current fragmentation of funding.

- The Government plans to:
  
  — integrate the funding for all personal health services—visits to doctors, prescriptions, other community-based services, hospital services;
  
  — place responsibility for managing all this funding with Regional Health Authorities (RHAs), which will then be in charge of purchasing total health care services for the people in their regions;
  
  — encourage better co-ordination in the management of total health care across general practice, other community-based health services and hospital services;
  
  — improve people's choice of different styles of health care delivery. For example: allowing more services to be delivered by nurse practitioners and other health professionals as well as doctors; and making it easier for doctors and other health professionals to do more health education and health promotion. To allow these and other innovative things to happen, the Government will encourage the development of a variety of ways of funding health services;
  
  — integrate funding for accident-related care with other health funding, so that people receive the same treatment whether they suffer an accident or an illness; RHAs will be responsible for funding accident-related services as well as illness-related services, though the funds RHAs receive for accident-related care will come from Accident Compensation Corporation (ACC) levies in the main.

- Integrating responsibility for funding total health care will help to ensure that patients do not fall between the cracks when they are referred to or discharged from hospital. It will also lead to better use of community-
based care and outpatient care, and so reduce the long waits people currently face for hospital appointments and inpatient treatment.

- Aligning funding for accident-related health care with other health care funding will provide access to treatment on a fairer basis, and will remove the incentive to shift costs on to the accident compensation scheme by classifying illness as accident.

- The Government has decided to address the problems of unfairness and wrong price signals in the current system of user part-charges for health services. Some user charges are to be reduced to make health care more affordable for low-income people. Other user charges will rise for middle and upper-income people, to have them bear a greater share of health care costs, and to encourage them to be mindful of the high costs of health care. User charges will be more even across different types of health service, including outpatient and inpatient hospital services. The new regime, described in the Budget Supplement on health involves changes to the levels of user part-charges for primary care, and the introduction of part-charges for secondary care.

- The Government believes that these changes will help to ensure that money is spent on the most effective forms of health care, and on the services which people need most.

Introduction

In our health system, responsibility for a person's health care is fragmented. For example, when someone visits a general practitioner (GP), the cost of that visit might be met from one or as many as four sources: the Department of Health pays a patient subsidy to the doctor, the patient pays a part-charge, the Accident Compensation Corporation (ACC) picks up part of the bill if the visit is for accidental injury, and a private insurer pays part of the bill for the over one million New Zealanders with private health insurance. If someone is referred to hospital, yet another organisation becomes involved—the area health board. If a person needs continuing care, or assistance to pay their medical bills, the Department of Social Welfare may pay for part of their care.

No one agency has responsibility for ensuring that a person's care is well-managed, or meets their needs adequately in a cost-effective way. It is little wonder that our health system suffers from poor communication and coordination, costly duplication of services and ample scope for shunting problems and costs around the system, with users at risk of falling between the cracks.
People suffer because communication between GPs, other primary care providers (such as pharmacists) and hospital staff is often poor. Frequently, when people are admitted to hospital, diagnostic tests already done by their GP or referring specialist are duplicated. Useful information the GP has about the patient is often not sent to the hospital. In other cases, GPs are sometimes not informed when one of their patients is discharged from hospital, or advised by the hospital of what follow-up assistance the discharged patient needs. The health system does not encourage co-ordination and co-operation between primary and secondary health care providers. The result is a failure to deliver properly managed, personal care to people.

The problems of fragmentation are made worse by the funding of different services in very different ways. For example, secondary care services are mostly provided by area health boards from a capped annual budget. By contrast, funding for most primary care and for continuing care of the elderly (in rest homes or private geriatric hospitals) is open-ended. That is, the Government has to pay out another subsidy every time someone uses the service. Consequently, boards can save money by shifting costs onto one of these open-ended subsidy programmes. As the Government has little ability to control its spending on such programmes, it faces considerable fiscal risk which must be borne ultimately by tax-payers.

The Current System of Funding and Provision

Health care services are funded largely from Government sources, but also through contributions from users of services and from private health insurers. Figure 3.1 shows the source of funding for various health services.

At present the Government funds health care in these ways:

- primary care services are subsidised through open-ended subsidies paid by the Department of Health. Subsidies vary between zero and 100 per cent and users are expected to pay part-charges which contribute towards the cost of some of these services. A number of not-for-profit agencies, like the Plunket Society, also provide primary care services. In general they are funded through contracts with the Department of Health. Area health boards also fund some services in this way;

- secondary care services are generally provided by area health boards (through their hospitals). Boards pay for these services with the annual capped grants they receive from Government. People are not charged for
Figure 3.1: Estimated Relative Shares of Funding in Major Areas of Health Care 1990–91


Note: The analysis employs the Abel-Smith categories of health expenditure developed for the World Health Organisation. Capital expenditure is excluded (but interest and depreciation are included). The Department of Health’s administrative expenditure has been allocated as an overhead to the relevant expenditure categories. Rest Homes are excluded from the Abel-Smith categories of health expenditure. Medicaments refers to all substances used in curative treatment including medicines, dressings, syringes and artificial limbs supplied by pharmacists or medical practitioners.
treatment. Private hospitals provide a limited range of usually less complicated procedures which will be paid for either by the user of the service, or by their insurer if they have private medical insurance;

- many forms of treatment for people injured by accident are funded by ACC. The level of assistance available to accident victims for primary care services is significantly higher than that available for people requiring health care for other reasons—it is virtually free of charge;

- continuing care is funded by the Department of Social Welfare, the Department of Health and by area health boards, with other agencies such as the Housing Corporation and ACC also running some programmes. Not only are services funded by different agencies, but programmes are funded in different ways. Some programmes have a fixed budget, while others are open-ended and get more money as demand for the service grows. Some continuing care services, both institutional and community-based, are provided directly by area health boards. Other institutional care and home-based care tend to be provided in the private sector, and by not-for-profit organisations and family members.

Problems with the Current System

The differing systems for funding health care services and the differing provision arrangements do little to encourage co-ordination in the health sector.

A number of problems were identified in previous reviews of the health system, in particular in Choices for Health Care¹ which reviewed all health benefits, including primary and secondary care, and to a lesser extent continuing care. Many of these problems were discussed in the Introduction to this Statement. The key problems are identified below.

Fairness

There is a much greater level of subsidy for primary care for people requiring services as a result of accidents than for people requiring services as a result of illness.

Low-income working adults are not eligible for a subsidy for a visit to the GP and face a higher level of prescription charges. Beneficiaries, however, get higher subsidies, but in many cases their income level and family circumstances may be little different from those of some low-income wage earners.

Access to health services is difficult for some people, particularly those in rural areas who sometimes must travel long distances to services.

**Efficiency Problems**

Neither providers nor consumers have much incentive to consider the costs and benefits of various treatment options. They do not see the real costs of services because costs are disguised by subsidies. Differential subsidy rates give wrong signals about how much things cost. Some services, laboratory tests for example, are fully subsidised and free to the user. Others have little or no subsidy, such as X-rays or physiotherapy (except after accidents). This means that people do not necessarily receive the type of care which is most appropriate to their needs; rather, they use the type of care which attracts the most subsidy, and costs least to them.

The present subsidy system encourages people to over-use secondary care services which are free to users.

**Responsiveness and Choice**

In the secondary care sector people have little choice about who provides their health care, or how it is provided. For example, in some centres there are no women obstetricians and gynaecologists.

Subsidies are linked to certain types of provider. This tends to restrict the range of services available. For example, there are subsidies for consultations with doctors, but not for consultations with a nurse practitioner, a counsellor, or other health and social service providers. There are high subsidies for pharmaceuticals and laboratory tests, but limited subsidies for health education activities. In the continuing care area, there are high subsidies for residential care, but much more limited subsidies for home-based care. In general the subsidy system tends to concentrate on services provided by a doctor, or services obtained on referral from a doctor. It also concentrates on particular forms of care, to the detriment of multi-disciplinary care and the effective management of total care for the individual.
Proposals for Reform

It has become clear to the Government that our health system must offer a more integrated approach to managing total care for individuals. This is critical to achieving improvements in cost-effectiveness, fairness, consumer responsiveness and efficiency. It means that the budget for the total health care costs of a person should not be fragmented, but be the responsibility of one agency. This is important if cost-shifting is to be eliminated. It will also encourage health care services to be provided in a well co-ordinated, managed way, appropriate to people’s health needs.

The previous chapter described the Government’s proposals to separate the purchaser and provider roles of current area health boards, and to establish Regional Health Authorities (RHAs), Crown Health Enterprises (CHEs) and community trusts. This is a necessary first step before total health care funding can be integrated.

Once RHAs are fully established, the Government will:

- integrate the funding for primary and secondary care services;
- place responsibility for this funding with RHAs, which will then be responsible for purchasing total health care services for their populations;
- encourage better integration in the management of total patient care across the primary and secondary sectors;
- encourage a more diverse range of contractual arrangements with providers of health care services, to improve consumer choice and responsiveness;
- integrate funding for accident-related care with other health care funding;
- rationalise the current system of user part-charges.

These reforms are discussed below.

As a further step in this reform process the Government has decided to allow people to take their budget for total health care to an alternative health care plan of their choice. These health care plans will manage the total health care requirements of their clients, and will hold an annual budget to pay for their clients’ care. Health care plans are discussed in detail in Chapter 4.
Integrated Funding for Primary and Secondary Care

The budgets for primary and secondary care will be amalgamated. Each RHA will receive a population-based share of the combined budget. This will allow RHAs to consider the most appropriate allocation of resources between various types of health services, depending upon the needs of their populations.

It is expected that this will lead to increasing emphasis on primary and preventive care services, which will have the potential for reducing demand for more expensive secondary care services in the longer term. As well, the integration of the budget will encourage the use of day stay surgical procedures and community-based care backed up by co-ordination with general practice, rather than higher-cost inpatient procedures.

As RHAs will have capped budgets, they will need to find ways to contain the level of primary care spending. If they do not, there is a risk that demand will lead them to over-spend their budget or reduce the funding available for other services. RHAs might use a variety of methods to achieve this aim, especially developing a range of contractual arrangements and payment systems for some primary care providers.

Alternative Ways of Paying Providers

At present, doctors working in public hospitals are paid salaries. Doctors working in private practice, most of whom are GPs, are generally paid on a fee-for-service basis. A variety of other ways of paying doctors and other health care providers is used in New Zealand and overseas. The options include:

- **salary.** Salary contracts are often accompanied by performance agreements specifying what hours should be worked and what responsibilities should be fulfilled. Sometimes salaries are supplemented with a bonus for achieving particular goals such as target numbers of cases treated, or expenditure targets. Good performance for salaried staff is also rewarded by promotion;

- **fee-for-service.** Under this arrangement the provider is paid a fee for each consultation or procedure. Sometimes the doctor sets this fee; sometimes it is a fixed amount, negotiated between the doctor and the insurer or Government agency which pays the fee;

- **capitation.** The doctor or other care provider is paid an annual fee for each patient enrolled in their practice. The fee is intended to cover all services
provided by the doctor during the year. Obviously, some patients require less services than others in any one year; the provider pools the capitation payments for all patients, so that the costs for those who require a lot of care are paid for in part from the fees of those who require less care;

- **risk-sharing contracts.** Doctors can be placed on contracts under which they bear a share of the cost of any prescriptions, diagnostic tests, hospital admissions, and so on, which they order for their patients. These kinds of contract are used to encourage doctors to choose cost-effective care for their patients, and strive to prevent their patients needing high-cost care;

- **budget-holding contracts.** Budget-holding is type of a risk-sharing contract. The doctor is given an annual budget for each client enrolled with their practice, and required to meet all of the costs of their prescriptions, diagnostic tests, and perhaps the costs of some other referrals, from this budget. This type of contract, with some modifications, has been introduced in some general practices in the United Kingdom.

There is no “right way” to pay doctors or other health service providers. Different types of contract have different strengths and weaknesses. Some contracts are suitable for particular types of health service, but less suitable for others. Some contracts lend themselves to particular styles of medical practice—which may suit some doctors and patients but not others.

For example, paying doctors on salary or capitation makes it easy to control the costs of doctors’ services, but can make it harder to ensure that doctors deliver the services people want. Hence salary contracts or capitation are often accompanied by performance agreements or bonus schemes. Salary and capitation lend themselves particularly to services that are not procedure-based, but rather require a complicated mix of diagnosis, advice and intervention.

By contrast, fee-for-service payment of doctors makes it difficult to control the overall costs of doctors’ services, but encourages doctors to see and treat more people. Hence fee-for-service payment tends to be accompanied by measures to help control costs and to discourage provision of unnecessary services. User part-charges are the main method used to control the costs of fee-for-service practice. Utilisation review, or second-opinion requirements, are also used to control costs, particularly for high-cost procedures. Fee-for-service payment lends itself to procedure-based medical care, and to services where patients can be expected to judge whether the service offered is really needed and to pick up a reasonable share of the costs. There are examples of modifications to fee-for-service payment systems which guarantee a minimum level of income for doctors. These are used in rural areas in New Zealand.

Risk-sharing and budget-holding contracts specifically recognise that doctors’ decisions drive a large part of health expenditure—on pharmaceuticals, diag-
nostic tests, referrals to specialists and admissions to and lengths of stay in hospitals. These kinds of contracts focus on directly encouraging doctors to be cost-conscious.

Our current health system fails to make the best use of the variety of options for encouraging better service through creative contracting with doctors and other service providers. We lock public hospital doctors into salaried remuneration and private sector doctors into fee-for-service, though there are a few capitated general practices.

We need to create an environment in which a variety of contractual and organisational approaches can be tried, in the interests of promoting greater responsiveness to the users of health services, and better value for money.

However, the history of the relationship between successive Governments and medical professionals over payment arrangements has been troubled. The majority of private sector doctors have fought for the right to set their own fees-for-services, and to avoid any limitations on the number or cost of their consultations, procedures, prescriptions, and referrals to other services. There is deep-seated suspicion of any contractual relationship with the Government.

Understandably, where the Government rather than a private organisation seeks to negotiate with doctors, there may be fears of state control and interference. This can make doctors very reluctant to enter into contracts. It is vital to prevent patients—in particular low-income and chronically ill people—being caught in the middle of this impasse to the detriment of their health.

Devolving responsibility for primary care funding to RHAs will at least partially allay some of the concerns of doctors about negotiation with the Government over subsidies for primary care. RHAs will have clear obligations regarding the services they must obtain for their communities, and clear obligations regarding access. RHAs will be encouraged to develop a range of contractual arrangements with health care providers. These will be negotiated on a voluntary basis.

Because RHAs will be focusing on purchasing services, rather than on subsidising providers, we can expect to see them develop a range of innovative arrangements for funding primary care. In rural communities, for example, which experience relative difficulty in retaining GP services, RHAs could negotiate arrangements linking GPs with nurses in the communities who could provide effective primary care, given appropriate professional support from a GP.

As well, the establishment of non-Government health care plans will provide new options for doctors and other providers. There will be scope for groups of
providers to establish their own health care plans, to meet the total health care needs of their clients. This possibility is discussed further in Chapter 4.

Integrated Management of Health Care

The integration of funding for primary and secondary care is only part of the answer for achieving better patient care. The other major facet of improved health care services is better working relationships and communication between hospital staff and those providing care in the community, in particular GPs.

GPs play a key role in any health care system, as they are often the first point of contact with it. They act as gatekeepers to other health services through referrals, prescribing and ordering diagnostic tests.

There are several examples of integrated approaches to health services currently operating in New Zealand. Voluntary arrangements for integration have provided effective solutions to local problems. They are ad hoc arrangements, however, established against the odds through the goodwill, vision and enthusiasm of local providers. Some examples are:

- An employer/employee relationship established in 1989 between the Tairawhiti Area Health Board and local GPs ensured the on-going viability of general practice services in the East Coast/Ruatoria area. The Board receives all General Medical Service subsidies (the subsidy for GP consultations) and other general practice patient subsidies claimed by the local GPs. The income of the GPs is supplemented by salary payments for part-time appointments in the base hospital at Te Puia Springs. This provides a guaranteed income for GPs. Recently, a community-based health care trust has become joint employer of the doctors with the area health board. General Medical Service subsidies and other primary care subsidies are now paid to the trust.

- The Canterbury Area Health Board maintains cottage hospitals in rural areas, which are staffed by local GPs.

These initiatives are potential options for the community trust proposals outlined in Chapter 2, and might be attractive to other communities.

Examples and models of the integrated management of health care services have developed in other countries. These include:
Multi-speciality group practices involve specialists, GPs, practice nurses, physiotherapists and other health professionals. People who use this type of practice have access to a wide range of health services and have continuity of care because there is greater co-ordination and management of the services they use.

Health maintenance organisations in the United States integrate primary and secondary care provision. Health professionals, funders and hospitals have close links. Together, they co-ordinate patient information and use screening, health education and illness prevention activities. They also use managed care approaches, which can involve a health professional acting as an agent or advocate for a person co-ordinating and approving referrals to other health providers. Health maintenance organisations, and their more recent variants such as preferred provider organisations, have tended to reduce hospital admissions and provide more care in the community, particularly through the use of primary care and day-stay care.

The employment of GPs in hospitals occurs in several countries. It has been advocated for New Zealand. It is argued that the employment of GPs in hospitals will lead to better discharge planning, a team approach, increased use of home- and community-based services and day surgery, better co-ordination of patient care and improved exchange of medical information.

Professor Laurence Malcolm (Department of Community Health, Wellington School of Medicine) in his submission to the Taskforce argued for the integration of primary and secondary care. He has long argued that it is vital that better links are built between services provided by area health boards and GPs on a partnership basis. This would involve both a financial and professional relationship.

At least in theory, area health boards were supposed to integrate primary and secondary care. The reality has been very different: a curious amalgam of hospital-based services and primary care delivery by non-GP health workers. GPs have expressed understandable misgivings about coming under the control of hospital-dominated area health boards. Separating the purchaser and provider roles of boards will enable integration to take place in a much better environment. GPs will be free to negotiate with RHAs without fear of hospital domination or loss of autonomy at the hands of a politically driven board.

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An integrated approach to the management and co-ordination of health care will provide considerable benefits for people and lead to improved quality of care. GPs and nurses who provide primary care will have a much more central role in the health system. They will continue to act as gatekeepers to other parts of the health system through referrals. Their role as agents and advocates of people requiring health care is strengthened, and they are better able to influence the provision of secondary care services.

**Benefits**

It is difficult to estimate precisely the savings that might be achieved through integrating primary and secondary care, through better management of care and improved co-ordination. However, there are strong indications of the potential benefits from better use of primary and community-based care. International studies have shown that up to 40 per cent of all surgery could be undertaken as day surgery. By comparison, day surgery as a percentage of all surgery in New Zealand currently ranges between 20 and 35 per cent across the 14 area health boards. Many boards set day surgery rate targets as part of their contracts with the Minister of Health. These targets range from as low as 20 per cent to 40 per cent. The potential for efficiency gains in this area is self-evident. Cost savings in the order of 50 per cent per procedure could reasonably be expected from most substituted procedures. This will mean that more people can be treated for the same amount of money, and surgical waiting lists reduced.

In addition, day surgery usually requires less invasive techniques and therefore recovery time is much shorter, so there are significant benefits for patients.

**Rationalisation of User Part-Charges**

The Budget Supplement on health announces that the levels of user part-charges for some primary care services are to be changed. These changes are

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also outlined in *Welfare That Works—A Statement of Government Policy on Social Assistance*.

These changes to user charges will increase the level of assistance for low-income people. This will improve access to primary health care services for this group of people. As noted on page 46, low-income working adults receive less Government assistance than beneficiaries for visits to the doctor and prescriptions.

**Extension of User Charges to Secondary Care**

In addition, user charges will be introduced for some secondary care services, in particular for outpatient visits to specialists; some accident and emergency services, and a contribution towards the cost of staying in a hospital. The introduction of part-charges for services currently provided by area health boards brings them into line with the part-charge regime for primary care. It will remove the current situation whereby primary care services are much more costly for consumers, yet the use of comparable services provided by area health boards, while free at point of service, costs significantly more to the taxpayer.

There will be different levels of user charges. The level will depend upon income. There will be an upper limit on the amount of charge faced by any one person or family in any one year. This means that the chronically ill and other heavy users of health services will still be able to afford necessary services.

User charges are being introduced only for middle and upper-income earners. Services provided by area health boards will continue to be free of charge for beneficiaries and low-income people.

The introduction of part-charges for secondary care services will discourage cost-shifting between primary and secondary care budgets, and will encourage people to consider the costs and benefits of various services and use those which are most appropriate for them.

**Future Developments**

The introduction of these measures will not solve all of the problems associated with the current user part-charge regimes. Differential rates of subsidy for primary care services remain, which means that people are not aware of the real costs of services.

In addition, user part-charge systems are managed by different organisations and different levels of maximum charges apply. There is no comprehensive or
global approach to the overall level of charges faced by an individual or family from all sources. This means that it is difficult to track the total level of charges paid, and that a family whose health expenditure is concentrated in one area will be better off than a family whose expenditure is more evenly spread.

Options will be investigated for a more comprehensive and rational system of user part-charges and for a system of administration which will enable a record to be taken of all user charges paid by a family or individual, and a maximum limit to be set. One possibility, Family Accounts (a method of keeping track of a family’s use of health services in a similar way to a bank account), is discussed in greater detail in *Welfare that Works*.

In the longer term, the Government intends to give responsibility for the user part-charge regime to RHAs and health care plans. The Government will ensure that these agencies protect low-income people and high users of health care from unaffordable levels of user charges.

**Benefits**

As discussed above, the changes to the user part-charge regime will improve access to primary care services for low-income families. Overall, it will create a fairer and more rational system of user charges.

The other major reason for extending user part-charges is to make people more aware of the costs of treatment, and therefore to encourage more appropriate use of services.

There is good evidence that part-charges in the primary care sector can induce lower total health care expenditure. The most comprehensive study of the effect of user charges was conducted across the United States from 1974 to 1982. This experiment (the Rand Health Insurance Experiment) involved the introduction of user charges for health services, with a maximum placed on the level of charges to be paid by any one family or individual (based on income). It found that with the introduction of user charges, total health care expenditure falls by about 19 per cent, where there is a 25 per cent part-charge rate for primary care services.

A review article discussing the impacts of user part-charges on utilisation of medical care concluded that the effects of price on usage are strongest if the

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6 Lohr, Kathleen N. [and others], “Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis- and Service-specific Analyses in a Randomised Controlled Trial”, *Medical Care*, September Supplement, Vol 24, No 9, 1983.
patient initiates the demand for care themselves, for example GP visits\(^7\). In the case of additional care prescribed by a physician, for example secondary care, the impact of user charges on the use of services is less. This is explained by the fact that the doctor is often seen as an authority and the patient is more likely to accept the doctor's advice rather than consider financial costs of the treatment. Studies show that the use of part-charges in hospital inpatient treatments decreases the patients' length of stay and reduces the number of admissions. Similarly, the use of outpatient care falls in response to part-charges.

The Funding of Accident-Related Health Care

The accident compensation scheme is funded by levying employers and motor vehicle owners. The Government also provides direct funding to the ACC to cover the health and compensation costs of accidents for non-earners.

At present, ACC funds primary care through fee-for-service payments to primary care providers. Health services are also provided to accident victims by public hospitals. These costs are not reimbursed by ACC. This means that the real costs of accident-related health care are not reflected in the levies charged to employers and motor vehicle owners.

Primary care subsidy levels are significantly higher for accident victims than for those with other health care problems. Access to secondary care services is easier for accident victims, as ACC will pay the costs of private health care services, based on a schedule of fees, in order to avoid public hospital waiting lists for people receiving earnings-related compensation. These different funding systems lead to serious inequities in the treatment and access to care between people whose health problems are caused by accident and those caused by illness. This difference in treatment is widely perceived as being unfair. It also encourages people, and their doctors, to classify health problems as being the result of an accident, rather than as an illness.

The Government has decided that the cost of work-related and motor vehicle accident-related health care should be reflected in the levies charged to employers and motor-vehicle owners. The component of levy funds which

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relates to health care will then be transferred in bulk to form part of the total funding for the health system. RHAs will then be responsible for the purchase of both accident-related and illness-related health care.

The Government also proposes that people gain access to health care, and face the same level of user part-charges, irrespective of the cause of their need for health care. This means that the RHAs will fund assistance for primary and secondary care for both accident and illness victims, and any further charges will be met by the users of those services.

Until RHAs are established, the ACC will continue to make direct payments to a variety of private health service providers. As a transition measure, the ACC will move to introduce user part-charges for these services by reducing the maximum fee it can pay under regulations. As well, from 1 February 1992, accident victims will pay user charges for some public hospital services on the same basis as the sick. Once costs have been assessed, accident victims will also pay the standard user charges for prescriptions and laboratory tests. It is intended, if possible, to have accident victims pay the same targeted user charges for GP visits as the sick. However, it will be necessary to assess the impact of the user charge regime on different categories of ACC claimants before the exact timing of this measure is determined. Further details are given in the 1991 Budget Supplement on ACC, Accident Compensation—a Fairer Scheme.

Benefits

The principal benefits of integrating funding for accident-related health care with other health care funding are to:

- provide access to treatment on a fair basis for people requiring health care as a result of accident and those requiring care as a result of illness;
- limit the potential for cost-shifting to ACC programmes from other health services, which has the effect of increasing overall health system costs and creating escalation in ACC levies;
- clarify the actual costs of accident-related care.

The Funding and Provision of Continuing Care Services

There are several problems with the current system of funding and providing continuing care services for the frail elderly and the physically, intellectually
and psychiatrically disabled. This has led to reviews of these services in recent years.

A confusing set of programmes exist for the four groups. Confusion is in part caused by the fact that various programmes are funded by different Government agencies, and in different ways. This fragmentation in funding creates incentives for agencies to cost-shift. As discussed earlier, cost-shifting increases overall costs and makes it difficult for the Government to contain the cost of the programmes. In addition, it leads to the provision of inappropriate services. At present, for example, funding policies encourage the use of institutional care rather than home-based care, though home-based care is a more appropriate and cost-effective option for many in the four groups.

There are differences in the levels of assistance for care, and the degree of means testing applied, both within and between the four groups. A situation has emerged where, depending on which group a person belongs to, and on what service they use, funding available can be more generous than that for another group. Some differences of treatment between the groups may be justified, but it is difficult to see as fair the current variation in assistance, and it leads to inefficiencies.

For two years now, members of the four groups affected have had to live with uncertainty about how their services would be funded and provided. The Government is determined to resolve that uncertainty, and intends to announce decisions in this area in time to permit implementation to begin in July 1992. Hasty and ill-conceived decisions will not be made. Instead, the Government will ensure that all options for the funding and provision of continuing care services are canvassed, that overseas experience is examined, and that the relationship between the funding and provision of continuing care services and other health and welfare services is comprehensively assessed before decisions are announced.

However, the Government has identified some key principles which should underpin the funding and provision of continuing care services. These are the same principles as underpin the other reforms to the health system described in this chapter. The principles are:

- All of a client’s funding for a particular purpose should be located in one agency. The advantages of this for continuing care are that members of the groups will find it easier to access the services they are entitled to if one agency is identified as the funder. Problems created by attempts to shift costs will be minimised, as will duplication of effort; and it will be clear who is responsible for funding care for any one client.
The Government has considered two main options for the location of funding for continuing care:

— within RHAs: under this option, continuing care clients would also be given the option of taking their share of continuing care funding to an approved health care plan. Health care plans are discussed further in Chapter 4;

— within the Department of Social Welfare.

There should be a separation of the funders or purchasers of services from the providers. This will allow different service options to develop, and create greater choice between providers for people using these services. The funding agency is more likely to opt for the service that provides the best value for money, and best suits clients, than an agency which combines both funding and provision roles, as the latter is likely to have a bias towards use of its own services.

The Government will consider these options in terms of their ability to meet the needs of clients, to encourage self-reliance, to prevent shifting of responsibility and costs between agencies, and to control expenditure efficiently.

**Advancing Decision-Making**

The Government has decided that the Minister of Social Welfare will take responsibility for advancing decision-making on the funding and provision of continuing care services, in close consultation with the Minister of Health. Ministers will maintain close links with those involved in implementing the health and other social assistance reforms. They will also consult with the four client groups before making decisions in this area. Decisions will be made in time to permit implementation to begin from July 1992.

**Summary of Decisions**

The Government has decided to:

- integrate the funding for primary and secondary care services and place responsibility for this funding with Regional Health Authorities (RHAs), which will then purchase total health care services for their regions;

- encourage RHAs to develop a diversity of contractual arrangements for paying health service providers, in the interests of allowing more innova-
tion in service delivery, more choice of styles of health service delivery, and better cost-containment;

- integrate the funding for accident-related care with other health funding and place responsibility for funding accident-related care with RHAs. RHAs will receive funds for the costs of accident-related care, however, from Accident Compensation Corporation (ACC) levy revenue;

- rationalise the system of user part-charges for health services in the interests of better access for low-income people, greater cost-sharing by middle and upper-income people, and better price signals about the costs of health services.
CHOICE OF HEALTH CARE PLANS

Key Points

- Once Regional Health Authorities (RHAs), Crown Health Enterprises (CHEs) and community trusts are fully established, people who would prefer a different approach to health care delivery from that offered by their RHA will be allowed to leave it and obtain all their health services through another health care plan of their choice.

- People will be able to take their entitlement to Government funding for health care with them from the RHA to pay the annual fee of their health care plan.

- Those who have higher-cost health needs will take a larger entitlement to funding with them, to encourage plans to take the sick as well as the healthy.

- Health care plans will manage the total health care requirements of their clients. They will be obliged to offer all their clients affordable access to the same range of services as RHAs. This compulsory range of services, called “core health services”, will be specified.

- Health care plans may take various forms. They may provide some health services themselves, but will contract with other health care providers—including CHEs and community trusts—to deliver core health services for their clients.

- Health care plans may specialise in meeting the health care needs of particular groups. Plans may be established around union health centres, group general practices, networks of general practices or multi-speciality groups. Community-based plans might be built around community trusts. Health insurers may wish to move into providing comprehensive managed health care by establishing plans. Large firms may want to underwrite a health care plan for their employees.

- Iwi authorities and other Maori organisations will be able to establish health care plans concentrating on Maori health needs, addressing Maori concerns about how health services are delivered. This will offer Maori a
vehicle for taking greater control over the resources used for health services for Maori.

- To protect clients of the health system, and to contain health care costs, health care plans will operate within limits set by regulation.

- Choice of health care plans will be phased in so as to allow time for development of the skills and experience required for this type of managed care.

Introduction

The over-riding goal for the Government’s reforms to the health system is to make sure it delivers the services people want, at an affordable cost. Establishing Regional Health Authorities (RHAs) with the sole task of purchasing the health services that best meet the needs of their communities will help to achieve this goal.

However, it will be vital to keep RHAs up to the mark. This can be done by:

- setting performance objectives for RHAs and monitoring them via the Department of Health;

- setting up channels for consumers to have an input into decisions about what health services are provided by their RHAs;

- allowing consumers the ultimate sanction against RHAs which fail to respond to their concerns: the ability to take their custom elsewhere.

At present, people are able to use private hospitals if they are dissatisfied with the services provided by the public health system. However, they have to pay for private sector services (or insurance to cover these costs) out of their own pockets. Private health insurance is more readily affordable by higher-income people. The consequence is that our health system is gradually turning, by default, into a two-tier system. The Government wants to give choice over health services to all users, not just those who can afford to pay more.

The Government also wants to forge a new relationship between the public and the private health sectors, based on clear lines of responsibility for managing people’s total health needs. Private insurance currently concentrates on providing only “top-up” insurance—supplementary insurance for services that are subject to waiting lists—and “gap insurance”, which pays for part or all of user part-charges. No one in the health system takes responsibility for managing
total care. The private sector is able to choose which aspects of health care it will provide. It does not provide high-cost intensive care, for instance, and private insurers refuse cover to people with certain chronic conditions like diabetes. Difficult and expensive treatments are left to the public sector.

The Problems

Limitations of RHAs

RHAs will offer services which reflect what people need, instead of being based on existing hospital facilities. However, there are risks where a Government agency has a monopoly on purchasing health services. Our existing health system has been described as monolithic and mono-cultural, and criticised for the way it serves women, Maori, those with mental health needs and other groups which have difficulty in influencing decision-makers. RHAs may not be as receptive as they should be to consumers who want different services, or to funding innovative health service providers. It is probably impossible for a single RHA to meet the preferences of all groups within a region.

One safeguard against badly performing RHAs is monitoring by the Department of Health. Central monitoring of something as complex and diverse as health services is always difficult, and is unlikely to provide a complete guarantee that RHAs will not perform poorly.

Consumer input is also vital to provide a check on RHAs. That is why Chapter 2 emphasised the channels for community input into RHAs. But RHAs cannot be all things to all people. Different people have different needs and preferences about how health care is delivered. The Government will allow those differences to be translated into diversity in health services.

The Relationship Between Public and Private Health Sectors

This country cannot afford to fund a luxury health system for everyone. We need to concentrate tax-payers’ resources on the highest priority services. Some New Zealanders will want to buy supplementary private health insurance to top up publicly-funded core health services, the services for which Government assistance is available. The Government accepts that people should be free to spend their own money on additional services that we cannot afford to deliver for everyone.

However, the relationship between the public health system and private health insurance is currently not as productive as it could be. Private insurers and care providers deliver only top-up coverage, leaving high-risk, high-cost health
services to the public sector. Responsibility for patient care is divided between
the public and private sectors, as well as between primary and secondary
sectors, and between the Accident Compensation Corporation (ACC) and other
funders. No one has responsibility for managing total patient care.

The integrated management of total patient care is crucial to improving the
quality of health care and the efficiency of the health system. That was the theme
of Chapter 3. It is desirable, therefore, to find ways of encouraging the private
health sector to take responsibility for managing total care.

In particular, gap insurance leads to inefficiency. Where private insurance picks
up part of the user charge for health care, the insured will use more services, and
the Government will face increased costs since Government subsidies pay for
the rest of the cost of care. Where the cost of a service is divided between the
Government and a private insurer, neither has strong incentives to control the
costs of that service.

As well, private health care providers do not always have an easy relationship
with the public health system. In particular, dealings between successive
Governments and medical professionals have often been troubled. There is a
deep-seated suspicion of any contractual relationship with the Government.
Chapter 3 discussed the need for RHAs to develop a variety of alternative
contractual arrangements with health care providers. Successful integration of
primary and secondary care requires health care funders and primary care
providers to find mutually acceptable ways of delivering affordable care while
setting limits to the Government’s financial obligations.

.Restriction of Subsidies to a Limited Range of Services

In both primary health care and continuing care, Government subsidies are
generally tied to particular types of service. For example, there is a subsidy for
consultation with a doctor, but not for consultations with a nurse practitioner,
a counsellor, a pharmacist or other health service providers. There are high
subsidies for pharmaceuticals and laboratory tests, but very limited subsidies
for health education activities. In continuing care, there are high subsidies for
institutional care, but much more limited subsidies for home-based care.

Some OECD countries make widespread use of nurse practitioners and other
health and allied professionals in both primary health care and in health
education. New Zealand does not. Apart from the recent moves to allow
midwives to practise independently of doctors and receive comparable subsidies,
nurses are generally unable to practise in their own right. Some rural areas have
CHOICE OF HEALTH CARE PLANS

established nurse-based practices with considerable success. However, this has been done only on a case-by-case basis, where no general practitioner (GP) has been available.

The way must be opened for this and other types of practice to be established much more readily. This will bring a larger number of women, Maori and Pacific Islanders into the delivery of primary care, helping to address some of the gender and cultural barriers to access to care. It will also open up new career paths for nurses and other health and social service professionals.

The Proposed Solution: Portability of Health Care Assistance

The Government has decided to allow people who prefer a different approach to the delivery of health care than that offered by their RHA to obtain all their services through another health care plan of their choosing. Unless people choose to leave their RHA, they will be automatically covered by it as of right. The RHA is, in effect, a large health care plan that covers everyone, unless they actively elect some alternative.

People will be permitted to leave their RHA, taking their entitlement to Government health funding to any other approved health care plan. People will also be permitted to return to the RHA if they wish. All individuals will therefore be covered by some part of the health system. Non-Government organisations will be permitted to establish alternative health care plans, offering access to the same range of services as RHAs. Chapter 5 discusses options for specifying this compulsory range of essential services, called “core health services”. Health Care Plans may contract with health service providers—including Crown Health Enterprises (CHEs) and community trusts, if they wish—to provide the full range of core health services. Plans will be required to ensure access to core health services of adequate quality.

The Government believes that choice of health care plans will address the three major problems outlined above:

- Limitations of RHAs

People who feel that their care needs are not being adequately met by their RHA will be able to turn to other organisations for health care cover. Health care plans can specialise in the care requirements of particular groups, such as women, families with young children, Maori and so on. Communities which are dissatisfied with the services the RHA funds in
their area will be able to take control of their own health funding. RHAs which want to keep clients will work harder to purchase more and better services with the money available.

Low-income people as well as high-income people will be able to go to alternative health plans. Everyone will be able to take their entitlement to Government funding with them, and use this to pay the fees of other health care plans. For low-income individuals, this entitlement will exceed the share of taxes they pay for health services.

### Relationship between public and private health sectors

The key to forging a new relationship between the public and private sectors is ensuring that one agency is responsible for funding or purchasing all of a person’s health services. If people want to pay for supplementary health insurance out of their own pockets, ideally they should obtain it from the same organisation that funds their core health services.

Health care plans will be required to purchase and manage core health services for their clients. They will not be able to shift responsibility for their own clients back on to RHAs. For instance, if their clients require a period of intensive care, and this is part of the required “core”, then the plan must be able to provide that service. If their clients want to buy supplementary insurance, rather than buying a separate policy from a private insurance company, they will be able to buy supplementary cover from their own health care plan. This means that their total care will be managed by one organisation, solving the problem of “gap insurance”. The difficult boundary between public and private sector responsibility for care will be eliminated. Commercial private insurers in New Zealand may want to develop health care plans, managing total care.

RHAs will negotiate subsidy and contract arrangements for primary care that enable them to control primary care spending. However, doctors have an alternative to negotiating with RHAs: they can take the initiative in establishing new health care plans or negotiating agreements with other plans. Plans are likely often to be built around primary care. They will offer GPs a leadership role in making primary care more effective, to reduce the need for hospital admissions.

### Restriction of subsidies to a limited range of services

People who choose to enrol with a health care plan will take their Government subsidy for health with them. Health care plans can use this money to develop their own package of health services. They are not obliged to purchase health services in the same way as RHAs. For example,
they may want to establish primary care clinics using nurse practitioners as well as doctors, to pay doctors on a different basis from fee-for-service subsidies, to develop their own methods of encouraging more economical use of pharmaceuticals, or to increase their emphasis on health education. Union health clinics, for example, might want to take advantage of this.

Of course, all health care plans will need to use properly qualified health professionals. They will also be required to provide core health services for all their clients, and required to limit any user charges they impose to affordable levels. Subject to these safeguards, plans can be innovative in delivering care, using the annual Government subsidy in the way that best serves their clients.

**Choice of Health Care Plan**

An immediate concern people may raise is whether these plans will take on only healthy, low-risk clients, leaving the sickest to be cared for by RHAs. To address this concern, people who are likely to have higher health care costs will take a larger sum of money with them if they leave their RHA, recognising their greater need for health care.

For example, older people tend to have higher health care costs than younger people. So older people who choose to enrol with a health care plan will bring to their health care plan a larger entitlement for paying the plan’s fees. This will encourage health plans to offer services to high-risk people as well.

When someone enrols with a health care plan, the plan will apply on their behalf for the share of the Government funds that would otherwise go to the RHA for their health care. Clear guidelines, approved by the Government, will determine the fair share of funding which will move from the RHA to the chosen plan.

People will be able to switch back to the RHA and to move from one health care plan to another. However, there will be limits on when people can switch plans. The period is likely to be fixed at either once every year or once every two years. Limits are needed to avoid the risk that people will be encouraged to switch plans whenever they have a high-cost health problem.

**Health Care Plans**

*What are health care plans?*

Health care plans will manage the total health care requirements of their clients. The Government’s vision for health care plans is of active management of total care for individual clients, with a strong focus on effective primary care.
CHOICE OF HEALTH CARE PLANS

Care plans will hold the annual budget for their clients' health care. Within that budget they will contract with health service providers to purchase comprehensive primary, community-based and hospital care services for their clients. They must provide all services included in the "core" health services.

Organisations which offer health care plans may provide some of their own health services, often primary care services. But they need not deliver the full range of health care services in-house. Indeed, if they were required to do that, there would be room for very few health plans in New Zealand. Instead, plans will have contracts with other health care providers, in the public or private sectors. In the foreseeable future, for example, all plans will need to contract with publicly-owned hospitals for highly specialised services that are available only in the public sector.

Health care plans will not be:

- supplementary health insurers (like most private health insurers in New Zealand at present), which cover only a fraction of the health services people need;
- "cost-plus" private health insurers, which passively reimburse patients for whatever health care they use;
- provider-dominated organisations, where care decisions might be driven by the interests of high-cost hospital-based specialist services;
- Government-owned or Government-guaranteed.

Types of health care plan

Various organisations might have an interest in establishing health care plans. Some of these may specialise in serving the health needs of a particular group, for example:

- plans established around existing union health centres, or area health board-funded health centres. These health centres generally serve low-income areas;
- plans specialising in women's health, offering female practitioners, choice of birthing options, better access to screening services and so on;
- plans based on iwi or other Maori organisations and associations, concentrating on Maori health needs and concerns about how health services are delivered. A more detailed discussion of how a Maori health care plan might operate is given below;
CHOICE OF HEALTH CARE PLANS

• community-based plans, where a community wants to take control of its own health care resources and address its concerns about rural access and the role of community hospitals. Community plans might be built around community trust hospitals;

• plans established around large group general practices or multi-speciality group practices, or around networks of general practices;

• plans established by organisations in the health insurance business, which have an interest in moving into providing comprehensive managed health care;

• plans established by large firms, willing to underwrite a health care plan for their employees.

Regulation of health care plans

To protect clients, and to contain costs, health care plans will operate within limits set by regulation.

The Government will put in place regulations specifying that RHAs and health care plans alike must purchase core health services for their clients. The range of core health services they must cover will be specified.

Plans will have to be approved by the Government. To receive approval, plans will have to demonstrate that they offer cover for all core health services, that they have sound cost-control strategies, and that they are able to manage the risk involved in their operations. There may be minimum capital requirements, for example, or requirements to re-insure, so as to reduce the plan's risk of becoming insolvent. The Government will establish a system to ensure that no one goes without needed medical care if their plan faces insolvency. However, the Government is concerned to avoid the pitfalls of consumer-guarantee programmes which effectively absolve plan managers or re-insurers of the responsibility for managing risks prudently.

Maori Health and Maori Health Care Plans

The incidence of and the mortality rates from most common diseases in this country are higher for Maori than for non-Maori. In general, Maori people experience higher levels of unemployment and lower earnings when they are working than non-Maori. They fare worse in the education system and are over-represented in penal institutions. These factors contribute to Maori people developing disproportionate rates of damaging lifestyle behaviour, such as cigarette smoking and alcohol consumption.
The report *Ka Awatea*, released in March this year, identified health as one of four areas of high priority for Maori affairs policy. The report suggested that the present health system has failed to respond adequately to Maori needs. It stressed the need for Maori to participate fully in and contribute to the development of New Zealand. The good health of Maori is recognised as particularly important for this. Positive incentives must be given to Maori as individuals and as members of whanau, hapu, iwi and other community groups to take responsibility for their own health.

The reform of the health system will create new opportunities for Maori development. Maori will be able to become involved in establishing health care plans. These have the potential to influence the way health services are delivered and to address factors which affect the health status of Maori.

**Maori health care plans**

The establishment of Maori health care plans would enable Maori people to transfer their share of health funding to organisations of their choice. These would act as agents to purchase access to comprehensive care. These organisations could recognise Maori values and cater for the specific needs and priorities of Maori people.

The option of enrolling in a Maori health care plan, as with any other health care plan, would be voluntary. Maori plans could also offer supplementary cover to members who want it.

Maori organisations with collectively-owned resources may decide to contribute some funding to health care plans. They could also make collective arrangements for payment for services, to lower user part-charges or provide additional services. This would be consistent with some of the initiatives of trust boards to invest funds in the development of people and important Maori institutions.

Maori health care plans could be directed by small boards of trustees, community trusts, iwi authorities, or some existing Maori authorities. Maori groups could also become involved with other agencies providing health care plans.

Health care plans offer the following advantages for Maori:

- the opportunity for delivering health services in a culturally appropriate way, thus removing some of the barriers that impede Maori from using existing services;

- the opportunity for Maori to specify their own health priorities and requirements for the style of practice, and reflect these in the contracts for health services negotiated with providers;
- scope to encourage new and innovative providers to deliver health services;
- the opportunity to negotiate access to providers at an agreed price, so that Maori as individuals and members of a collective group are aware of health costs and the need to take greater responsibility for their health;
- in the longer term, the ability to reduce the overall cost of health care by encouraging preventive health measures;
- the opportunity to recognise the complex social and economic factors that affect Maori health and to support Maori development through managing resources.

The Role of Private Health Insurance

The Government recognises the not-insignificant role played by supplementary private health insurance in the New Zealand health care system. The private sector has helped to relieve pressure on the public health system. However, it is desirable to encourage integrated management of the total costs of a person's health care.

RHAs will have difficulty controlling their costs if their clients are able to continue to take out gap insurance to cover user charges for their publicly-funded care. In the short term, given the extensive role of private health insurance, gap insurance will continue. Over time, however, the Government will examine options for addressing the problems caused by gap insurance. For example, it may be desirable to require those who wish to supplement their publicly-funded care out of their own pockets to obtain their total health care cover from a single health plan.

Private health insurers have skills and experience which will be important in the reformed health system. Some may want to move into providing managed health care and establish their own health care plans. They may also have an interest in acting as re-insurers or as risk-management advisors for other health care plans.

Getting There

Staged Implementation

Ultimately, health care plans will fund total health care for their clients. This will allow plans to achieve the fullest possible benefits of integrated management of client care.
However, developing the skills and experience to carry out this type of managed care will take time. Over the next two years, the Government will do detailed work on developing the information base, legislation and regulation necessary to permit a choice of health care plans. We will consult with other countries which have been developing similar policies, notably the United Kingdom and the Netherlands.

Staging the implementation has the advantage of allowing time for the development of the skills and resources necessary for offering a choice of health care plans. Some of the skills are likely to grow out of the RHAs’ purchasing decisions. For example, in small communities, RHAs might contract with a group of local health care providers to manage a range of health services for their communities within a budget. The experience local providers would gain through this would help to equip them to develop their own health care plan, if they wished.

There are three broad alternatives the Government plans to consider for staged implementation.

*Phase-in for the non-elderly population*

One of the main reasons for seeking to phase-in choice is to allow plans and reinsurers to develop experience at managing the risks involved in underwriting health care cover. These risks are much greater for the elderly, and increase for the older elderly.

As a first stage, plans might be permitted to offer care only to non-elderly clients, among whom high health care costs are more randomly spread. The appropriate age cut-off needs to be considered. Over time, plans could be permitted to cover progressively older age groups.

*Phase-in with a limited range of services*

Initially, people might be able to choose an alternative plan for only some of their health care services. For example, they might be able to obtain their primary care through alternative health care plans. RHAs would purchase secondary care services for all New Zealanders. Once health care plans had developed sufficient experience, they would be permitted to offer cover for these services also.

A limited variant on this approach has been adopted in the United Kingdom in their recent reforms of the National Health Service. General practices have been given the opportunity to hold and manage the budgets for their patients for all primary care, outpatient services, and a range of elective surgery. While we see no need to restrict budget-holding to general practices, we can draw upon the
United Kingdom experience in determining the advisability of this type of phase-in.

If choice is to be restricted initially to a limited range of health services, very careful thought must be given to deciding on that range. It must be clearly defined, so as to avoid uncertainty and dispute about which services are the responsibility of RHAs and which are the responsibility of alternative health plans.

It is also important to define the range in such a way as to encourage the most appropriate form of care. For example, if plans are given responsibility only for primary care, they may be tempted to refer patients to hospital for conditions that can be adequately treated in general practice, in order to reduce their costs. The definition must avoid this type of adverse incentive.

Phase-in with a dollar limit

Another option for phasing in choice would be to allow alternative health care plans to purchase total health care for their clients, but place a dollar limit on the level of health care costs a plan was obliged to meet for any one client in a year. Beyond this limit, all health care costs (or a high percentage of costs) would be borne by the RHA.

Under this approach, a single episode of high-cost care may place someone in the situation where all their subsequent health costs, including all primary care, would become the responsibility of the RHA. This would create some difficulties for RHAs, who would face uncertainty about what type of services they would be required to purchase and for whom. It would also create discontinuity in care management for a client whose health expenditure reached the dollar limit.

Summary of Decisions

The Government has decided to:

- allow health care plans to be established as alternatives to RHAs, once RHAs, Crown Health Enterprises and community trusts are fully established;
- draw up regulations within which health care plans will manage the budgets for all of their clients' health care requirements;
- allow people to leave their RHA and enrol with a health care plan, taking their entitlement to public funding with them;
- allow people to switch between health care plans and their RHA at intervals.
CORE HEALTH SERVICES

Key Points

- "Core health services" are the health services to which we believe everyone should have access, on affordable terms and without unreasonable waiting time. The Government has an obligation to assist people to obtain core services. If people also want non-core services (such as cosmetic surgery), they must pay for them out of their own pockets, or through private insurance.

- The Government believes we must define more explicitly what are to be included in core health services for New Zealand. This explicit list will make clear what services Regional Health Authorities (RHAs) and other health care plans are obliged to offer to all their clients. It will be used to protect the level of health services and hold RHAs and health care plans accountable.

- A list of core health services is based on an evaluation of whether the value people place on a health service justifies its costs. It must reflect the community’s priorities. The definition of core health services may be a negative list (of services that are not publicly-funded), or a positive list (of services everyone should have access to), or a combination of both.

- By defining core health services, we can get better value for scarce resources and seek to limit the growth of medical expenditure. If we do not do this, new medical technology and pressures arising from demographic change will overwhelm our health system.

- The Government has decided to appoint a National Advisory Committee on Core Health Services, combining consumer, ethical and expert input, and charged with engaging in a process of public consultation about the core.

- The Government believes it is particularly important to consult the public and health professionals about how core health services might be determined in New Zealand. Specific issues on which consultation is sought are set out at the end of this chapter.

Introduction

Earlier chapters pointed out that area health boards, when faced with a budget constraint, can cut services rather than trying to make better use of resources.
It is difficult to ensure area health boards make available the most important health services. In the new health system, the Government wants to hold Regional Health Authorities (RHAs) to account for purchasing the health services their communities most need. Health care plans must also be required to purchase an adequate range of services for their clients, so that they succeed by managing care better rather than by excluding services or clients.

For both reasons, we need to define more clearly the range of services we believe everyone is entitled to as an adequate minimum level of health care. The term “core health services” is used to describe this. An explicit core defines the “floor” in our health system: the minimum level of services that RHAs and health care plans must offer to all their clients.

Core health services can also define the “ceiling” on the Government’s obligations to assist people to access health care. It can thus ensure provision of priority health services while protecting tax-payers from paying more and more for health care costs over which they have no control.

Setting limits to health spending has become unavoidable. The level of sophistication of health services we can enjoy as a nation depends on our economic performance. In a budget-constrained system, there is increasing pressure on the availability of health services and more debate about what is important and what is not. This pressure is exacerbated by demographic pressure—in particular the ageing of the population—and by advances in medical technology, which continually extend what the health system can offer.

Core health services are not necessarily available free of charge. The Government might ask people to pay user charges for these services. However, it would always seek to ensure that user charges were affordable. Targeting the limits on user charges according to people’s income is one way of ensuring this.

People may choose to purchase health services that are outside the core, but they would have to pay for these services themselves. People could take out supplementary private insurance cover for non-core services. They might also take out gap insurance to pay for part or all of the user charges imposed by the Government for core services. Chapter 4 discussed some reasons for setting limits to gap insurance.

Why Define Core Health Services?

At present, the Government does not make explicit which health services people are entitled to. There is no list or description of what services area health boards and other health care providers must deliver. There is instead rationing
of access to health services through fixed budgets, partial payment for services and making people queue. Most people acknowledge that there are some services the Government should leave people to pay for themselves, even if they are on low incomes. Cosmetic surgery is an obvious example.

The lack of definition of what services are important has caused significant problems.

There is considerable variation between regions in the services available. Some boards offer only limited treatment of alcoholism and substance abuse, for example. Some boards carry out substantially lower than average rates of elective surgery such as cataract and total hip replacement, with the result that people in their regions wait long periods for surgery.

When boards are under budgetary pressure, they can cut services without breaching the terms of their contracts with the Minister of Health. They may make cuts to all services instead of prioritising and protecting the most important. For instance, pre-natal care, which prevents premature births and thus is highly cost-effective, may be cut by as much as high-risk surgery, which has little prospect of success. There is also a risk that low-profile “cinderella” services, such as mental health services, will be cut even if they provide greater health benefits relative to their cost than some of the more glamorous services that survive.

If there is a clearer definition of what health services everyone is entitled to, boards—or RHAs and health care plans in the new health system—will not be able to cut important services or neglect low-profile services.

Boards themselves suffer from the lack of clarity about what services they are obliged to provide. People often assume that the public health system will provide comprehensive health care of as high a quality as anywhere in the world. The reality is, however, that New Zealand cannot afford to provide all the services people would like. Our economic performance has been such that we have to be particularly careful about how we spend our health funds. The task facing boards—and in the future, RHAs and health care plans—would be much easier if the community’s expectations of their health system recognised the need to set priorities and accept limits to what the nation can afford to provide for all citizens. In fact, Health Boards New Zealand Inc. in its submission to the Taskforce, has recommended explicit debate about core health services.

Our health system is faced with economic stringency at a time when the demand for services is growing. Demographic change is increasing the demand for services. Older people typically have higher health care costs than any other
group in the population. Currently an estimated 44 per cent of Vote: Health is spent on those aged 60 or more, and it is projected that the proportion of the population in this category will increase by 50 per cent in the next 30 years (from 15 to 22 per cent of the population).

Figure 5.1: 1989–90 Vote: Health Expenditure by Age Group

Key

$\Box[000] per head
NZ average


Note: Per head expenditure is an estimate only.
The ageing of the population is not the only source of demographic pressure on health care costs. Another is the trend for women to have children later in life. In the five years from 1982 to 1987, there was a 73 per cent increase in births to women over the age of 35. With these pregnancies there are greater demands for tests such as amniocentesis and ultra-sound scans.

If our health system is to continue to meet the needs of everyone—and, in particular, the growing numbers of elderly people—we must set clear priorities for health spending. We must focus on what is most important, and on how to deliver more effective services for the money spent.

Setting priorities requires us to scrutinise the benefits of high-cost new medical technologies, and to re-evaluate old technology and practice. The development, and ever-widening application, of new technology is already straining the health system. MRI (magnetic resonance imaging) scanning is a good example. This expensive technology is more effective at showing up some conditions than older technology, such as X-ray, ultra-sound or CT scans. When first introduced overseas, it was used only where it could make a vital difference to the diagnosis. However, as more MRI machines have been purchased, the extra capacity has created incentives to extend its use to lower-priority applications such as evaluation of knee joints.

Not all increases in technological demands on health spending are the result of spectacular new hardware. There are also increases in high-volume, low-cost technologies which, in total, can incur substantial rises in expenditure. For example, ACE inhibitors (a drug used for the treatment of high blood pressure) were only just entering the market a decade ago; they now cost the Government approximately $40 million per year. Where the costs of care rise like this, we need to consider whether the benefits have also risen.

Relatively new technologies which are highly effective, such as laser treatment of birthmarks, prevention of blindness from diabetes with laser therapy, artificial lens replacement for cataracts, and new finger joints for rheumatoid arthritis, are growing. Public demand for these technologies is understandable, but the expectation of what health services should be available may exceed the Government’s—and ultimately the nation’s—ability to fund them. Tension between what is expected and what is affordable will increase.

A recent example of problems with our current mechanisms for limiting the spread of very expensive technologies is Eprex. This drug costs approximately $17,000 per person per year, though the costs per person range from $8,000 to $32,000 per year. It is most often used to treat anaemia resulting from long-term reliance on an artificial kidney. A working party of experts estimated the maximum demand for this drug, and on the basis of these recommendations, it
was made available to those meeting the criteria at no cost to users or area health boards. Within six months of its availability, demand has exceeded the estimated maximum by 50 per cent, and the over-run means that this money is not available for some other higher priority area.

There will be rationing of access to health services in any system because the demand for health care is virtually unlimited where the price is very low or zero. In some countries, access is rationed by people’s willingness and ability to pay. In other countries, such as New Zealand, rationing is also done by queueing or denial of care. In the past, rationing has been done informally and often without public scrutiny or control. Defining a set of “core health services” more explicitly will help to ensure that the services the public believe to be the most important will be provided. It will also acknowledge more honestly that there are limits to the health services we can afford.

How an Explicitly Defined Core Addresses the Problems

While there are limits to the precision and detail with which we can define core health services, New Zealand to date has done little to clarify what health services all citizens are entitled to. A more explicitly defined list of core health services could reduce the problems described above, by:

- making clear the range and level of services consumers can expect to receive;

- making clear the range and level of services RHAs and health care plans are obliged to contract for, for their clients;

- setting priorities for health expenditure, thereby helping to limit Government spending;

- creating realistic expectations of health services.

The following benefits can result:

- increased certainty of entitlement for consumers;

- better value for scarce resources in the health system, and another way of containing costs;

- greater accountability of RHAs to the Government;
- protection of important but lower-profile services;
- reflection of the community’s priorities.

How Might Core Health Services be Defined?

Alternative Approaches to Listing Core Health Services

The basis for determining a list of core health services is whether the value people place on a health service justifies its cost. This can be used to develop positive or negative lists of core services.

Negative lists

If some services are judged to cost too much, the Government may choose not to fund them. A negative list of core services would include everything that fell into this category, so that people were entitled to all forms of health care except those listed.

The negative list may include services (eg, adult dental services, general surgery), conditions (eg, uncomplicated varicose veins) or forms of treatment (eg, some transplant surgery) which are then excluded from coverage.

Several countries use negative lists:

- The federal Government of Canada explicitly lists some services that are excluded from coverage in its public health system. The list excludes most adult dental services, chiropody, optometry, physiotherapy, osteopathy, ambulance, dietetics, hearing aids, psychology, pharmaceuticals and other ancillary services, except when provided in hospitals. (However, some individual provinces in Canada subsidise some of these excluded services at their own expense.)

- In the United Kingdom, one regional health authority has recently listed procedures it excludes from coverage unless there is “over-riding clinical need”, such as treatment of uncomplicated varicose veins, treatment of many types of benign lumps and removal of tattoos.

- Many countries, including New Zealand, have excluded some high-cost “experimental” technology, especially procedures which do not yet have proven benefit.
Cosmetic surgery is excluded in many countries.

**General positive lists**

If services are judged to be valuable enough to people to justify their cost, the Government is likely to want to ensure that everyone has access to them. These services would be included in a positive list of core health services. A positive list defines all the services to which people are assured access. In this case, anything not on the list is deemed not to be in the core.

The positive list may identify services that must be offered (e.g., maternity services), or conditions or categories of conditions for which appropriate treatment must be offered (e.g., asthma, diabetes, coronary artery disease, hypertension) but not necessarily the mode of treatment. The list might include all life-threatening conditions, and other categories defined by urgency.

Several countries have developed or are developing positive lists:

- The Netherlands has introduced legislation specifying the services that must be covered under its social insurance scheme, such as general medical and surgical services, obstetric care, dental care, medicines and dressings, hospital admission, and so on. The legislation imposes some conditions and limits on the core within these broad categories, such as:
  - limits on the type of practitioner prescribing treatment or delivering the service;
  - limits on the quality of hospital accommodation;
  - limits on the length of hospital stay for some conditions; and
  - requirements for authorisation by the social insurance fund for some high-cost services.

- Legislation has been developed in the State of Washington which would specify the services covered by a proposed insurance-based Washington Healthcare Plan.

It is possible to set out criteria that health service purchasers may use to determine priorities among the health services they offer. The criteria might permit RHAs and health care plans to use cost-effectiveness to determine which kinds of treatment they will offer. (This involves evaluating the benefits of health services by their effect on the length and quality of life, such as QALYs—quality adjusted life years.) RHAs and plans might then be given a list of health conditions and the services required to deal with them, and obliged to provide
all the services listed, using proven cost-effective methods. The criteria might also stipulate that decisions to limit health services be consistent with medical ethical principles. Such criteria can be a feature of legislation setting out core health services. The State of Washington legislation establishes criteria that insurers may use to ration care.

If core health services are defined using a general positive list of services, the Government will need to set a budget constraint for RHAs, if it wishes to control health expenditure. Rationing decisions will then become the responsibility of RHAs, using the criteria set out in legislation.

Priority-ranked positive lists of conditions and treatments

This approach defines the core services in more detail. It ranks health conditions and their treatment in order of priority. Ideally, the priority ranking is based on cost-effectiveness and community consultation. The list can also include disease prevention and health promotion activities. It can be extended to include diagnostic procedures as well as treatment. This approach is used in the State of Oregon.

A priority-ranked list can be used to limit total health expenditure. In effect, the Government can “rule a line” at any point in the list depending on the level of health expenditure it chooses. Treatments below the line would not be publicly subsidised, even for low-income people. With a general positive list of core services, RHAs and health care plans have delegated responsibility for rationing decisions. By contrast, the priority-ranked list involves collective decisions about rationing, made at central Government level.

Other Aspects of Defining Core Health Services

The list of core health services can be used in conjunction with additional rules for RHAs and health care plans which protect access or contain costs, such as:

- limits on permissible waiting times;
- limits on the level of user charges;
- encouragement to use medical treatment protocols for particular treatments (especially high-cost ones). Treatment protocols set out criteria for identifying which patients are likely to benefit from a particular treatment and which are not;
- encouragement for RHAs and health care plans to set quality guidelines, review the treatment practices of medical staff, or use other tools for
managing health care so as to achieve the best outcomes for clients within a constrained budget;

- assessment of the effectiveness (whether the technology really works outside of experimental situations) and cost-effectiveness of new diagnostic or treatment technology. Technology assessment can help to develop the definition of core services, particularly if a detailed prioritised list of treatments is used. It can establish lists of services excluded from the core, or assist with the development of treatment protocols. New Zealand might do some of its own technology assessment, but we can draw heavily upon research and assessment from other countries.

**Advantages and Disadvantages of Alternative Approaches**

The different approaches to defining core services can be used together. Positive and negative lists can be combined to define the core. If there are clear exclusions—services or treatments the Government has no intention of funding, such as cosmetic procedures—they should be explicitly listed. A positive list is required as well, however, if the Government wishes to control its liability for funding health services.

A decision is needed about whether to combine a negative list with a general positive list or with a detailed, priority-ranked positive list. The following comparison focuses on the differences between the two.

**General positive list (eg, positive list of services or conditions plus principles for rationing)**

- **Advantages:**
  - devolves more of the difficult choices over treatment to the individual, their family and their practitioner;
  - allows medical practice to respond more flexibly to rapidly changing technology (subject to any rationing criteria), and to differences between individual patients (such as the presence of multiple diseases), and differences in cultural or gender preferences;
  - leaves more room for clinical independence and diversity of care options.

- **Disadvantages:**
  - less certainty of entitlement and obligation;
— more difficult to monitor and enforce;

— leaves more scope for variation between regions and alternative pur-
chasers in the care provided (though, within limits, variation may be ac-
ceptable, even desirable, where different regions and client groups have different needs);

— harder to use the core as a lever for long-term cost-containment;

— potential for litigation.

*Highly explicit priority-ranked positive list (of conditions and treatments for those conditions)*

**Advantages:**

— certainty of entitlement for consumers and obligation for RHAs and health care plans;

— more precise monitoring and accountability;

— strong emphasis on cost-effectiveness, making the best use of scarce resources.

**Disadvantages:**

— highly politicised decision-making about difficult choices to limit treatment; ethical choices for individuals about medical treatment are made by the community as a whole through a political process;

— risk of raising expectations of what health services can deliver, particular-
ly if the process of defining the core is seen as an opportunity to advocate the interests of particular specialities or client groups;

— less flexible in taking account of individual circumstances (such as presence of multiple diseases), rapidly changing technology, or differences in cultural or gender preferences, unless specified in detail with continual up-dating;

— danger of bias towards procedure-based medical care, and away from prevention, education and counselling;

— leaves least room for clinical independence, and so is likely to encounter opposition from many medical practitioners who argue that doctors and patients are best placed to decide which treatment is most appropriate;
— creates greater demands for expert skills and research to define the core;
— creates scope for highly technical litigation;
— the more explicit the core, the more it implies a financial commitment on the part of the Government to ensure access to that core.

Processes for Defining Core Health Services

Defining the core services requires input from the public and from experts. Consumer input is vital, since the core services need to reflect the values and preferences of the people served by the health system. In particular, the process of defining the core must ensure that priorities for health care expenditure are not dictated by the special interests of health care providers, but genuinely reflect the priorities of the community.

Expert input is required also, since definition of the core involves consideration of which health services are effective, which are most cost-effective and which are most urgent, given the health needs of New Zealanders. It will also involve ethical considerations. Medical, epidemiological, economic, legal and ethical skills are therefore needed.

The Government will appoint a National Advisory Committee on Core Health Services, and charge it with the task of engaging in public consultation about the core. This body will be accountable to the Minister of Health.

The Committee membership will combine consumer, ethical and expert input. It will consult with the public, through public meetings, submissions processes, surveys and other methods.

How the Core Might be Implemented and Enforced

The list of core health services would be specified in general legislation, which would also specify penalties for RHAs or health care plans which failed to provide core health services. The core would be enforced either through the general courts system or a specialist tribunal established by legislation, which would ensure that RHAs and health care plans did indeed provide core health services for all their clients. However, it would be the role of policy decisions, rather than legal decisions, to define what services fall within the scope of the core.

The Government is currently considering establishing the Office of the Health Commissioner. This office might be a suitable place to locate responsibility for enforcement of the core.
Timeframe for Implementation

There are no models for defining core services that could simply be imported into New Zealand. A core service specification must be developed specifically for New Zealand. However, we will be able to draw upon a substantial body of overseas research and evaluation in doing this.

The Government could begin to define the obligations of RHAs by specifying the services currently provided by area health boards. Initially, the Minister of Health might wish to implement core health services via contracts with RHAs specifying the services they are to provide.

A more general core specification might take two years to develop and implement. A highly detailed and explicit Oregon-style core might take several years, depending on the level of detail the Government wished to achieve. However, it would be possible to phase in this approach, prioritising some areas of service first, and others later, and gradually increasing the detail.

Summary of Decisions

The Government has decided to:

- define more explicitly the set of core health services, which all Regional Health Authorities and health care plans must offer to their clients;
- appoint a National Advisory Committee on Core Health Services, combining consumer, ethical and expert input, and charged with engaging in a process of public consultation about the core.

Issues for Public Discussion

The Government believes it is particularly important to consult the public and health professionals about how core health services might be defined in New Zealand. Once the National Advisory Committee on Core Health Services is established, it will embark upon a process of consultation about what services, conditions or treatments should be included in the core.

In the immediate months ahead we seek comment on this issue:

How should core health services be defined in New Zealand? That is, what combination of the following approaches should be used:

- a negative list;
- a general positive list, with obligations to provide all services on the list, using treatments of proven cost-effectiveness;

- a detailed priority-ranked positive list?
FINANCING HEALTH CARE

Key Points

- Health care is a key component of our standard of living. But we are now faced, as a community, with either requiring some people to pay a larger share of health care costs, or accepting a diminished level of core health services.

- User charges can meet only a small share of the total costs of health care if they are to be kept affordable for everyone. This is because a small proportion of the population accounts for quite a large share of health care costs.

- The options for financing the greater part of health care costs include:
  - financing from general tax revenue, as we do at present;
  - establishing a system of social insurance premiums to pay for health care, levied on each family, with income-related assistance to help people pay the premiums (premiums might also be adjusted to reward healthier lifestyles).

- Three other options exist, but these are not feasible or desirable for New Zealand in the foreseeable future. They are:
  - financing health through tied taxes with the funds raised dedicated solely to health spending. Tied taxes can create a presumption that health is beyond the usual scrutiny applied to Government expenditure. For this reason, the Government does not favour tied taxes for financing health care;
  - establishing a system of compulsory insurance, in which Regional Health Authorities and health care plans collect premiums from their clients, with the Government ensuring that everyone is covered and giving income-related assistance to help people pay the premiums. This option might deserve consideration if most people choose to obtain their health cover from health care plans; however, it is not considered feasible in the next few years;
  - leaving people to take out private health care cover on a voluntary basis, with the Government providing a safety net for those who cannot obtain
insurance. The Government believes that the problems with this approach are so great as to rule it out of consideration for New Zealand. This is the system used for financing health care in the United States.

The options for financing health care need to be evaluated against the following criteria:

— affordable access for all to core health services;
— scope to assist those least able to provide for themselves;
— incentives for individuals to take care of their health and for providers and their clients to keep the costs of health care down;
— avoidance of disincentives to work and save;
— clarity about the costs of health care and who pays for them;
— simplicity and economy of administration.

The Government has decided to consult the public about which of these options should be used to pay for health care. A combination of approaches can be used. However, in the foreseeable future tax increases are not likely, for reasons discussed in this chapter. Specific issues on which consultation is sought are set out at the end of the chapter.

Introduction

As pressures on health care costs increase, the Government needs to secure guaranteed access for all to core health services, while protecting tax-payers from ever-escalating pressure for spending on health care. The previous chapter discussed the role of defining core health services in achieving these objectives. The other major vehicle is the policy for financing health services.

Decisions about how health care is paid for are perhaps the most difficult and complex of all the decisions we face in health. They are almost certainly the most contentious. In a climate of rising health expenditure and constrained ability of tax-payers to fund services, we have to find a way of sharing the costs of health services that is sustainable and fair. Our current approach to financing health is neither.

We are faced, as a community, with making decisions about the financing of health care: are we going to require some people to pay a larger share of health care costs, or are we to accept a diminished level of core health services? We
must all grapple with the difficult choices this will entail. For these reasons, the Government has decided to consult the public over the options for financing health care. Clearly, these choices are related to those we must make about the range of health services we include in the core. It is therefore appropriate that these two areas be the subject of consultation.

How We Finance Health Care

Today

At present, health services are paid for by a combination of general tax revenue, user charges and Accident Compensation Corporation (ACC) levy revenue. Private individuals may purchase supplementary insurance to pay for a higher level of services or more prompt service than is available from area health boards. Private insurance policies usually include gap insurance, to cover part or all of the user charges for health services. The shares of health care paid from these different sources are set out in Figure 6.1.

Chapter 3 discussed problems with the way user charges operate at present. They are arbitrary and unfair, and give wrong signals about the cost of alternative services. Accident cases, and people with private insurance, face little or no charge for services, and so are more likely to make wasteful use of health care. The tax-payer typically picks up part of the cost of that wasteful use.

There are other problems with the way we finance health care. The largest share of the costs is borne by the tax-payer. Individuals, health service providers and private insurers all have incentives to push as much of health care costs on to the tax-payer as they can. Individuals can use accident and emergency services to avoid the cost of a visit to their general practitioner. Doctors can bill the Government for $25 for seeing a young child, even if the consultation took only a couple of minutes, or was really for the child's parent. Providers have few incentives to choose the most cost-effective forms of care. Private hospitals and private insurers can avoid the high-risk high-cost cases by having patients admitted to a public hospital as soon as their diagnosis or treatment becomes complicated.

However, simply raising taxes would not address these problems. If everyone in the health system shifts risks on to the tax-payer and health consumers, without regard for the real costs and benefits of health services, two things happen in the current system:

- costs are shifted on to area health boards, leading to service cuts for consumers, as boards try to live within their annual budget limits;
Figure 6.1: Estimated 1990–91 Health Expenditure by Source of Funds


Note: The analysis employs the Abel-Smith definitions of what is, and is not, classified as health-related expenditure. The classification system was developed for the World Health Organisation. Capital expenditures are excluded (although depreciation and interest is included). General taxation is allocated to health primarily through Vote: Health. However, health-related expenditures of Education, Social Welfare, Ministry of Agriculture and Fisheries, Labour, Justice, Defence and Police are also included in the estimates. Household expenditure is given here net of any ACC or health insurance reimbursements. Voluntary organisations’ expenditure is net of any Government subsidies or grants. All expenditure is inclusive of GST.

- costs are shifted on to open-ended subsidy programmes, leading to either:
  - cuts in subsidies, which raises user charges and thus deters low-income people from accessing services; or
  - growth in spending, and hence a need to raise taxes or cut spending in other areas.

In our current circumstances, it is not realistic to increase Government spending on health and increase taxes to finance it. Our debt levels are very high and must
be reduced in order to strengthen our economy and permit the growth needed to sustain our social services in the long term. Constraining the level of the tax burden is also critical to this recovery of growth. As well, it must be remembered that any significant increase in tax revenue can be achieved only by increasing the taxes paid by people on modest incomes. New Zealand simply does not have a large enough population of very high-income people to allow us to raise much revenue while protecting the incomes of most people.

While the Government would be interested in moving away from a system as dependent on tax-financing as the present one, it recognises the real tension between comprehensive coverage and the private insurance market’s natural desire to avoid covering high risks. The Government’s concern with increasing the scope for private insurance is the evidence from overseas that as private insurers select out the better risks, for a given premium, they are able to fund a more extensive, higher-quality range of health services for that group. This escalation in standards increases the costs to the Government of providing health services to the higher-risk groups remaining with the state. If the Government is unwilling or unable to finance the same level of services for everyone, a two-tier health system will develop. The only alternative is an escalation in health costs.

The reality in New Zealand today is that multiple service standards are beginning to emerge, where income, insurability and geographic location determine the quality and range of access to some health services. This tension is part of the reality of any health system. It is not unique to a private insurance system, but is a feature of a mixed public and private system. Unless private provision and insurance are banned, that is, a state monopoly for health created, this tension will be a feature of the New Zealand health system. Whatever financing arrangement is selected, these issues must be understood and addressed. The implication is that an appropriate regulatory regime is necessary, as the Government is not prepared to risk less than comprehensive coverage and must limit the risk of escalating health care costs to central Government and the community at large.

Options for Financing Health Services

Principles for Policy

The Government is committed to reforming social policy to ensure that those least able to provide for themselves receive the greatest support. In addition, the Government seeks to increase efficiency, self-reliance and fairness, and en-
hance personal choice. In keeping with these objectives, the Government sets out the following principles to guide choice among the options for financing health care. These principles sometimes conflict. We have to strike a balance between them.

- Health care should be financed in a way that ensures everyone has affordable access to core health services.
- Health care financing should enable the Government to provide greatest assistance to those least able to provide for themselves.
- Health care should be financed in a way that creates incentives for individuals and, more importantly, for health service providers who advise them, to keep down health care costs. This occurs through individuals taking care of their own health and through providers and their clients avoiding wasteful use of health services.
- Health care should be financed in a way that avoids disincentives for people to work and save.
- Health care should be financed in a way that makes explicit the costs of a person’s care and who pays for it.
- The administration of health care financing should be simple and cost-effective for consumers, the Government, and third parties who may be involved in collecting revenue (such as employers collecting income tax).

**The Role of User Charges in Financing Health Care**

As previous chapters have discussed, user part-charges are charges that people pay each time they use a health service, such as the charge for visiting a general practitioner (GP) or the prescription charge. User charges are to be distinguished from insurance premiums or tax contributions for health, which are paid regularly, independently of an individual’s actual use of health services.

Insurers, or Governments where they meet most health care costs, have good reason to levy user charges to cover part of the costs of health care. There is overwhelming evidence that user charges play a vital role in encouraging consumers to consider the costs of health services, and economise on their use. This is particularly true of services which people decide to use themselves, for instance GP visits. For services obtained only on referral from a doctor, incentives for the doctor to economise are more important, but even there user charges do help to moderate use.
Of course, user charges also pay part of the cost of health services and so reduce the burden to be borne by other financing mechanisms. In this way, they can be used to achieve some fiscal savings.

This chapter sets out a number of options for financing the bulk of health care costs. User charges will feature alongside any of these options as a means of sharing the costs and risks of health expenditure with providers and users.

In any financing system, raising the level of user charges too high will increase demand for gap insurance. Chapter 4 discussed the undesirable effects of this.

The Government believes that it is important to extend and rationalise the system of user charges in our health system, as discussed in Chapter 3. However, the Government is committed to improving access to health care for low-income people. So we must ensure that user charges are affordable for those who do not have gap insurance. For this reason, it is necessary to target user charges according to income. We must also provide protection for the chronically ill, who are heavy users of health services. The 1991 Budget Supplement on Social Assistance—Welfare that Works—outlines measures which take a first step towards achieving our goals for user charges.

Because of the need to keep user charges affordable, the scope for raising revenue through them is somewhat limited. The reason is that a small proportion of the population accounts for quite a large share of health care costs. Many of these people lack the means to pay anything more than modest user charges.

Financing the Rest of Health Care Costs

General tax revenue

The bulk of health care costs (77 per cent) in New Zealand is financed from general tax revenue. This approach to financing health care has these characteristics:

- Contributions are compulsory.
- The Government sets and collects contributions.
- Core health care services are paid for out of tax revenue derived from whatever mix of tax bases the Government chooses to use. The major sources of tax revenue in New Zealand at present are personal income tax, GST (a value-added tax on goods and services) and company taxes.
- Individuals’ contributions towards the cost of health care are based on a mixture of their income (through the income tax) and their expenditure
Financing health care through GST, plus other indirect taxes such as petrol tax and the excises on alcohol and tobacco. This means that higher income individuals pay a larger share of the costs of the health system.

- Individuals' contributions towards health care costs are not related to the value of the health services they receive, nor to how serious their health risks are likely to be. High-income people will generally contribute more than the value of the health services they expect to receive. Healthy, low-risk people will generally pay more than their share of health care costs. People who take poor care of their health, and people who over-use health services, pay just the same as those who take good care.

- People's contributions combine the effects of distribution from rich to poor with the effects of distribution from healthy to sick. These two types of redistribution are not made explicit.

- Decisions about how much tax revenue is spent on health typically form part of the Government's general expenditure review, though it is possible for the Government to commit itself to a particular level of health expenditure for several years.

**Tied health taxes or levies**

New Zealand has made little use of tied taxes or levies in recent years. It would be possible to finance a greater share of health care costs through a tied tax.

Financing health care through tied taxes can take various forms, so it is difficult to characterise this option precisely. Tied taxes share many of the characteristics of general tax-financing of health care, outlined above. The key difference is that funds raised through the tied tax are supposedly dedicated to health expenditure; the Government may not spend them on other purposes.

In practice with most tied taxes, if too much revenue is raised in any one year these funds are used for other purposes. If the tied tax raises too little revenue, then health care costs are met in part from general tax revenue. In this situation, the tied tax serves little purpose.

It would be possible to run a tied tax as the sole source of revenue for health, with the funds raised genuinely dedicated to health. Excess revenue raised in any one year would be accumulated as reserves and invested for future years. If the tied tax raised too little revenue in a year, the Government would draw on reserves accumulated in previous years.

The usual rationale for introducing tied taxes is to create a presumption that health expenditure should be exempt from the normal expenditure review
processes. However, this would expose the Government to the fiscal risks of having a sizable area of expenditure placed beyond normal scrutiny. It would hamper the Government’s ability to argue that some other spending programmes should be given higher priority than aspects of health expenditure.

For these reasons, the Government does not favour tied tax as an option for financing health care.

**Social insurance premiums**

Another option would be to design a system of social insurance premiums in which people’s contributions to health care costs are better related to the value of the health care they expect to receive. With this type of scheme, the Government would bill each individual or family regularly for their expected share of the costs of the health system.

This should be distinguished from what is called “social insurance” in many countries. In practice, many existing social insurance schemes amount to systems of tied tax, often taxes on the pay-roll.

With the development of adequate information systems, these regular payments—or social insurance premiums—could be adjusted to reflect individual differences in the costs people imposed on the health system. It might be possible, for example, to adjust the premiums to impose penalties on particular types of unhealthy behaviour—such as smoking, dangerous driving or alcohol abuse.

The Government would need to ensure that everyone was able to afford their social insurance premiums. For lower-income people, the Government could pay a larger share of their premiums out of tax revenue. Alternatively, it could give lower-income people sufficient income assistance to enable them to pay the full premiums themselves. Government assistance for payment of social insurance premiums could abate as family income increased, as part of its overall abatement regime for targeting social assistance.

It is important to note that the social insurance regime proposed for public discussion would involve significant subsidies for low-income people and for those with poorer health status. These subsidies would be paid from general taxes. Using general taxation to pay for 100 per cent of the premiums for children and to fix a dollar limit on the premiums faced by the elderly should enhance the acceptability of such a scheme. It would not materially affect the advantages or administrative costs of it.

This kind of social insurance scheme has these characteristics:

- Contributions are compulsory.
The Government would set and collect premiums.

Contributions are, in effect, premiums for cover for core health services. If the list of core health services is expanded, or if the costs of the core rise, premiums would be increased.

The Government could give targeted assistance for people to meet the costs of their premiums. This could take the form of additional income maintenance assistance or of income-related subsidies for the premiums.

Premiums could be risk-adjusted, so that they reflect people's expected health care costs. However, the Government could set premiums so that low-risk people pay more than their expected share of health costs, and subsidise the premiums of high-risk people. If everyone paid the same premium regardless of risk, the premium would be “community rated”. It would then be equivalent to a poll tax for health care.

Social insurance premiums would allow the Government to make explicit how far it is redistributing from high- to low-income people and from healthy to sick. Healthy low-income families would not need to be asked to subsidise sick high-income families.

The Government would have to take care, under a social insurance scheme, that health expenditure covered by premiums was not exempt from the normal expenditure review processes.

**Compulsory insurance**

Under either tax-financing or a social insurance scheme, the Government collects contributions or premiums from everybody. It then directs the funds raised to Regional Health Authorities (RHAs) through a population-based formula. Money paid to those who choose to enrol with health care plans is then taken away from RHAs.

If, in the future, the majority of people choose to enrol with health care plans, the Government will face the costs of first collecting revenue and then returning it to individuals or health care plans to pay the annual fees of plans. At this point, the Government may wish to consider another approach to financing health care to reduce these costs. RHAs and health care plans could be given the task of collecting premiums from their clients directly.

However, because the Government is concerned to ensure that everyone does have health care cover, it would have to set up systems for ensuring that everyone is enrolled with either an RHA or a health care plan.
As with a social insurance scheme of the sort outlined above, the Government would need to provide assistance from general tax revenue to help low-income people pay their premiums.

A compulsory insurance scheme has these characteristics:

- Contributions are compulsory; the Government would need to ensure that everyone is covered by either an RHA or a health care plan.

- Premiums are set and collected by RHAs and health care plans. Premiums are likely to be risk-adjusted to some degree: that is, those with higher expected health care costs will face higher premiums than those with lower expected costs. However, RHAs and health care plans will make their own judgements about whether the complexity of risk-adjusting premiums is worth it in terms of encouraging more healthy behaviour. In fact, RHAs and plans are likely to use group schemes, in which all members of the group are charged the same premium. These group schemes may be based on place of employment, or membership of a common interest group such as a union, iwi or church.

- Premiums will be set to cover the expected cost of core health services. If the Government expands the definition of the core, premiums will rise.

- The Government can give targeted assistance for people to meet the costs of their premiums. This can take the form of additional income maintenance assistance or of income-related subsidies for the premiums.

- Health expenditure will not be included in Government expenditure reviews. The Government would control its health expenditure by controlling the definition of core services and the amount it spends on subsidising premiums.

It must be recognised that this approach to financing health care in New Zealand could not be implemented in the next few years. Rather, it is an option which may become relevant if health care plans grow to serve most people.

Voluntary insurance with a government safety net

Another way of ensuring that everyone has access to core health services, is for the Government to make it voluntary for people to take out health insurance, but provide a safety net for those who could not obtain insurance.

Since many people might prefer to use the safety net, if that enabled them to avoid paying insurance premiums, the Government would have to set conditions for access to the safety net. These conditions would include both means testing and assessment of health risk. In general, low-income and high-risk people might need access to the safety net.
The Government has overwhelming reservations about this option for New Zealand. The United States health system (apart from the Medicare programme covering the elderly) is financed through voluntary insurance, with public safety net policies. The problems evident in that system are so major that the Government does not intend to consider this option for New Zealand.

These problems include:

- Many insurance policies exclude high-cost health conditions, such as AIDS. Clients who have serious health problems may be unable to get insurance; insurers “cream-skim” low-risk clients and seek to dump high-risk clients.

- Unless people are able to obtain health insurance through their employer (who receives a tax break for health insurance), it is prohibitively expensive and difficult to obtain insurance.

**Comparison of the Options**

The options outlined above can be compared by evaluating them against the principles set out earlier in this chapter, namely: affordable access for all, assisting those least able to provide for themselves, incentives for health and prudent use of health services, avoidance of disincentives to work or save, explicitness of the costs of care and who pays for them, and economy of administration.

Clearly, detailed comparison of financing options is possible only if they are specified precisely. This would require setting out exactly what tax rates, what type of tied tax, what level of health premiums and what social assistance regime were under consideration as alternatives. The following comparison attempts only to indicate the issues that would need to be considered in a more detailed evaluation of specified options.

**Affordable access**

Health care systems financed from general tax revenue fare well with respect to affordable access, as long as tax burdens are fairly distributed. Contributions are related to ability to pay.

Social insurance or compulsory insurance premiums reflect the expected cost of someone’s health care and a maximum is set, regardless of income. That means that healthy upper-income people will not have to pay more simply because they earn more. However, the Government can offset the income distribution effects of the premiums with changes to the income tax and welfare
systems—increasing the redistribution from high-to low-income people through taxes and benefits.

Assistance for those least able to provide for themselves

Tax and welfare systems allow the Government to redistribute income from high-income to low-income people. However, this redistribution does not adequately target those least able to provide for themselves. Healthy, low-risk people may be well placed to provide health care cover for themselves, for example, even if they have low or modest incomes.

By contrast, health premiums enable the Government to target assistance with health care costs to those least able to provide for themselves, whether because of low-income, high health risk, or both.

Incentives for health and prudent use of services

Tax-financing does not create any financial incentives for taking care of one’s health or considering the costs of health services used.

Health premiums can be adjusted to reflect risky behaviour and underlying health risk. This may encourage healthy behaviour and more cost-effective use of health services.

Disincentives to work and save

Higher marginal rates of income tax reduce people’s incentives to work and save. The effect on incentives to work is most serious for women and youth.

Health premiums are not related to earnings, so the premiums themselves do not discourage earnings. However, targeted social assistance for payment of premiums will abate with income. People with incomes in the abatement range will face strong disincentives to earn.

In general, targeted assistance will expose a small number of people to high disincentives, whereas tax-based financing will expose a large number of people to lesser disincentives.

Explicitness of costs and of who pays

Tax-financed health care hides the costs of the health system among overall Government spending. Tax-financing bundles together redistribution from high- to low-income people with redistribution from the healthy to the sick.

Health premiums make very clear the costs of the health care cover an individual or family receives. Income-related assistance for paying the premiums is explicitly distinguished from any redistribution from healthy to sick. The
latter is associated with the decision to community rate premiums—that is, to make lower-risk groups pay more than their expected costs, to subsidise the premiums of higher-risk groups. If the Government finances health care through social insurance premiums, it will have to make explicit decisions about these two types of redistribution.

*Economy of administration*

Given that we already have a tax collection system, the administrative costs of raising more revenue through taxes are very low.

Establishing a new system for collecting health premiums from all families will have large implementation and on-going administration costs, whether it is administered by the Government or by RHAs and health care plans. The on-going costs may amount to between 5 and 10 per cent of the total costs met by premiums. These costs must be weighed against the benefits of improved incentives. The information costs and problems associated with establishing a social insurance scheme which targets premiums so as to encourage healthy behaviour could be very considerable.

This comparison of the options for financing health care is summarised in Table 6.1.

**Table 6.1: Health Care Financing Options**

<table>
<thead>
<tr>
<th></th>
<th>General Tax Revenue</th>
<th>Social Insurance Health Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affordable access</strong></td>
<td>Performs well</td>
<td>Performs well, if the Government adjusts taxes and benefits to make premiums affordable</td>
</tr>
<tr>
<td><strong>Assistance for those least able to provide for themselves</strong></td>
<td>Performs poorly: healthy people receive too much assistance; sick people receive little</td>
<td>Performs well: Government can target those with high health costs relative to income</td>
</tr>
<tr>
<td><strong>Incentives for health and prudent use of services</strong></td>
<td>Performs poorly: creates no financial incentives for healthy behaviour or prudent use</td>
<td>Performs well: premiums can be adjusted to encourage healthy lifestyle and behaviour</td>
</tr>
</tbody>
</table>
### Issues for Public Discussion

The Government seeks submissions on the options for financing core health services outlined in this chapter. The debate must be forward-looking, assessing the risks and benefits of the financing options in a world where we can never hope to afford all known medical interventions for everyone. The ageing of the population and growth in medical technology will place increasing pressure on Government health spending. In this context, we are faced with:

- limiting the range of health services funded by the Government;

- increasing taxes; or

- introducing a new source of revenue through a social insurance scheme, with health premiums supplemented from tax revenue to give targeted assistance to help people pay their premiums.

A combination of approaches can be used. However, in the foreseeable future, tax increases are not likely, for the reasons already given. Those making submissions may wish to comment on the appropriate mix of sources of financing for health care, including the extent to which we should rely on user charges to finance health care.
Key Points

- Public health strategies are essential long-term investments in better health for all New Zealanders. Examples are campaigns aimed at reducing the consumption of fatty foods or discouraging smoking, and health protection activities designed to ensure healthy and safe food and water supplies.

- In the existing system, area health boards are responsible for overseeing public health activities in their region. But in some cases this is not happening. With funding on a tight rein, boards are often reluctant to spend money on activities that are less visible and the benefits of which occur only in the medium to long term.

- The Government has therefore decided to:
  - separate the funding and management of population-based health strategies from personal health care services;
  - separate the purchaser and provider roles in public health services by establishing a Public Health Commission to co-ordinate and contract for the provision of public health services, and a Public Health Agency to provide regionally-based public health services;
  - establish contestable contracting arrangements to provide national public health services (such as some health statistics and research services) and contestable sub-contracting arrangements to provide specific regional public health services.

- The aim is to ensure that public health services are delivered consistently across the country through a much simpler and more transparent system than at present. Efficiencies will result from contracting out appropriate services.

- Some health promotion and disease prevention services are delivered to individuals and families, often by general practitioners, public health nurses and other community-based health professionals (immunisation is one). These services will form part of an integrated primary health service, funded by Regional Health Authorities and health care plans.
Introduction

Public health services are targeted at whole populations rather than individuals and families. They are often directed at health hazards in the physical and social environments. Figure 7.1 illustrates some of these hazards and their sources. Public health strategies aim to improve people’s health, minimise the risk of disease and reduce the need for hospital and other health services.

Figure 7.1: Correlation Between Health Hazards and Illness Groups

<table>
<thead>
<tr>
<th></th>
<th>Cardiovascular diseases</th>
<th>Mental illness</th>
<th>Skeletomuscular disease</th>
<th>Tumours</th>
<th>Injuries</th>
<th>Respiratory diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upbringing environment (social)</td>
<td>*</td>
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<tr>
<td>Work environment (social) and</td>
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<td>unemployment</td>
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<td>Work environment (physical)</td>
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<tr>
<td>Living environment (social)</td>
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<td>Living environment (physical)</td>
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<td>Air/water pollutants</td>
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<tr>
<td>Traffic</td>
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<tr>
<td>Diet</td>
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<tr>
<td>Alcohol and drugs</td>
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<tr>
<td>Tobacco</td>
<td>**</td>
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</tbody>
</table>

Key

* Some correlation
** Strong correlation

Clearly, some personal health services also aim to prevent disease and promote good health. Immunisation is a good example. These personal services will be the responsibility of Regional Health Authorities (RHAs) and health care plans. They are an important dimension of personal care, and are closely linked with the primary care services, because they are often provided by general practitioners, practice nurses, public health nurses and other primary providers.

The Government is aware that the apparent integration of responsibility for health service delivery with that for health promotion in area health boards has attracted enthusiastic endorsement from some quarters. Close inspection suggests that many community-based health activities funded by area health boards and called "public health" at present are essentially board initiatives in primary care. This is an understandable response to the fact that fragmented funding has denied area health boards the ability to integrate primary and secondary care. These activities are more appropriately part of an integrated primary health care service than part of hospital services or population-based health services. The decision to integrate primary and secondary funding through RHAs will overcome the problem boards have faced. RHAs will be responsible for funding integrated primary care services taking in promotion and prevention services for individuals and families.

In contrast, the public health activities that are the focus of this chapter involve population-based strategies such as publicity campaigns to discourage smoking, or measures to prevent diseases spread through food and water.

These strategies are essential long-term investments in better health for all New Zealanders. In the current system, much lip-service is paid to the importance of public health activities, but this is not always matched by provision of the resources necessary to carry out effective programmes.

The Government, as principal funder of health services, has an interest in effective public health activities because they reduce publicly-funded treatment costs. Some campaigns bring rapid benefits, for instance, drink-drive campaigns over holiday weekends aimed at reducing motor-vehicle crashes. In other cases, it will take longer for benefits to show up, for example, campaigns to reduce rates of smoking and lower the incidence of lung cancer, or nutrition and exercise campaigns aimed at lowering the incidence of heart disease.

Area health boards are responsible for overseeing public health activities in their region at present. However, with health funding on a tight rein, boards are often unwilling to put money into less visible activities, the benefits of which are not immediately obvious. Urgent health needs too easily take priority over spending on longer-term programmes.
The Government believes that resources for public health activities must be explicitly identified and decisions about spending on these longer-term investments made at a national level, with direct accountability to the Minister of Health. To achieve this, funding and management of population-based health services must be separated from personal health care services. The purchaser and provider roles in public health services must also be separated. These reforms do not imply a rejection of the key role to be played by primary and secondary care providers in health promotion. The practice of managed care in the reformed health system will make health promotion increasingly worthwhile for RHAs and health care plans.

This chapter sets out how these changes will be made, and outlines the structure and functions of the reformed public health service.

**Public Health Activities**

Public health activities can be divided into three areas: health protection, health promotion and disease prevention. Public health campaigns often involve a combination of all three.

*Health Protection*

Health protection activities are designed to ensure a healthy and safe food supply, clean air, soil, water and the safe disposal of chemical wastes. Such services are largely invisible to the public, coming to attention only in a crisis, as when water supplies or food are contaminated.

*Health Promotion*

Health promotion activities are designed to reduce disease and the number of deaths related to lifestyle, for example, the effects of smoking, poor diet or drinking and driving. Past major health promotion programmes in New Zealand have been directed at reducing injuries from motor-vehicle crashes, heart disease and lung cancer.

*Disease Prevention*

Disease prevention activities aim to reduce the incidence of preventable diseases and therefore to lower the costs of disease to the health sector and society.
Some activities are aimed at individuals, for instance, screening for cervical cancer or the immunisation of children. RHAs and health care plans will be responsible for these activities. They will fund these services through contracts with primary care providers, such as general practitioners and public health nurses.

Other programmes focus on the population at large. The unexpectedly high increase in the number of cases of meningococcal meningitis in Auckland in 1985 and 1986, for example, called for a co-ordinated response. The ensuing vaccination and public education campaign was so successful that the level of the disease in the subsequent year fell well below the expected number of sporadic cases. Figure 7.2 illustrates this.

**Figure 7.2: Group A Meningococcal Disease in Auckland, 1985–1989**

![Graph showing the number of cases of meningococcal disease in Auckland from 1985 to 1989. The graph includes the months of vaccination and education campaigns.](image)


*Note:* The most likely reason for the epidemic subsiding so quickly was the immunisation programme.
The New Public Health System

In the reformed health system, RHAs and health care plans, like existing area health boards, may not have strong incentives to buy public health services. This is because the benefits of such programmes are diffuse and emerge only in the long term. As well, if some of their clients leave to obtain care from other health care plans, these plans will reap the benefits of any investments by RHAs or health care plans in public health.

The Government has therefore decided to create a new public health structure to overcome problems of inadequate co-ordination, lack of national focus and lack of an identified responsibility for public health.

The new system will mirror the overall health reforms by splitting the purchasing and provision functions. This will encourage high-quality and efficient provision of services, and make sure that advice on policy, regulations and priorities for spending is not dominated by the special interests of providers.

The purchasing role will be carried out by a Public Health Commission. The provision role will be carried out by a variety of public and private sector providers.

The reforms should ensure that the public health services the Government requires are delivered consistently across the country, through a system which is much simpler and more open to scrutiny than at present.

Public Health Commission

At present, public health policy, regulation and funding responsibilities are spread throughout different sections of the Department of Health and area health boards. This makes it difficult to monitor progress and the effectiveness of programmes. It is even difficult to identify the total funds spent on public health.

The Public Health Commission will be located within the Department of Health, but will be an independent unit. The structure envisaged is similar to that of the Ministry of Consumer Affairs, which operates with a high degree of independence within the Ministry of Commerce. The Commission will be placed in a Government department because it will have responsibility for advising on policy and for developing and promulgating regulations. It will be located within the Department of Health to allow sharing of information and to achieve economies of administration.
The Commission will manage the total budget for public health activities. It will advise the Government on public health priorities, taking into account national needs and particular regional requirements. It will develop public health programmes and fund them. It will advise the Government on regulations to best serve the public health, and promulgate these regulations. It will also advise the Government, RHAs and health care plans on personal health care services required to meet public health objectives, for example, immunisation. These services could then be included in the list of core health services which RHAs and health care plans are obliged to purchase for their clients. In this way, providers of health services will not be cut off from health promotion and disease prevention initiatives.

The Commission will not directly carry out public health programmes. It will contract for these services from the regional offices of the Public Health Agency, from national public health providers or from private or voluntary organisations.

Certain types of public health activity will be contracted out to the Public Health Agency. The reasons for this are outlined below. However, to stimulate efficiency, the Public Health Commission will be able to contract out some activities to a wide range of organisations. These might include specialist health groups such as the Cancer Society, the National Heart Foundation and the Hillary Commission, and non-health organisations with other expertise, such as advertising agencies.

The Commission will need contracting skills and technical expertise. A ministerial Advisory Board will ensure these are provided. The Board will consist of members appointed by and responsible to the Minister of Health, including people with expertise in epidemiology, public health medicine and business management, and a key person from the RHAs to ensure that links with the purchase of personal health services are not severed. The Commission will also seek input from the public, through appropriate consultation mechanisms.

The Commission will monitor the activities of the Public Health Agency.

**The Public Health Agency**

The Public Health Agency will be the major publicly-owned provider of public health services. Its responsibilities will include the development of strategies to ensure that food and water supplies are safe and healthy, and that sewage, chemical and other waste products are disposed of safely. It will also administer public health legislation and regulations.
The Agency will collect information on compliance with food regulations, on communicable disease levels and on waste disposal activities. It will provide advice to RHAs, health care plans and local authorities on public health issues. It will maintain the capacity to respond to events potentially affecting the health of whole communities, for example, an outbreak of food poisoning or an epidemic. It will also manage food and drug recalls. The Agency will directly manage this aspect of the public health function through contracts with the Public Health Commission.

The Agency will be permitted to contract out those of its public health functions which are well-defined and predictable, and thus able to be contracted out efficiently. These include inspection of food premises, public swimming pools and water treatment plants.

The Agency will receive its funding from the Public Health Commission. It will have three regional offices: northern, covering the northern RHA region; central, taking in both of the lower North Island RHA regions (including Nelson-Marlborough); and southern, covering the South Island (except Nelson-Marlborough). It is envisaged that each regional office will share information and maintain close links with the RHA(s) in its region.

The Agency will have a board, appointed by the Minister of Health, so that it can draw on a wide range of public health and business expertise from different sectors.

As with the Commission, staff with a highly technical skill mix will be required and may have to be recruited from existing public health staff in area health boards and the Department of Health.

The Agency will be accountable to the Public Health Commission for the delivery of contracted population-based services.

As well as putting some of its activities out to tender, the Agency may itself contract to carry out regulatory functions for other Government departments. Examples might be: monitoring compliance with the Sale of Liquor Act on behalf of the Department of Justice, or monitoring compliance with the health requirements of the Child Care Centre Regulations on behalf of the Ministry of Education.

**Specialist Public Health Providers**

The Public Health Commission will contract on a contestable basis for key national public health services involving specialist functions, including na-
tional laboratory services, statistical services, health education services and health research services.

Those currently providing such services include the Department of Scientific and Industrial Research, and sections of the Department of Health such as the National Radiation Laboratory and Health Statistics Services. Under the new system, the Commission can contract either with these bodies or with other competing agencies, such as universities, private industry, Government departments and agencies. The contracts will be based on both regional and national needs. In general, private and public agencies will be able to compete for contracts and they need not be geographically based in any specified centre.

Figure 7.3 sets out the elements of the new public health system, and indicates the relationships among different agencies.

**Benefits of the New Public Health System**

Separation of the funding of population health measures from the funding of personal care means that the level of funding to be spent on public health is specifically defined and cannot be diverted to short-term needs. This will protect important long-term investments in health. As the Government, and ultimately the tax-payer, bears the cost of most health problems, it has incentives to apply appropriate levels of funding to health protection, promotion and disease prevention activities.

A better co-ordinated and more efficient use of resources will be possible than under existing arrangements based on 14 area health boards. The skills required for negotiating and purchasing the best-quality public health services at the best price are in short supply. There are not enough people with such skills to cover all 14 area health boards. This would, anyway, simply increase the fragmentation and duplication of services which exist under present arrangements. The new system should instead improve co-ordination and planning of services. It will also be clearer who is accountable for public health responsibilities.

The new system will be able to provide a rapid response to epidemics, natural disasters and major environmental accidents.

The three public health regions will be of a size (over 800,000) which allows the development of effective monitoring and evaluation of public health activities.
Figure 7.3: The New Public Health System
The Public Health Workforce

The creation of area health boards saw a large workforce of public health nurses transferred to boards from health development units (previously district offices of the Department of Health). The successful integration of primary and secondary care funding means that the skills of this workforce can be teamed up with those of other primary care providers.

In purchasing comprehensive primary care in the community, RHAs will be able to purchase services from public health nurses, who may seek to work in conjunction with general practices, community trusts, health care plans, or as part of their own independent provider organisations.

Only those public health workers whose functions relate exclusively to population-based health strategies are likely to become part of the Public Health Agency.

Summary of Decisions

The Government has decided to:

- separate the funding and management of population-based health services from personal health care services;

- separate the purchaser and provider roles in public health services by establishing a Public Health Commission to co-ordinate and contract for the provision of public health services, and a Public Health Agency to provide regionally-based public health services;

- establish contestable contracting arrangements to provide national public health services, and contestable sub-contracting arrangements to provide specific regional public health services.
OTHER KEY COMPONENTS OF THE HEALTH SYSTEM

Key Points

- The Government will ensure that the future of several functions carried out in the health sector, which are central to the provision of high-quality, reliable health services, will be addressed as part of the health reform process.

- It will:
  - review the funding for the education and training of health professionals, in line with wider reforms to education and training policy;
  - separately fund and contract with health service providers for clinical training;
  - create incentives for improving and monitoring the quality of care;
  - transfer Government funding for dental treatment services to the Regional Health Authorities (RHAs);
  - distribute Government funding for ambulance services to the RHAs;
  - give RHAs the responsibility for ensuring that health services are available in rural New Zealand;
  - ensure that the voluntary sector can bid for contracts with the RHAs;
  - re-define and strengthen the role of the Department of Health as a key policy advisor to, and monitoring agent for, the Government.

Introduction

Several functions carried out in the health sector are central to the provision of high-quality, reliable health services, but have not been discussed in earlier chapters. These include the education and training of health professionals,
funding of medical research, the assessment of new medical technology, and the provision of dental and ambulance services.

Certain issues must not be lost sight of as the health reforms are implemented. These include maintaining and improving the quality of care, the effects of the reforms on rural communities, and the role of the voluntary sector in the reformed health system.

Finally, the Department of Health, as the Government's principal advisor on health policy, as well as its monitoring and contracting agent, will face new and challenging roles as a result of the reforms. It will also have a key role in ensuring that the existing health system continues to function while the reforms are being implemented.

**Education, Training and Research**

**Education and Training**

A well-educated and comprehensively trained body of health professionals is critical if New Zealand is to maintain a high-quality health system.

The separation of the purchasing and provision roles will require a change in the way health professionals are educated and trained. At present, education and training is carried out in educational institutions, such as polytechnics and universities, and also through practical clinical experience, for example in hospitals and the community. The reforms will increase awareness of the time, and therefore the cost, involved in assisting with the clinical training of health professionals. Providers may therefore be reluctant to bear the additional costs involved in assisting with clinical training.

In order to maintain a highly-qualified and well-trained health workforce, funding for education and training of health professionals will be separated from the funding for health services. Selected providers will be explicitly contracted and funded to provide clinical training.

At present, funding for the education and training of health professionals comes mainly from the Government. There are several different funding mechanisms. Even in the absence of wider reforms, there is a need to rationalise current multiple funding sources. The Government will, therefore, review funding for the education and training of health professionals. The review cannot be carried out in isolation from the wider reforms proposed in the education and training sector. The Government will also consult with the medical schools, polytechnics and the teaching hospitals as part of this review.
Health Research

Currently, health research accounts for an estimated one per cent of total health expenditure in New Zealand. The Government is the principal funder of that research. Much of the research funding is allocated by the Health Research Council of New Zealand, which is required to purchase quality research along a spectrum stretching from basic bio-medical research to applied public health research. It is required to pay particular attention to health problems affecting Maori people.

The key role of the Health Research Council will continue. Funding of health research will be done in a way consistent with the Government’s overall policy on research funding. Specifically, the relationship between the Foundation for Research, Science and Technology and the Health Research Council will be examined in the forthcoming year.

Much research has to be carried out in provider settings (for example, hospitals). The Government expects providers to continue to facilitate this research. Without it, providers will not be as effective or innovative in the services they provide. The research may well have commercial applications, from which the provider can benefit.

The Quality of Care

The Government’s basic health goal is to ensure that everyone has access to an acceptable level of health services. Acceptable care is synonymous with quality care. Quality encompasses the meeting of specified standards (both technical and inter-personal), the skills of health professionals, and the state of the facilities within which care is provided. High levels of quality depend on more than just the level of total expenditure.

The current health system has few mechanisms to measure and improve quality. Those that exist relate to only part of the system. The attainment of high standards of staffing and facilities, working relationships and outcomes will receive increased emphasis in the reformed health system. Many features of the new system will create incentives for improvements in, and increased monitoring of, the quality of care.

Overseas experience of health care systems which are characterised by competition between providers for funding suggests that providers may compete on quality rather than price. However, there may be a potential conflict, and associated trade-off, between price and quality. Contracts between Regional
Health Authorities (RHAs) and providers must emphasise improvements in the quality of services provided, not just low-cost provision.

The Department of Health (and other regulatory agencies), RHAs, providers and individuals will all have a role in defining and monitoring quality. RHAs will be held accountable for developing mechanisms for the effective monitoring of the quality of services provided. The Government will advise RHAs on the mechanisms that should be developed. Several approaches can be used in developing such mechanisms. Health care accreditation, licensing of facilities and of health professionals, peer review, patient outcome monitoring, and quality improvement programmes need to be considered.

Assessment of New Medical Technology

New medical technology—including equipment, devices, medicines, tests, and even facilities—is constantly being developed. Once technology is developed, pressure is applied by the developers and individuals for it to be made widely available.

In New Zealand some specialist health technologies, like cardiac surgery or treatment of spinal injuries, are provided only regionally or nationally. While the Government recognises the value of developments in medical technology, many attract a high cost which has to be met out of existing health funding. The Government would be concerned if the pressure described above resulted in the proliferation of expensive, under-utilised technology.

Technology assessment involves evaluating the costs of the technology against the value of what it can do, and the value of any existing technology it may replace. It can help to develop the definition of core services, particularly if a detailed prioritised list of treatments is used. It can establish lists of services excluded from the core, or assist with the development of treatment protocols.

Dental Services

Dental services are currently provided free to all children and to secondary and tertiary students under the age of eighteen. Adults must pay for the complete cost of their dental services, unless they are unable to do so.
Historically, Government policy has been that dental care for financially disadvantaged adults should be provided by hospitals and later area health boards, subject to a means test. This service has been restricted largely to bigger cities and, where available, is now mainly reduced to providing emergency care. In more remote areas, where a private dental practice would not be viable, a few area health boards have provided part-time dental services, in conjunction with community health facilities. Where services are not available through a hospital dental department or area health board facility, the Department of Social Welfare has usually been prepared to provide beneficiaries with a special needs grant for dental care.

The funding presently earmarked for dental treatment will be transferred to the RHAs.

Ambulance Services

There is no national ambulance service in New Zealand. Ambulance services are provided by a variety of operators, most of which are independent. Eighty per cent of services are provided by volunteer groups, most prominently the Order of St John. Citizens' organisations and area health boards provide the remainder. The principal sources of funding for ambulance services are the Department of Health and the Accident Compensation Corporation (ACC). The majority of smaller centres rely entirely on voluntary support for staffing and fund-raising for their services.

The Government considers that RHAs should contract with ambulance operators, or their umbrella organisations, to provide emergency services. The funding currently provided for ambulance services by the Department of Health and the ACC will be distributed to RHAs. It is expected that many of the existing provider groups will maintain their close links with the community and will continue to benefit from the voluntary support of community members.

In the absence of a national service, and while there are no registration requirements for ambulance officers, there remains a need for an organisation to monitor service standards and patient safety and to co-ordinate the training of staff and volunteers. The New Zealand Ambulance Board has taken that responsibility since February 1989. RHAs may elect to allocate a portion of their funding to support the activities of the New Zealand Ambulance Board or a similar organisation. Until the RHAs are established, the Government will ensure that the Board continues to function.
Rural Communities

A number of the submissions received by the Taskforce related to rural health services. Concerns expressed in them focused on access to general practitioner (GP) services and worries about the closure of small community hospitals.

Schemes have been implemented by successive Governments to encourage GPs to practise in rural areas. They have provided support for general practice and, in poorer areas, have been essential to maintain the financial viability of some practices. The current schemes are not sufficiently flexible to allow some options, such as greater use of nurse practitioners and mobile clinics, to be utilised.

The provision of secondary care in rural areas is also problematic. Many small country hospitals have been closed or threatened with closure. Diagnostic services such as X-ray facilities have been reduced. The employment of medical staff and specialists in these areas has always been difficult and often not viable.

The Government does not regard the present availability of health services in some rural areas as satisfactory.

The Government supports the current initiatives in communities such as Eketahuna and Ruatoria to find local solutions to doctor shortages. Those communities have developed community health trusts or nurse practitioner services in conjunction with their local area health boards. However, these solutions are, to date, the exception rather than the rule.

Under the new health system, RHAs will have a duty to ensure access to adequate primary health services in rural and remote areas. The current rural incentive schemes will be disestablished once new arrangements are in place to ensure continuity of the care provided under them. RHAs will then be free to purchase services in a much more flexible way than at present, tailored to the needs and skills of specific communities.

The establishment of community trust hospitals would provide one option for rural communities to tackle primary and secondary health needs. The establishment of rurally-based health care plans, incorporating GPs and other health professionals, would also ensure the availability of health services in rural areas. Other options include mobile GP clinics, co-ordinated use of district nursing services or community health workers, independent nurse practitioners, and the provision of primary services from community hospitals.

There will be potential for a wider range of health providers to contract with RHAs. This should open up new career paths for nurses and other health and social service professionals in rural communities.
The Voluntary Sector

The voluntary sector has made a substantial contribution to health care in New Zealand. Examples are groups focusing on health education and disease prevention, societies which support the sufferers of particular diseases, and providers of continuing care services and ambulance services. The Government recognises and values this strong community input into health care. Under the proposals to establish RHAs and health care plans, the voluntary sector will be encouraged to continue its contribution.

The work done by organisations such as New Zealand CCS, the Royal New Zealand Foundation for the Blind and the Plunket Society, to name a few, will be supported by contracts with RHAs or health care plans. One of the benefits from separating purchasers from providers is more opportunities for voluntary groups to bid for funding to provide services. This will in turn result in the provision of more appropriate services to many groups in society.

The Role of the Department of Health

The role of the Department of Health will change significantly as a result of these reforms. It will, however, remain a key advisor to the Government on health policy, and will have a vital role in monitoring the overall efficiency and effectiveness of the health system. In addition, it will ensure that the current health system continues to function while the reforms are being implemented.

At present, the Department negotiates annual contracts for the provision of services with area health boards, on behalf of the Minister of Health. If the operation of RHAs is governed by legislation or regulations, then the Department will not have to negotiate contracts with them, but will monitor whether RHAs fulfil their legislative requirements. If RHAs operate under contracts, however, then the Department will continue to have an important policy, negotiation and monitoring role in this area.

Other features of the proposed reforms will also impact on the Department. For example, the integration of primary and secondary care will affect its operational activities in respect of health benefits and subsidies. The public health reforms will affect its current role in funding and providing such public health activities as health protection, health promotion and disease prevention. As noted in Chapter 7, the Government has decided to separate the funding of population-based public health activities from the funding for personal health
services. Responsibility for the management of public health funding is to be placed with a Public Health Commission, to be established as a separate unit in the Department.

One of the new roles we expect the Department to take responsibility for is the approval of health care plans and the administration of regulations governing them. In general, the Department will be responsible for administration of regulations and legislation governing the operation of all organisations within the reformed health system.

The Department of Health will continue to be responsible for funding and servicing a number of committees and functions at national level.

The Proposal to Establish the Office of the Health Commissioner

The Government is currently considering establishing the Office of the Health Commissioner. The role is similar to that of a Human Rights Commissioner, but is concerned specifically with health issues.

At present, individuals dissatisfied with the quality of health care they have received can lodge a complaint with area health boards, the relevant professional disciplinary tribunal, or with the Ombudsman. Arguably, what is required is a complaints mechanism more accessible to the individual. The aim of the Office would be to assist in the resolution of individuals’ complaints quickly and efficiently.

Summary of Decisions

The Government will:

- review the funding for the education and training of health professionals, in line with wider reforms of the education and training sector;
- separately fund and contract with providers for clinical training;
- create incentives for improving and monitoring the quality of care;
- transfer Government funding for dental treatment services to the Regional Health Authorities (RHAs);
- distribute Government funding for ambulance services to the RHAs;

- give RHAs the responsibility for ensuring that health services are available in rural New Zealand;

- ensure that the voluntary sector has the opportunity to bid for contracts with the RHAs;

- re-define and strengthen the role of the Department of Health as a key policy advisor to, and monitoring agent for, the Government.
IMPLEMENTATION

Key Points

- Implementing the health reforms will be one of the Government’s top priorities for the next two years. The Government will ensure that implementation is well-managed, co-ordinated and timely.

- The Government wants to assure the public of continuity in the provision of health services while the reforms are being implemented. We also want to manage the reforms so that staff in the health sector understand how they are affected, and are able to carry out their work productively during the transition.

- To facilitate continuity of service and ensure clear management of the separation of purchasing and provision roles of area health boards, the Government has decided to replace the current area health board members with appointed Commissioners.

- The Government has decided to establish a special structure to implement the health reforms. The main parts of this will be a National Interim Provider Board, and a Policy, Regulation and Implementation Directorate. The latter will comprise a Funding Group, a Communications and Consultation Group and a Policy and Regulation Group.

Introduction

Implementation of the health reforms will be one of the Government’s top priorities for the next two years. Because we are committed to improving all aspects of the health system through the reforms, we intend to ensure that implementation is well-managed. We will be relying on the skill and dedication of departmental officials and area health board staff, as well as drawing on private sector skills and experience, and the experience of other countries which have implemented similar reforms in recent years.

While we are strongly committed to reforming the existing health system, we will also ensure that it continues to function while being reformed. The Government acknowledges that this will not be easy. We have decided to appoint Commissioners to head the area health boards. We consider that this is
necessary to ensure continuity of service and minimal disruption to the public at a time of significant change.

Experience gained from other major reform exercises has demonstrated that the successful implementation of reform on this scale can be achieved only if those involved in it have a clear understanding of what is expected of them. It is important that people employed in the health sector, and all New Zealanders, know when change will happen and how it will affect them. We will ensure that people are kept informed throughout the reform process. The Government has developed a timetable for change, which we intend to stick to as closely as possible.

Recognising the magnitude of the reforms, the Government has also decided to set up a special change management structure, bringing together a team of people with the necessary skills and experience to implement the reforms.

**Appointment of Commissioners**

During the reform process, area health boards must continue to provide health services for the people in their regions. In recent years, other agencies which have been restructured have suffered from considerable decreases in productivity during the period of restructuring. This must be minimised in a sector as vital as health. The Government will ensure that the business of running hospitals and providing health services continues while the reforms are implemented.

The reformed health system, with the roles of purchasers and providers separated, will not require area health boards in their current form. The Government does not want to put board members in the unenviable position of having to respond to the communities which elected them while also having to follow Government directives on reform. Divided responsibilities cannot secure the continuity of health services during the transition, or facilitate the implementation of the reforms, no matter how well-intentioned people are.

In order to ensure continuity of services, and to facilitate the separation of purchasing and provision roles, the Government has decided to replace the current area health board members with appointed Commissioners. The Government will work closely with the appointed Commissioners to ensure a high quality of service provision is maintained in the areas they are responsible for.

The Government expects that there will be opportunities for current area health board members to be involved in the appointed boards of new agencies—the Regional Health Authorities (RHAs), the Crown Health Enterprises (CHEs), the Public Health Commission and the Public Health Agency.
A Structure for Reform

The Government has decided to establish a special structure to implement the health reforms in a well-managed, co-ordinated and timely manner (see Figure 9.1).

Figure 9.1: Implementing the Health Reforms—Transition Structure
The key groups in the structure are the Commissioners (whose role has been outlined above), the National Interim Provider Board, and the Policy, Regulation and Implementation Directorate. These three groups will report directly to the Minister(s) responsible for implementing the reforms.

**The National Interim Provider Board**

The National Interim Provider Board (NIPB) will have two functions:

- to disentangle the current service provider, purchaser and other roles of the existing area health boards, and to establish their health service provider functions as either CHEs or as community trusts;
- to establish the Public Health Agency.

The Board will consist of members appointed by the Minister of Health. They will be selected on the basis of the health management, business and financial skills and experience they can bring to the process. The Board will be assisted by staff from the public and private sectors. It will liaise with the Policy, Regulation and Implementation Directorate on the policy and regulatory environment under which provider units will be established.

Once provider units are fully operational, the Board will be disbanded. The Government expects the Board to function until at least July 1992, and possibly until July 1993, depending on the speed with which provider units are established.

**The Policy, Regulation and Implementation Directorate**

The Directorate will be headed by a full-time manager (Director). The Director will be assisted by staff seconded from the public sector and contracted from the private sector. The Directorate will co-ordinate the work of three groups: the Policy and Regulation Group, the Communications and Consultation Group, and the Funding Group.

**Policy and Regulation Group**

The Policy and Regulation Group will be responsible for further policy development, and for the design and drafting of legislation and regulations to give effect to the announced reforms. It is expected that the work of this group will go on for at least two years.
Communications and Consultation Group

The Communications and Consultation Group will assist the Government in informing the general public, and those within the health sector, about the detail of the reforms, and assist with the submissions process and any general correspondence regarding the reforms.

Funding Group

In conjunction with the NIPB, the Funding Group will: identify resources currently devoted to purchasing services within area health boards and the Department of Health; develop a framework for contracts with secondary providers during the 1991/92 financial year; and, if the RHAs are not fully functioning, commence contracting with CHEs and community trusts for secondary services from July 1992. Contracting with primary providers will occur later. The Funding Group will also set up the RHAs, and will then assist them with contracting arrangements.

The timeframe for the Group to complete its tasks will depend on the time it takes for the NIPB to set up providers, and for providers to have adequate accounting systems in place. It will also depend on the speed with which RHAs are established. The Government expects the Group to complete its tasks between July 1992 and July 1993.

Timeframe for Implementation

During July 1991-June 1992 the following will occur:

- appointment of Commissioners to run area health board services;
- appointment of National Interim Provider Board and the Policy, Regulation and Implementation Directorate;
- contracts between the Minister of Health and area health boards to continue for 1991/92;
- National Interim Provider Board to identify purchaser, provider, public health; and education and training resources and services. Provider resources will be used to establish Crown Health Enterprises (CHEs) and community trusts;
- Funding Group to work with National Interim Provider Board in identifying resources used for health service purchasing, and to collect information on the health services currently purchased for the community by area health boards;
Implementation

- Funding Group will commence establishment of Regional Health Authorities (RHAs);
- Policy, Regulatory and Implementation Directorate to work on policy issues and legislative and regulatory regimes for all proposed health reforms;
- introduction of changes to user part-charges outlined in the Budget Supplement on Social Assistance;
- first steps towards integrating accident-related health care and other health care funding, as announced in the Budget Supplement on Accident Compensation, Accident Compensation—a Fairer Scheme;
- first steps towards establishing a National Advisory Committee on Core Health Services.

During July 1992-June 1993 the following will occur:

- full establishment of CHEs and community trusts;
- winding down of the National Interim Provider Board;
- winding down of the role of Commissioners;
- Funding Group assists RHAs to commence contracting with CHEs, community trusts and private and voluntary providers;
- preparation for transfer of responsibility for primary health care funding to RHAs;

During July 1993-June 1994 the following will occur:

- once RHAs are established, they will have responsibility for primary, secondary and accident-related health care funding;
- RHAs will begin to develop and negotiate new payment arrangements for health care providers;
- RHAs will implement further rationalisation of the user part-charge regime;
- people will be allowed to enrol in health care plans.
The Government is seeking submissions on a number of issues relating to the health reforms. The Government hopes that a wide variety of interested individuals and groups will take this opportunity to have a say in their future health services. The Government encourages Community Health Committees to act as a channel for people in their areas to express their views, for incorporation in submissions from the Committees.

Throughout this Statement, the Government has indicated those areas where it has made decisions about the future of the health sector. These include:

- separating purchasing from provision (Chapter 2);
- integrating funding for all types of health service (visits to general practitioners, prescriptions, laboratory tests, other community-based services, hospital services and accident-related care) so that care is managed as a total package (Chapter 3);
- allowing choice among health care plans (Chapter 4);
- separating the funding of public health services (health strategies directed at whole populations) from personal health care services (Chapter 7).

The Government wants there to be wider debate on some areas of health policy before it makes major decisions about them, specifically:

- the definition of core health services (Chapter 5);
- the future financing of health services (Chapter 6).

Submissions should focus on the issues outlined below, which are repeated from the chapters above.

**Core Health Services (Chapter 5)**

The Government believes it is particularly important to consult the public and health professionals about how core health services might be defined in New Zealand. Once the National Advisory Committee on Core Health Services is
established, it will embark upon a process of consultation about what services, conditions or treatments should be included in the core.

In the immediate months ahead we seek comment on this issue:

How should core health services be defined in New Zealand? That is, what combination of the following approaches should be used:

- a negative list;
- a general positive list, with obligations to provide all services on the list, using treatments of proven cost-effectiveness;
- a detailed priority-ranked positive list?

Financing Health Care (Chapter 6)

The Government seeks submissions on the options for financing core health services outlined in Chapter 6. The debate must be forward-looking, assessing the risks and benefits of the financing options in a world where we can never hope to afford all known medical interventions for everyone. The ageing of the population and growth in medical technology will place increasing pressure on Government health spending. In this context, we are faced with:

- limiting the range of health services funded by the Government;
- increasing taxes; or
- introducing a new source of revenue through a social insurance scheme, with health premiums supplemented from tax revenue to give targeted assistance to help people pay their premiums.

A combination of approaches can be used. However, in the foreseeable future, tax increases are not likely, for the reasons discussed in Chapter 6. Those making submissions may wish to comment on the appropriate mix of sources of financing for health care, including the extent to which we should rely on user charges to finance health care.

How to Make Submissions

Submissions should focus on the issues set out above, clearly indicating which chapter and issue the submission is addressing.
Written submissions will be accepted until 5pm on Friday, 29 November, 1991. They should be sent to:

YOUR HEALTH AND THE PUBLIC HEALTH
Health Reform
P.O. Box 55
WELLINGTON

Not all groups feel comfortable making written submissions. The Government will therefore initiate consultations with groups which may want to present oral submissions.
Annex 1

Terms of Reference: Ministerial Committee on the Funding and Provision of Health Services (The Health Services Taskforce)

Policy Goal

The basic goal of the Government’s health policy is to ensure that everyone has access to an acceptable level of health services on fair terms. It is likely that the Government will continue to be principal funder of health services. Therefore, it has a continuing direct interest in ensuring that individuals’ responsibility for their own health is recognised and fostered.

Objectives

Accordingly, the Taskforce has been set the following objectives:

(a) to ensure that everyone has access to an acceptable level of health services;
(b) to focus Government assistance on those who are least able to make provision for themselves;
(c) to make health service funders and providers more efficient and more responsive to consumer preferences. This will require:
   (i) greater freedom for consumers to choose between alternative funders and providers of health services;
   (ii) competition between public and private sector funders and providers of health services, and organisational reform of public sector service providers;
   (iii) minimising barriers to competition among funders and providers of health services;
(d) to protect the public from malpractice and unsafe practice;
(e) to recognise and foster individual responsibility for health;
(f) to ensure that disease prevention and health promotion activities are used to appropriately limit the Government's exposure as the principal funder of health services.

Description of the Task

The Taskforce will:

(a) Identify and investigate options for defining the roles of the Government, the private sector, and individuals in the funding, provision and regulation of health services which best achieve the objectives outlined above. In investigating the options, the Taskforce will first address itself to the following issues:

Funding:

(i) Is it desirable that Government assistance for health services (including primary care, secondary care, continuing care, and accident-related care) be delivered by a single funder, or are separate funding systems desirable?

(ii) Should Government assistance for health services be channelled through a single regional agency (such as area health boards at present) or though competing agencies?

Targeting Assistance:

(iii) What are the rationales for and implications of assessing ability to pay in determining eligibility for Government assistance with the costs of health services?

(iv) What criteria other than inability to pay should determine eligibility for Government assistance with the cost of health services?

Service Provision:

(v) Is a separation of the funder and provider roles of area health boards required to promote competition among providers?

(vi) How should public hospitals and related service providers be organised to best encourage an efficient health service sector?

The Taskforce will receive further instructions from Ministers once these issues are resolved.
(b) Advise the Minister of Health on the alternatives and recommend a preferred approach.

(c) Develop an implementation plan for the option that Ministers prefer, specifying:

(i) required changes in legislation;

(ii) required changes in policy not involving changes in legislation;

(iii) mechanisms and institutions for the provision of policy advice, the administration of funding (including the targeting of assistance), the regulation of health service funders and providers, and the provision of services.

The Taskforce will draw upon the work of the Change Team on Targeting Social Assistance, which will consider targeting across a number of areas. Its work must also be co-ordinated with that of the Ministerial Working Party reviewing the Accident Compensation Corporation (ACC).

The responsibility for the Taskforce will lie with the Minister of Health. The membership of the Taskforce will be approved by the Minister. The manager of the Taskforce will report directly to the Minister.

The Minister of Health will report on the work of the Taskforce to the Prime Ministerial Committee on the Reform of Social Assistance and thence to the Cabinet Strategy Committee. The Prime Ministerial Committee will ensure that the policy review and development activities being undertaken by the Government are co-ordinated and consistent.
Annex 2

Taskforce Members: Ministerial Committee on the Funding and Provision of Health Services

Taskforce Members

Roderick Carr BCom(Hons) L1B(Hons) MBA. Chairperson
Chief Manager, Retail Finance Services and General Manager of BNZ Life Insurance Ltd. Previously served as a member of the Government’s taskforce reviewing financial assistance for post-compulsory education in the late 1970s and has been a member of the Council of the University of Otago.

Gordon Davies DHA FIHM(NZ) CHM AFACHSE(Aust) FCIS ACA AFNZIM
Manager Corporate Services, Canterbury Area Health Board. Prior to this: General Manager, Review, Department of Health and Deputy Director-General of Health. Former Chief Executive of the Waikato Hospital Board. Recipient of fellowships awarded by the World Health Organisation and the Nuffield Provincial Hospitals Trust. Seconded as Chief Executive to the Hospitals and Related Services Taskforce.

Henry Doerr AB(Hons) MD DipObs FRNZCGP
General Practitioner in Pakuranga, Auckland. Educated at Harvard University then University of Minnesota Medical School. Previously worked in Canada and Papua New Guinea. Has held office in the New Zealand Medical Association and the Royal New Zealand College of General Practitioners. Currently chairperson of East Care A&E afterhours service.

John McLeod MB ChB DPH MCCM(NZ) DHA
Deputy General Manager, Chief Health Officer and Medical Officer of Health, Auckland Area Health Board. Previously Deputy Medical Officer of Health, South Auckland, Medical Officer of Health, Takapuna, Auckland and Northern Region. Consultant to World Health Organisation and Clinical Reader, School of Medicine, University of Auckland.

Norma Restieaux BMedSc MB ChB MD FRCP FRACP
Associate Professor of Medicine, University of Otago, Consultant Cardiologist, Otago Area Health Board, Head of Department of Cardiology, Dunedin
Hospital. Has worked as a cardiologist in Dunedin for 20 years and has held posts in many medical organisations.

Acknowledgements

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The Taskforce also extends its thanks to the many individuals and organisations who have contributed to its endeavours. The help has been in the form of numerous papers, submissions, meetings, telephone calls, and often entailed heroic hours. In particular, the Taskforce wishes to thank the following consultants and departmental assistants: Anna Aitken, Juliet Ashton, Sue Begg, Barry Bershow, Gillian Bishop, Jill Calveley, Will Chapman, Annette Davies, Stephanie Devine, Jan Dowland, Gillian Durham, Lorna Dyall, Paul Gini, Judy Glackin, Shenagh Gleisner, Jeff Goldsmith, Chris Gould, Susan Irvine, Alan Jones, Ichiro Kawachi, Bette Kill, David Malcomson, John Marwick, Alan Maynard, Craig McKendry, Janet Mitai-Ngatai, Alan Morris, Eleanor Morris, John Morton, Reinhard Pauls, Judith Reinken, Claudia Scott, Clive Smee, Denis Snelgar, Suzanne Snively, John Stacey, Harvey Steffens, Helen Stevens-Smith, Frances Sutton, Geoffrey Swier, Murray Tilyard, Banks Warden, Michael Webster, Brent Wheeler, John Wyn Owen.
Annex 3

List of Submissions

Submissions to the Taskforce were received from:

Aetna Health Corporation Ltd (Lynds, T. A.)

Association of Salaried Medical Specialists (Powell, Ian)

Auckland Homebirth Practitioners (Donley, J.; Burgess, Sian; Gulbransen, G.)

Auckland Hospital, Department of Critical Care Medicine (Judson, James A.)

Auckland Women's Health Council Inc. (Conway, Kim)

Bay of Plenty Area Health Board (Wilkinson, Sally)

Bierre, Trevor H.

Borrie, Don

Bryson, Jean G.

Burdon, Lesley N.

Burns, S. A. & J.

Calder, Lester (Community Medicine Specialist, Auckland Area Health Board)

Canterbury Area Health Board (Beaven, D. W.)

Catholic Health Association Aotearoa New Zealand (Sister Raye Boyle)

Cherry, Jean

Collins, Heather

Cornish, G. A. & V. F.

Coughlan, John (Manager of Surgical Services, Canterbury Area Health Board)

Cox, Andrew
Crook, David J.

Crowe, Margaret

D. F. Bell and Associates Ltd (in association with 3M Health Information Systems) (Bell, David F.)

Drage, Alan (University of Auckland, School of Medicine)

Dyall, L. C. T.

Eade, M. N. (Consultant, Northshore Hospital, Senior Lecturer, University of Auckland, School of Medicine)

Federation of New Zealand Ostomy Societies Inc. (O’Neill, J. E.)

Gilbert, R. J. R.

Glennie, Henry R. R.

Gray, D. J. S. (University of Canterbury, Student Health and Counselling Service)

Harris, E. A. (Physician-in-Charge, Department of Clinical Physiology, Auckland Area Health Board)

Harrison, Graham P.

Hasman-Judd, Rebekah

Hawkes Bay Area Health Board; Manawatu-Wanganui Area Health Board; Nelson-Marlborough Area Health Board; Northland Area Health Board; Southland Area Health Board; Tairawhiti Area Health Board; Taranaki Area Health Board; West Coast Area Health Board (Joint submission, consensus view)

Health Boards New Zealand Inc. (Beasley, D. M. G.)

Health Information Association of New Zealand (Prestidge, Graeme W.)

Hokianga Community Health Committee (Marriot, Eunice)

Hospice New Zealand (Burns, Tim)

Hospital Safety Company Ltd (McKinnon, G.)
Hull, F. T. L.
Huronui District Council (Chaffey, J. R. A.; McKendry, A. J.)
Insull, Timothy
Kaitaia Mangonui Community Health Committee (Minogue, Gill)
Kapiti, Wairarapa and Porirua Community Health Committees (Joint submission, Jones, Hugh; Brazendale, Elaine; Genet, Edna)
Lambert, Helen
Large, R. G. (Senior Lecturer, University of Auckland, School of Medicine)
Liaw, Stephen
Linehan, Brian
Love, Kate
MacKay, John
Malcolm, Laurence (Department of Community Health, Wellington School of Medicine)
Maling, John D.
Matata Community Health Committee (Horan, B. F.)
McGowan, D. G.
McGowan, Rae
The Medical Acupuncture Society of New Zealand (Kelly, Robin)
The Medical Council of New Zealand (Briant, Robin)
Medlab South Ltd (Mathewson, J. B.)
Ministry of Women’s Affairs
Ministry of Youth Affairs
National Hormone Assay Service of New Zealand (France, John T.)
National Mutual Life Association of Australasia Ltd (Boyd, David)
Nelson-Marlborough Area Health Board (Baldick, Glenys)
New Zealand Ambulance Board (Wakelin, R. H.)
New Zealand Association of Optometrists Inc. (George, Peter)
New Zealand Blue Cross Blue Shield Medi-Care Society (Ryan, Gerald)
New Zealand College of Community Medicine (Durham, Gillian)
New Zealand Council of Christian Social Services (Robinson, Shaun)
New Zealand Council on Healthcare Standards (O'Connor, Peter)
New Zealand Dental Association (Simpson, E. F.)
New Zealand Diagnostics Ltd (Haines, Cavan)
New Zealand Institute of Health Management, Northland Branch (Pointon, Brian)
New Zealand Nurses' Association (Williams, Gay)
New Zealand Nurses' Association, Independent Nurse Practitioners Section, Greater Auckland Region (Cowan, Caril; Rosen, Sonja; Messervy, Lyn)
New Zealand Nurses' Association, National Practice Nurse Division (Brown, Keryn)
New Zealand Nurses Union (Breen, Steph)
New Zealand Private Hospitals Association Inc. (Burns, Tim)
New Zealand Private Physiotherapists Association (Lamont, Michael)
New Zealand Public Service Association Inc. (Slater, Mary)
New Zealand Society of Pathologists Inc. (McCafferty, J. F.)
Newtown Liaison Group (Reid, Tina)
Northland Area Health Board (McKernan, Anna, Advisory Officer: Board Duties)
The Nurse Maude District Nursing Association (Bowden, Anthea H.; Averill, C. E. W.)

Otago Area Health Board (Cooper, M. H.)

Otumoetai Health Centre (Foggo, B. A.; Seddon, T. D. S.; Simon, J. E.; Singh, A. G.; Tallon, R. G.)

Pannett, J. R. (General Manager, Southland Area Health Board)

Parkinson, Peter

The Paul Ramsay Group (Gracie, Stephen; Grier, Pat)

Porirua Community Health Committee (Genet, M. E.)

Presbyterian Support Services, Northern (Poole, G. E.)

Pridgeon, W. R. M.

Prier, Mary

Public Health Association of New Zealand Inc. (Hornblow, Andrew)

Read, June E.

Researched Medicines Industry Association of New Zealand Inc. (Andrews, Nigel)

Reynolds, F.

Rooney, J.

Royal Australasian College of Physicians, New Zealand Committee (Jones, D. T.)

Royal Australian and New Zealand College of Psychiatrists, New Zealand Branch (McKergow, Tim)

Royal New Zealand College of General Practitioners (Bassett, E.; Crook, David)

Royal New Zealand Plunket Society Inc. (Geddis, David C.)

Rural G.P. Action Group (London, Martin)
Sainsbury, Richard (Senior Lecturer/Physician, Canterbury Area Health Board)

Smith, Lawrence

Snow, P. G.

Southern Cross Healthcare (Smith, Peter A.)

Southland Area Health Board (Pannett, J. R.)

Southland District Council and Southland Area Health Board (Joint submission, Casey, J. P.; Faul, A.)

Stewart, A.

Stewart, R. David H. (Division of Health Sciences, University of Otago)

Tairawhiti Area Health Board (Faulkner, G. E.)

Taranaki Area Health Board (Matthews, P. D.)

Terry, C. H.

Trenwith, Bryan

Turner, A. S.

University of Auckland (North, J. D. K.)

University of Canterbury, Student Health and Counselling Service (Gray, D. J. S.)

Vujcich, Peter

Waikato Lithotripsy Services Ltd (Papps, D. N.)

Wairarapa District Community Health Committee (Brazendale, Elaine)

Wairarapa Health Action Committee (Wright, Colin)

Warkworth Health and Medical Centre (Armbrust, Penny; and others)

Wellington Area Health Board (Henare, M. R. H.)

Wellington Area Health Board, Combined Medical Staff Executive (Haas, L. F.)
Wellington Community Mental Health Services Group (Robinson, David)

Wellington School of Medicine, Joint Relationship Committee, Wellington Area Health Board/University of Otago (O'Donnell, T. V.)

Whangarei Council of Social Services Inc. and 33 Community Network Organisations (Trewin, Dianne)

Women's Division, Federated Farmers of New Zealand Inc. (McIntyre, Jeanette)

Woods, H. J.
Community trusts: Smaller community hospitals and other local facilities will be offered to local communities, to be controlled and managed by the community as a trust. Communities will be able to decide on the range of services provided, employ staff and seek to obtain contracts for services from Regional Health Authorities and other health care plans.

Continuing care: Care provided on a long-term basis for frail elderly people, and psychiatrically, intellectually and physically disabled people. Continuing care covers a wide range of services, from daily living support, such as help with feeding and bathing, to specialist medical care. It may be provided in a large institution, a smaller residential unit, or in a person’s own home.

Core health services: The acceptable minimum range of health services which Regional Health Authorities and health care plans will have to provide for their clients. This will provide certainty so that all New Zealanders will have access to a guaranteed core of services, no matter where they live or what their circumstances, and whether they are enrolled with a Regional Health Authority or with a health care plan.

Crown Health Enterprises: Larger health care services, currently owned by area health boards on behalf of the Government, will become autonomous, publicly-owned business units called Crown Health Enterprises (or CHEs). They will be contracted by Regional Health Authorities and health care plans to provide health services. A typical Crown Health Enterprise could be a single metropolitan hospital, or a group of hospitals, and could include other services such as outpatient clinics and accident and emergency clinics.

Health care plans: Health care purchasers offering clients an alternative to Regional Health Authorities. Health care plans will purchase comprehensive health care for their clients, but will be able to provide services in whatever way is most appropriate for their clients’ needs. They may act as providers for some services by providing services “in-house” or they may contract with other providers, including Crown Health Enterprises, community trusts and the private and voluntary sectors, to supply services for their clients. People will be able to take their health care “budget” from a Regional Health Authority and use it to buy services from another health care plan.

National Advisory Committee on Core Health Services: Appointed by the Minister of Health and charged with engaging in a process of public consultation about defining core health services.
**National Interim Provider Board:** Appointed by the Minister of Health to oversee the transition of area health board facilities into Crown Health Enterprises and community trusts. Will function until at least July 1992, and possibly until July 1993.

**Policy, Regulation and Implementation Directorate:** Will co-ordinate the work of the three groups needed to oversee the transition to the new structure. The Policy and Regulation Group will be responsible for policy development, and legislative and regulatory changes required. The Communications and Consultation Group will help the Government inform the public and health sector personnel about the reforms as they proceed, and manage the submissions process. The Funding Group will work with the National Interim Provider Board to identify purchasing resources, develop contracts for health services and set up Regional Health Authorities.

**Premiums:** Individual or family contributions made to finance health care costs, paid either to the Government or directly to Regional Health Authorities and health care plans. Premiums differ from taxes in that they are related to the value of the health services individuals or families expect to receive.

**Primary care:** The first level of contact people have with the health system, or other services provided in the community to support these basic services. Primary care services include doctors in general practice, nursing services such as Plunket, domiciliary midwives and district nursing, accident and emergency services, laboratory services, occupational therapists and community-based pharmacy services.

**Provider:** The health service facility or health service worker. A provider may be, for example, a large metropolitan hospital, a general practice clinic, an individual doctor, nurse, physiotherapist or private radiologist, a country maternity hospital or a private city hospital.

**Public Health Commission:** An independent unit within the Department of Health responsible for funding public health strategies, including health protection, health promotion and disease prevention programmes. Public health is concerned with the care of populations rather than the care of individuals.

**Public Health Agency:** A Government-owned national service provider with three regional offices to provide regional public health services. It will contract with the Public Health Commission for the delivery of services.

**Purchaser:** The organisation which decides, at a detailed level and in consultation with its clients, what services should be provided, what mix of services would best meet clients' needs and how those services should be provided. Health care
purchasers will contract with providers for health care services and pay for them. Purchasers in the new health system include the four Regional Health Authorities and health care plans, which are purchasers of personal health services, and the Public Health Commission, which will purchase public health services.

Regional Health Authority: Four Regional Health Authorities (or RHAs) will have the role of purchasing total health care on behalf of their populations. They will be funded by the Government on a population-based formula.

Secondary care: Services available only on referral from a primary care provider. Predominantly associated with hospitals, although care may be provided either by admitting patients (inpatient) or through outpatient services.

Social insurance: A system for financing health care. Under the type of social insurance scheme considered in this Statement, every individual or family pays a compulsory premium to the Government or to Regional Health Authorities and health care plans. Premiums are related to the value of the health services individuals or families expect to receive. Premiums can also be related to particular types of unhealthy behaviour, such as smoking. The Government would ensure that everyone was able to afford their premiums, either by paying a share of the premiums out of tax revenue for low-income or high-risk people, or giving low-income and high-risk people sufficient income assistance to enable them to afford their premiums.

User part-charges: Charges that people pay each time they use a health service. User part-charges (or simply "user charges") will generally cover only part of the cost of care, but have an important role in encouraging people to consider the costs of each service they use. The level of charges will be based upon income in future. There will be a limit on the amount of user part-charges an individual or family will face in any one year. This limit will be based upon income also.
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Ministry of Health
Wellington