The "Reform" of the New Zealand Health System - 1991-the present

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The reform of the New Zealand health system (1) has to be judged by its success in providing care for the sick and disabled in that country. To make such a judgement it is necessary to understand how New Zealand's health service worked before the reform was undertaken, and then review the changes that have occurred. The intellectual elegance of the proposals in terms of market theory, if such elegance can indeed be discerned, is no more relevant than the elegance of any untested hypothesis.

The health service that was fashioned between 1938 and 1944, and lasted with relatively little change in philosophy until 1991, provided the population with benefits that subsidised primary care and paid the full cost of public hospital treatment. Primary care was delivered by general practitioners in private practice who competed for patients. Most hospital care was provided in publicly owned hospitals which operated to a budget. Hospital staff were salaried, though a proportion of the senior staff operated private practices where patients could also be eligible for minimal subsidies.

The subsidy for a primary care consultation in 1941 represented 75-100% of the general practitioner's fee. Initially the subsidies were universal, but later proportionately higher subsidies were paid for children and pensioners. By1984 the subsidy had shrunk to 10% of the usual fee for an adult and 35% of the usual fee for a child. In 1992 targeting of subsidies was adjusted so that adults in families receiving more than an average income received no assistance, while subsidies were increased for various other categories of patients. For example low income earning adults received a 40% subsidy and children of the indigent under 5 years of age were most heavily subsidised at 80% of the average fee. Some of these subsidies have since seen minor adjustments, but co-payments for primary care were, and remain, very substantial. (2) Pharmaceutical benefits were also targeted towards the less well to do form 1990 when prescription charges were introduced, but useful subsidies were retained for all. Between 1989 and 1991 non-subsidised costs for medicines rose so that while 19% of the cost of an average prescription was unsubsidised in 1989 this rose to 27% in 1991. (4)

Primary care services were therefore subject to rationing by price, and the full potential primary care has to limit needs for hospital care was not realised.

A consequence of large co-payments at the gateway to care and treatment was shown by a household survey in1992-3 which noted that four percent of the population had needed to go to a doctor in the preceding four weeks but had not gone, cost being the predominant explanation. (3) The average of visits to a general practitioner annually, at four, was also low by most developed countries' standards.

Public hospital services were limited by the budgets set annually. Between 1980 and 1992 public hospital funding per head of population expressed in 1996 dollars had declined - $NZ 900 in 1980, $NZ 859 in 1992. (4) In a decade in which there was rapid advance in useful medical technology, and a progressive rise in the numbers of elderly, this resulted in an escalating failure to meet reasonable patient demands. This was reflected in rising private spending on medical care - $NZ 174 per person in 1982, $NZ 351 in 1992 (1993 dollars) and growing public hospital waiting lists. (4)

The New Zealand reform, therefore, set out to solve two problems in the provision of health services; defective access to primary care, and insufficient service capacity in secondary care. The government had two other concerns; an almost unique failure of the economy to grow, with an increasing disparity between New Zealanders' per capita income and that of most of the developed world, and the far from unique problem that advances in medical capability demanded that serious thought be given to setting priorities among health services. While it also claimed that health care spending was out of control and delivered inefficiently (5), this was never the case. (6) In 1991 total health care spending represented only 7.36% of GDP, below the OECD average.

Because of the country's economic problems it was decided that no additional funds would be made available for illness care from central government, though the separate accident care service, funded by the Accident

Compensation Corporation, was allowed to continue outside this limit. It was claimed that, by increasing the efficiency of the health service by establishing some kind of health care market, extra services could be purchased. It was assumed that setting up a market for hospital services would lead to efficiencies. To effect this 23 hospitals or groups of hospitals were established, labelled "Crown Health Enterprises" (CHEs), and expected to compete forthe purchaser's dollars.

Each CHE was established as a company with a fresh balance sheet. It was envisaged that they would write contracts with the relevant regional health authority, government's purchaser of services, to develop an adequate cash flow.

There are two ways of judging how this has worked. One can use commercial facts or review informed opinion.

After the first full year of the "reform" all but three of the CHEs were operating at a loss and some had had to suspend elective surgery to restrict losses. Collectively the CHEs income for the December quarter of 1993 was $625 million while the cost of providing services was $678 million. The operating deficit was 12% higher than in the preceding quarter. The book value of fixed assets was $2,051 million and total debt was $1,263 million at December 31 1993. This situation has not significantly changed since. The commercial facts hardly suggest healthy enterprises. (7)

Informed opinion is provided by the chairman of the CHE Board's consultative committee who wrote to the ministers of health and finance in mid-December outlining the CHE Boards anxieties. Some of his comments are quoted below:

> "I believe . . . the Boards . . . were expecting the corporate structure to be commercially realistic . . . There is dismay at the fact that this has not happened and serious doubts that it will happen".
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> "There was an expectation that the opportunities for CHEs to compete with other providers would see the early establishment of a market where the participants had similar opportunities and where market forces would be largely unfettered and thereby ensure that the best service was obtained at a reasonable cost. At this stage there is little confidence that such a market will be created". (In his penultimate paragraph he comments, "The CHE group are of the view that this business of providing health is not a genuine commercial mode. We are not able to significantly influence the market, adjust prices or alter the nature of supply in order to capture a market in the way that other commercial organisations do".)
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> "There was an expectation that there was an absolute commitment to proceed to establish this structure and make the necessary fiscal and political decisions to establish the process. There are doubts that this commitment continues". (8)

The Ministry of Health, in briefing papers to the incoming Minister of Health in November 1993, confirmed these views in saying;

> "CHEs are currently facing several major problems: underdeveloped management systems, valuation and balance sheet difficulties, and operating deficits".
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> "At this stage, most CHEs are not able to finance their capital and cash requirements by borrowing from the private sector. . . Before CHEs can become bankable in the private sector, however, they will need to develop business plans that demonstrate significant efficiency gains, and (if possible) some increase inrevenue from sources other than [the government]". (9)

Since the revenue available to the purchasing authorities is capped, and the revenue available to the CHEs isessentially what is left after the purchasing authorities have met both their administrative costs and the components of primary care which they must fund, for "efficiency gains" one must read "reduced services" (for the chairmanof the CHE chair's consultative committee acknowledges that the "CHE Boards are simply not prepared to be bound by levels of expectation prevalent in the market pre June 1993 which suggest that there were gains available to the order of 15% to 20% and in some instances more"). (8)

More revenue from non governmental sources, on the other hand, essentially means shifting costs onto individual sick people, or their private insurers, accelerating the trend which saw 88% of all health costs funded by the government in 1980, but has only 76.5% of such costs covered by government by mid 1993. (4)

New Zealanders have seen a rise in out of pocket expenses for medical care from 13% of total health care spendingi n 1984 to 23.5% in 1996. In most countries out of pocket costs have been either static or reducing. In

the USA out of pocket costs have fallen from 23.3% in 1984 to 17.1% of all health care spending in 1996. In the United Kingdom costs fell from 3.3% in 1994 to 2.9% a decade later. Canada saw a small rise, 14.6% in 1988 rising to 16.2in 1996. (10)

The mean unsubsidised cost for a prescription has risen to 31% of the total by 1996.(4)

The success of any health policy cannot be measured in financial terms alone; an analysis of the degree to which health needs are met is also required. This can be discovered by epidemiologic surveys, but these are not available in New Zealand. Waiting lists and waiting times, though recognised as imperfect instruments for the purpose, are what we often have to rely on. Between 1991 and 1993 the average waiting time for orthopaedic surgery rose from 10.3 to 16 months, for cardiothoracic surgery from 4.7 to 11 months, for ophthalmologic surgery from 12.5 to 16 months. (11)

In an effort to deal with this intractable problem the government introduced a "booking" system in 1998. This involved scoring patients who had been referred for any given procedure. The original proposal was that "patients should be assessed by defined criteria, according to their need and likely benefit . . . " The ethical basis for this proposal has been criticised as having a bias against the elderly and those who are seriously ill but who stand to gain little objectively or gain for a limited period - those requiring palliative treatments for cancer for example. A queue is established based upon the score a patient receives, and if the score is above the financial threshold, determined by the money available, the relevant service is provided, theoretically within 6 months. Those who require thetreatment but do not score highly enough to reach the financial cut-off are placed on the "residual waiting list".According to the second quarterly report dealing with the booking system, 83,000 New Zealanders were waiting for surgical treatments of some kind at the end of 1998, and of these 18,358 had been waiting for more than 24 months.

The introduction of the system has been resisted by many doctors, and hospitals have found it hard to administer. Many see it as a cynical system to justify denying treatment to many who would benefit from it.

The scoring systems have been less than accurate, furthermore.

A study that raised particularly serious concern was that of the Green Lane Hospital Cardiology Department. Reviewing a group of 130 patients who scored less than the 35 points necessary to achieve a booking for coronaryby-pass surgery, but who were judged to require such surgery by their attending doctors, they found that just under half (46.5%) of the group denied surgery on their "CPAC" score had required surgery within the follow up period of 20 months and about a fifth (24/130) required urgent or emergency treatment with its attendant clinical risks and costs. Four patients in this group died, 8 suffered myocardial infarction and 12 suffered episodes of unstable angina requiring hospital admission. The average treatment cost of the 46.5% who were treated surgically was almost double that of those treated electively.(13)

The chief reason that waiting lists are so intractable, and that hospitals are struggling to cope with the burden of winter illnesses this year, is the lack of investment over many years in public hospitals, and their continuing underfunding. Public hospitals received $900 per head of population in 1980 (1996 dollars) but only $769 per head in 1996.

The reform was undertaken to deal with the four problems referred to earlier. The *price barriers in primary care* have not been touched. The *deficiency in secondary care services* is worsening as described, partly because the transaction costs involved in creating a pseudo-market exceed the relatively small savings generated by the stricter financial "management " of care, partly from lack of real investment. The problem of *rationing* has been addressed by the establishment of a committee to review the services that should be available to New Zealanders, but no serious work has been done to establish a list of "core services" or a statement of the meaning for New Zealanders of the undertaking, made as a signatory to the International Covenant on Economic, Social and Cultural Rights of 1966 (Article 12), that the state should provide "conditions which would assure to all medical service and medical attention in the event of sickness", so as to ensure "the enjoyment of the highest attainable standard of physical and mental health".

Where the reform can perhaps be said to be succeeding is in *controlling (some) government expenditure*, but at the cost of denying or delaying services to some who cannot buy private care, and encouraging, or forcing, those who can to pay for private care. For example, a single person without dependents and over the age of 50, and any single person over 65, who has a terminal illness, essentially defined as any illness creating a disability requiring institutional "services that are likely to be required to be provided indefinitely" (12), must pay personally for institutional care, until their assets are reduced to $NZ6500, before a state subsidy is available.

Where the patient has a spouse still living independently, the joint assets of the couple must be used to pay for care until they have dwindled to $NZ40,000, a house and a car.

On paper the New Zealand reform *had* some coherence, though often only because the words used were given the flexibility of meaning associated with Humpty-Dumpty. It is hard to take seriously the idea that the government is the purchaser of primary care services for that half of the adult population who receive no subsidy for their visit to a general practitioner, or that there will be competition between secondary care providers in provincial centres where only one base hospital could ever exist without ruinous expense. In practice it has little coherence and no obvious policy beyond cynical monetarism. By 1996 the OECD was able to discern that the services being delivered were no better than those provided by the old system. While the survey referred to the reform as " a promising way of responding to patient demands while containing costs" it recognised that any improvement in the volume and efficiency of services reflected the changes that were well underway before the reform began.. But it recognised too that little that had been promised had been achieved. In particular " for most health services, there appears sofar to have been little real competition between providers either because of natural local monopolies or because of regional health authorities' difficulties in specifying the services they want to buy with sufficient precision to permit tendering" . (14)

In short, the plan foundered because it did not deal with the realities of health care and the geography of NewZealand. No elements of the original plans to introduce competition and a "market" are now discernible. Rather than a market economy in health, what exists is a command economy.

The health system in each country of the developed world is unique, rising out of the nation's history and moulded by its recent social and economic experiences. The New Zealand reform teaches that to borrow elements of a healthcare system from other countries without replicating fully the environment which provides the reasons, often arcane, of why it works for them, may be disastrous.

It also teaches that economic policy alone cannot provide a policy for health.

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