New Zealand
Health System Review

Asia Pacific Observatory
on Health Systems and Policies
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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system, and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with international editors. To facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

A HiT profile seeks to provide relevant information to support policymakers and analysis in the development of health systems. This can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems;
- to describe the institutional framework, process, content and implementation of health-care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences between policymakers and analysts in different countries implementing reform strategies; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological issues. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services is based on a number of different sources, including the World Health Organization (WHO), national statistical offices, the Organisation for Economic Co-operation and Development (OECD) health data, the International Monetary Fund (IMF), the World Bank, and any other sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.
The HiT profiles can be used to inform policymakers about the experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analyses of health systems. This series is an ongoing initiative, and the material will be updated at regular intervals.

Comments and suggestions for further development and improvement of the HiT series are most welcome and can be sent to the apobservatory@who.int. HiT profiles and HiT summaries for countries in Asia Pacific are available on the Observatory’s website at www.healthobservatory.asia or https://apo.who.int.
Acknowledgements

This Health Systems in Transition (HiT) profile on New Zealand was written by Dr Jacqueline Cumming.

This HiT draws upon the previous editions from 2013, written by Dr Jacqueline Cumming, Janet McDonald, Colin Barr, Dr Greg Martin, Zac Gerring and Jacob Daubé (Health Services Research Centre/Te Hikuwai Rangahau Hauora, School of Government, Victoria University of Wellington, New Zealand) and edited by Christian Gericke (Wesley Research Institute and the University of Queensland School of Population Health, Brisbane, Australia). This was a joint publication of the Asia Pacific and European Observatories on Health Systems and Policies: the HiT was initiated by the European Observatory and finalized under the guidance of the Asia Pacific Observatory. Both observatories were grateful to Toni Ashton, Peter Davis, Judith Healy and the New Zealand Ministry of Health for reviewing this earlier report. The 2013 report drew on an even earlier report from 2001, written by Sian French and Andrew Old, and edited by Judith Healy.

The author is grateful to Nima Asgari-Jirhandeh and Radhika Arora for their support for this work. She also thanks two peer-reviewers, staff at the Ministry of Health, and others at a wide range of New Zealand agencies for their assistance in providing information and for their invaluable comments on drafts of this report.
This report analyses the health and disability system in New Zealand, focusing on the system that was in place up until 30 June 2022. On 1 July 2022, the system was restructured; the restructured model is discussed in Chapter 6 of this report. Generally, key aspects of the health and disability system that were in place prior to, and remain in place from, 1 July 2022 are discussed in the present tense, while aspects that changed on 1 July 2022 are reported in the past tense.

The report reflects data available in September 2022.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACART</td>
<td>Advisory Committee on Assisted Reproductive Technology</td>
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<td>ACC</td>
<td>Accident Compensation Corporation</td>
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<tr>
<td>AHB</td>
<td>Area Health Board</td>
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<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<tr>
<td>APO</td>
<td>Asia Pacific Observatory on Health Systems and Policies</td>
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<tr>
<td>ASH</td>
<td>ambulatory sensitive hospitalization</td>
</tr>
<tr>
<td>BSMC</td>
<td>“Better, Sooner, More Convenient” (a health policy)</td>
</tr>
<tr>
<td>CAM</td>
<td>complementary and alternative medicine</td>
</tr>
<tr>
<td>CHE</td>
<td>Crown health enterprise</td>
</tr>
<tr>
<td>CIC</td>
<td>Capital Investment Committee</td>
</tr>
<tr>
<td>CPAC</td>
<td>clinical priority assessment criteria</td>
</tr>
<tr>
<td>CSC</td>
<td>community services card</td>
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<tr>
<td>CT</td>
<td>computer tomography (scanner)</td>
</tr>
<tr>
<td>DALY</td>
<td>disability-adjusted life year</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>GPC</td>
<td>general practice</td>
</tr>
<tr>
<td>GST</td>
<td>Goods and Services Tax</td>
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<tr>
<td>HCH</td>
<td>health care home</td>
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<tr>
<td>HDC</td>
<td>Health and Disability Commissioner</td>
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<tr>
<td>HFA</td>
<td>Health Funding Authority</td>
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<td>HHS</td>
<td>hospital and health services</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>HNZ</td>
<td>Health New Zealand</td>
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<tr>
<td>HRC</td>
<td>Health Research Council of New Zealand</td>
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<tr>
<td>HQSC</td>
<td>Health Quality and Safety Commission</td>
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<tr>
<td>HUHC</td>
<td>high-use health card</td>
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<tr>
<td>IFHC</td>
<td>Integrated Family Health Centre</td>
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<tr>
<td>IPA</td>
<td>Independent Practitioner Association</td>
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<tr>
<td>IT</td>
<td>information technology</td>
</tr>
<tr>
<td>LMC</td>
<td>lead maternity carer</td>
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Medsafe  The New Zealand Medicines and Medical Devices Safety Authority
MELAA  Peoples from the Middle East, Latin America, and Africa
MHA  Māori Health Authority
MHWC  Mental Health and Wellbeing Commission
MIQ  managed isolation and quarantine
MMP  mixed member proportional (representation system)
MoDP  Ministry of Disabled People
MoH  Ministry of Health
MP  Member of Parliament
MRI  magnetic resonance imaging
MSD  Ministry of Social Development
NA  data not available (in tables)
NEMA  National Emergency Management Agency
NGO  nongovernmental organization
NHB  National Health Board
NHC  National Health Committee
NHEP  National Health Emergency Plan
NHI  National Health Index
NIR  National Immunisation Register
Not app  not applicable (in tables)
NZDep  New Zealand Deprivation Index
NZPHDA  New Zealand Public Health and Disability Act 2000
OECD  Organisation for Economic Co-operation and Development
PAYE  pay as you earn (income tax)
PHARMAC  Pharmaceutical Management Agency
PHC  primary health care
PHCS  Primary Health Care Strategy
PHO  Primary Health Organization
PPP  purchasing power parity
RHA  Regional Health Authority
RPHU  Regional Public Health Unit
SIA  services to improve access
SLM  system level measures
TWO/HNZ  Health New Zealand
US$  United States dollar (all $ values quoted in this book are New Zealand dollars unless otherwise stated)
VLCA  very low-cost access
### Māori words and phrases

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<th>Māori word/phrases</th>
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<tr>
<td>Hapū</td>
<td>subtribe</td>
</tr>
<tr>
<td>Hauora</td>
<td>health, wellbeing</td>
</tr>
<tr>
<td>Hui</td>
<td>gathering or meeting</td>
</tr>
<tr>
<td>Iwi</td>
<td>tribal group</td>
</tr>
<tr>
<td>Kaupapa Māori</td>
<td>Māori themes or policies</td>
</tr>
<tr>
<td>Mana whenua</td>
<td>local tribal groups’ authority and rights over local land; sometimes taken to mean the local tribal groups themselves</td>
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<tr>
<td>Pae Ora</td>
<td>Healthy Futures (overarching goal for Māori health); name of 2022 legislation for the health sector</td>
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<tr>
<td>Pākehā</td>
<td>a New Zealander who is descended from Europeans</td>
</tr>
<tr>
<td>Rangatiratanga</td>
<td>the right of Māori to rule themselves; self-determination</td>
</tr>
<tr>
<td>Tamariki ora</td>
<td>child wellbeing</td>
</tr>
<tr>
<td>Tangata whenua</td>
<td>people of the land (i.e. Māori)</td>
</tr>
<tr>
<td>Taonga</td>
<td>treasure, anything prized</td>
</tr>
<tr>
<td>Te Ao Māori</td>
<td>the Māori world</td>
</tr>
<tr>
<td>Te reo</td>
<td>Māori language</td>
</tr>
<tr>
<td>Te Tiriti o Waitangi</td>
<td>the Treaty of Waitangi</td>
</tr>
<tr>
<td>Tino rangatiratanga</td>
<td>autonomy and self-government for Māori to the fullest extent possible</td>
</tr>
<tr>
<td>Whānau</td>
<td>extended family</td>
</tr>
<tr>
<td>Whānau Ora</td>
<td>a major initiative to support improved Māori whānau health; a philosophy, approach, and goal for achieving improved Māori health/wellbeing at an extended family level</td>
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New Zealand is a Pacific nation of just over 5 million people.

Māori are the Indigenous people of New Zealand. They are of East Polynesian ancestry and are believed to have arrived in New Zealand in the late 13th century. Since the signing of the Treaty of Waitangi between Māori chiefs and the British Crown in 1840, New Zealand has shifted from a predominantly Māori population and cultural heritage to one that is dominated by European cultural traditions. There has been widespread failure by the Crown to uphold the Treaty over the following century and consequently significant loss of Māori land and other economic and cultural resources. In 1975, the Waitangi Tribunal was established to hear claims from Māori about breaches of the Treaty; the Tribunal makes recommendations to the government about recompense, including in relation to the health and disability system.

The population is predominantly of New Zealand European ethnicity (70.2%), with significant Māori (16.5%), Asian (15.1%) and Pacific Island (8.1%) populations. About 20% of the population is aged 0–14 years, while the proportion of the population aged over 65 years (16%) is growing.

The Head of State is the British Sovereign. In September 2022, this became King Charles III. The Sovereign is represented in New Zealand by a Governor-General who gives royal assent to all legislation. In practice, the powers of the Sovereign are limited, and it is the New Zealand parliament that enacts laws and governs the country.

New Zealand has a unitary system of government, i.e. a single, central government that governs the whole country. It is a democracy with a parliament elected every three years, under a mixed member proportional (MMP) representation system that has been in place since 1996.

The Central Government is responsible for health and disability policy in New Zealand, with Government-appointed Ministers leading policy, regulatory and funding decision-making. Health and disability services are predominantly tax-funded, providing universal coverage. The population enjoys high health status overall, but with significant inequalities for Māori, as well as for Pacific peoples, people on low incomes and the disabled.
The main details of the health and disability system up until 30 June 2022 were as follows. A central Ministry of Health (MoH) oversaw both health and disability policy. It directly funded some national services, but most funding was allocated to 20 district health boards (DHBs), which were responsible for planning and funding health and disability services for their geographical areas, as well as for running publicly owned hospitals and delivering a wide range of services, including hospital inpatient and outpatient services, as well as many community-based services. DHBs in turn allocated funding for PHC services through 30 primary health organizations (PHOs) that received capitation funding for their enrolled populations, and which then worked with general practices and other service providers to deliver comprehensive PHC in the community. DHBs also in turn allocated funding for community services delivered by both for-profit and not-for-profit service providers.

There are no user charges for inpatient or outpatient services in publicly owned hospitals. Patients may pay extra billing user charges for PHC services, although the government provides additional funding so that most children under 14 years of age pay no user charges.

The Pharmaceutical Management Agency (PHARMAC) manages the New Zealand Pharmaceutical Schedule and negotiates the purchase of drugs, vaccines, and devices from suppliers, successfully controlling supply-side expenditure.

The Accident Compensation Corporation (ACC) is a comprehensive, social insurance, no-fault, personal injury scheme that funds treatment, rehabilitation and income compensation for people who are injured in New Zealand. It also has a focus on accident prevention. It sits alongside the tax-funded health and disability system, and funds a wider range of services than the health and disability system, including faster care through privately owned hospitals. There are therefore significant concerns over inequities in access to services between those whose health or disability is due to illness and those whose condition is a result of an accident.

Current challenges include significant inequities in health and disability and in access to services, an inadequate emphasis on PHC and ensuring access to PHC, the need to better manage the growing burden of long-term conditions, major workforce issues, long waiting times for some services, and fragmentation of services within and between PHC and secondary care and inter-sectorally between health and other social services.

Since the 1980s there have been seven major reforms of the health and disability sectors. These have typically had similar goals, such as improving
equity, enhancing public health and prevention services, and improving access to and the scope of services delivered in PHC.

The most recent reforms introduced a new structure on 1 July 2022. The MoH is continuing its lead policy role in health, with a new embedded Public Health Agency focused on improving public (population) health policy and services. A new Ministry of Disabled People (MoDP) has been established to take over the lead policy and service funding roles for disability policy and services. The 20 DHBs have been amalgamated into a single national organization Health New Zealand (HNZ), which has also taken over purchasing roles from the MoH and DHBs, as well as running publicly owned hospitals and associated services. A new organization, the Māori Health Authority (MHA) has been established to oversee Māori health, including purchasing Māori-led health services, and co-purchasing other services. PHOs remain for now but will formally disappear in the next few years. Every part of New Zealand will by then have become a part of a locality, with an expected 80 localities to be established by mid-2024. Localities will enable greater community input and a wider range of local (including PHC) services to be delivered through stronger networks of providers. With the reforms having very similar goals to earlier restructures, key lessons from these earlier restructures will need to be heeded if these latest reforms are to be a success.
Executive summary

Introduction

New Zealand is a Pacific nation of just over 5 million people.

Māori are the Indigenous people of New Zealand. They are of East Polynesian ancestry and are believed to have arrived in New Zealand in the late 13th century. In 1769, modern New Zealand was claimed for Great Britain by Captain James Cook. European settlement gradually followed.

The Treaty of Waitangi was signed in 1840 by numerous Māori chiefs and the British Crown, but there are important differences in the wording and interpretations of the English and Māori versions of the Treaty. There was widespread failure by the Crown to uphold the Treaty and consequently significant loss of Māori land and other economic and cultural resources. Since the 1970s, New Zealand has been striving for a more bicultural approach – so that Māori and Pākehā (a New Zealander who is descended from Europeans) exist on equal terms. In 1975, the Waitangi Tribunal was established to hear claims from Māori about breaches of the Treaty; the Tribunal makes recommendations to the government about recompense, including in relation to the health and disability system.

Since the signing of the Treaty in 1840, New Zealand has shifted from a predominantly Māori population and cultural heritage to one that is dominated by European cultural traditions. Today, the population is predominantly of New Zealand European ethnicity (70.2%), with significant Māori (16.5%), Asian (15.1%) and Pacific Island (8.1%) populations. About 20% of the population is aged 0–14 years, while the proportion of the population aged over 65 years (16%) is growing.

New Zealand is heavily reliant on foreign trade and, in common with the rest of the world, recently experienced a period of economic downturn due to the outbreak of the COVID-19 pandemic in 2020.

The Head of State is the British Sovereign. In September 2022, this became King Charles III. The Sovereign is represented in New Zealand by a Governor-General, who gives royal assent to all legislation. In practice, it is the New
New Zealand parliament that enacts laws and governs the country. New Zealand has a unitary system of government, i.e. a single, central government that governs the whole country. New Zealand is a democracy with a parliament elected every three years under a mixed member proportional (MMP) representation system. The Labour party (centre-left) is currently the governing party. Local government consists of many regional and local territorial authorities, with a review of arrangements currently under way.

Local governments have their powers set by the Central Government, and are concerned with environmental and civil defence, as well as local infrastructure, building control, and public health inspections.

New Zealanders generally enjoy a high level of health status, according to international comparisons. Life expectancy is about 84 years for women and 80 years for men. The main causes of death are noncommunicable diseases, particularly cancer, ischaemic heart disease, cerebrovascular disease, and chronic lower respiratory diseases. Māori and Pacific Island peoples, those on lower incomes, and disabled people have lower overall health status than that of New Zealanders of European ethnicity, those on higher incomes and those who are not disabled. Asian peoples tend to have overall high levels of health. Less is known about the health and health needs of people from the Middle East, Latin America, and Africa.

In terms of natural and human-induced disasters, New Zealand has had recent earthquakes, a volcanic eruption, a major Campylobacter outbreak, mosque shootings, and the COVID-19 pandemic, each of which resulted in major injuries and illness and a loss of life (although the number of deaths from the Campylobacter outbreak are not certain). Major reforms to responsibilities for water are now under way, while New Zealand has had one of the strongest and most successful approaches to managing COVID-19, albeit at a significant economic cost.

Organization and governance

New Zealand has a predominantly publicly funded, universal coverage health and disability system with services provided by publicly owned, privately owned and nongovernmental (voluntary or third sector [not-for-profit]) organizations.

The foundations for New Zealand’s health and disability system were laid in the late 1930s, with the passing of the Social Security Act 1938. However, regular reviews of the system emphasized the need for a greater focus on prevention and primary health care (PHC) services, concerns over rising user charges for PHC leading to significant barriers to access to PHC, fragmented
service delivery across many health-care provider organizations and health professionals, and growing inequities in health and access to care. As a result, there have been seven major reforms of the system between the 1980s and 2020s.

The Ministry of Health (MoH) oversees the health system and is the lead advisor to the Minister of Health. Prior to 1 July 2022, the MoH also directly funded some services. A Health Quality and Safety Commission (HQSC) supports quality improvement.

Prior to 1 July 2020, 20 district health boards (DHBs) were responsible for planning and funding health and many disability services for their geographical areas. They were funded by, and their performance was managed by, the MoH. They owned and operated many hospital and community services (e.g. district nursing, mental health), and contracted for a range of PHC and community services (e.g. health promotion, mental health, disability support, home care and residential rest home care) from a range of privately owned organizations.

PHC is coordinated through primary health organizations (PHOs), which received capitation funding for their enrolled populations. Patients are free to enrol with a privately owned general practice (GPC) of their choice; the GPC then chose which PHO to join. PHOs are to have no formal place in the newly restructured health system.

Many PHC and community services are delivered by a range of privately owned service providers, many of which are nongovernment organizations (NGOs), which are not-for-profit. This includes an increasing number of Māori-led and Pacific-led service providers.

Most New Zealanders have a choice of GPC, although this may be limited in rural areas and there are now many practices with closed books. Most people access hospital services through their local DHB’s hospital, with usually no choice over hospital or specialists. Those with private health insurance or who pay privately for services have the choice to receive services from privately owned hospitals, although these are largely located in the main centres.

Recent governments have developed a number of overarching policy strategies for the health and disability system. This includes specific strategies for improving Maori and Pacific peoples’ health and wellbeing, and the wellbeing of disabled people. DHBs and PHOs have been held
accountable for delivering on these strategies through a variety of mechanisms, such as annual plans and annual reports.

New Zealanders can purchase private health insurance that provides complementary service coverage for services typically not available through the publicly financed system (e.g. adult dental care); complementary coverage for the user charges paid for publicly financed services; and for supplementary services, such as faster access to elective/planned services, delivered by privately owned hospitals.

The accreditation process for health professionals is governed by the Health Practitioners Competence Assurance Act 2003. The 17 authorities created under the Act are responsible for overseeing practitioners of a particular profession or professions, including their registration, and managing complaints. A range of colleges is responsible for the training, examination, and recertification of health professionals. Many professional bodies advocate on behalf of their members and are engaged in collective bargaining on salaries and working conditions.

New Zealand has had several arrangements in place since the 1990s to set priorities, including national committees. This work now largely falls to the MoH. The Pharmaceutical Management Agency (PHARMAC) is the government agency responsible for deciding which medicines should be funded by government, and its role has expanded over time to include vaccines and medical devices.

Health and disability services (including medical, mental health, surgical, and obstetric services, aged care facilities, and other health-related services) are regulated by the Health and Disability Services (Safety) Act 2001 and associated regulations. These set standards, provide for certification, and establish a framework for the monitoring of compliance. Medsafe is an MoH business unit that regulates therapeutic products, including medicines and devices.

In addition to the information that health and disability organizations and health professionals provide, information for patients is provided nationally through the MoH, a national healthline service, regional disability information centres and by a large number of not-for-profit groups that support patients with particular health or disability conditions.

Since 1996, New Zealand has had a Code of Health and Disability Services Consumers’ Rights, and the office of the Health and Disability Commissioner (HDC) investigates complaints. Until recently, the HDC also included a Mental
Health Commissioner; a separate Mental Health and Wellbeing Commission was established in 2021 to oversee the transformation of the mental health and addiction system. An Aged Care Commissioner has recently begun working from the HDC to oversee the aged care sector.

Consumer and/or community participation in the health system occurs at a number of levels in New Zealand. Prior to their disestablishment on 1 July 2022, DHBs included locally elected members. There are often advisory boards for particular initiatives or organizations, including for the MoH, PHARMAC and health care providers, while some health care providers have community governance. Consumers and communities are also involved in running a wide range of community organizations. The Health Quality and Safety Commission (HQSC) has a Partners in Care initiative to encourage the system to become more patient-centred and to take a co-design to service delivery.

**Financing**

In 2020, New Zealand ranked 18th in the Organisation for Economic Co-operation and Development group of countries (OECD) for health expenditure as a percentage of GDP at 9.7% (the same as the OECD average). Health expenditure as a percentage of GDP rose from 7.5% in 2000 to 9.7% in 2022. However, New Zealand health expenditure per capita at US$ 4469 in purchasing power parity (PPP) in 2020 was below comparable countries, such as the United Kingdom (US$ 5019), Australia (US$ 5627) and Canada (US$ 5828).

New Zealand finances health care primarily through government sources (80.1% in 2020), largely through the MoH, with the balance coming from the Accident Compensation Corporation (ACC) to fund injury-related services; direct payments by service users; and private health insurance. The total appropriation for health spending in the 2021–2022 government budget was NZ$ 24 398 million, an increase of NZ$ 1167 million or 5% over actual expenditure in 2020–2021.

Most health services funding was until recently allocated to DHBs (66.3%), with DHBs funded through a population-based funding formula. DHBs then provided a wide range of hospital and community services themselves, as well as funding privately owned providers through service agreements for PHC, community care, residential rest home and home care services.

The New Zealand health and disability system provides universal access to a broad set of health and disability support services. In addition, 35%
of the population holds complementary and supplementary private health insurance (representing 7.9% of total health expenditure).

Outpatient and inpatient hospital services, including maternity services, are free of charge for service users. Following the introduction of the Primary Health Care Strategy in 2001, capitation funding has replaced fee-for-service funding of GPC services, but service users continue to pay extra billing user charges. Most adult prescriptions have a co-payment of NZ$ 5 per item. Basic dental services are free for children and young adults to the age of 18 years; adult dental care and optometry are paid for privately. Long-term care is funded both publicly and privately.

The State-run ACC provides injury compensation through a fully comprehensive, no-fault insurance scheme. ACC is funded through employer, employee, self-employed and car-licensing levies. It also provides funding to the MoH for accident-related care costs incurred by public hospitals and pays private providers for approved treatment for accident-related care.

A mix of payment mechanisms are in place for health workers. Salaries are used to pay many workers – doctors, nurses, allied health staff, management – working for both publicly and privately owned health provider organizations (e.g. staff in DHBs, as well as staff in GPCs, pharmacies, rest homes, or working for home care providers). Medical specialists working in the privately owned sector are paid on a fee-for-service basis, while midwives are paid via a case-based arrangement per trimester of care. Owners of GPCs might be paid via a range of mechanisms, such as capitation, salary, or fee-for-service payments. Pay equity is a significant issue for the health sector, with recent settlements for care and support workers and upcoming settlements for nurses and midwives.

**Physical and human resources**

In 2018, the MoH concluded that DHBs operated with an accumulated underinvestment in assets and that many believed DHBs’ assets to be in a poor condition and not fit for purpose. The same year, the Minister of Health announced the government’s intention to address the poor state of health infrastructure in the country.

All DHBs had to maintain an asset management plan and report annually on capital intentions through the District Annual Planning process. Prioritizing capital funding and investment in the health sector and advising the ministers of health and finance on these matters was the role of the Capital Investment Committee (CIC), a part of the MoH.
Overall, acute care hospital bed capacity has been reduced in recent years and average lengths of stay have been falling over time. Medical equipment and devices are regulated for use in New Zealand. DHBs could make decisions regarding purchasing capital assets, up to set limits.

In 2021, New Zealand had 16.62 magnetic resonance imaging (MRI) units per million population and 44.99 computer tomography (CT) scanners per million population. Compared to Australia, the one comparable country for which data are available, New Zealand’s MRI rate is a little higher than that of Australia, but far lower for CT scanners.

New Zealand hospitals have multiple information technology (IT) systems, and GPCs are also highly computerized. Electronic messaging is extensively used, including for sending referrals, payment claims, laboratory and pathology results, and hospital discharge summaries. E-prescribing has increased significantly in recent years and grew further during the COVID-19 pandemic. There are, however, significant issues with digital and data systems and information, which have been slow to be rectified. Infrastructure planning of IT in early 2022 is a role of the MoH.

New Zealand’s health and disability sector employs around 220 000 people, or 8.5% of the total workforce. It is the largest sector employer in the country. Just over a third have until recently been employed in DHBs, with DHBs often the largest employers in their region. Clinical staff, employed directly in caring for people, make up 66% of the workforce. Personal carers and assistants (at 23% of the workforce), nurses and midwives (at 21%) are the largest groups of workers. There are over 30 000 allied health workers across at least 43 groups delivering care.

In 2021, there were 3.53 physicians, 10.91 nurses, 0.56 midwives, 0.52 dentists, 0.72 pharmacists and 1.14 physiotherapists per 1000 population. New Zealand has a relatively high proportion of migrant doctors and nurses. In 2020, 42.4% of New Zealand’s doctors and 28.6% of its nurses were foreign-trained. The rate at which New Zealand-trained doctors move overseas has reduced in recent years – of late, all New Zealand-trained doctors have remained in the country two years after graduating and 93% five years after graduating.

Gender representation in the health workforce varies significantly depending on the profession. Over 90% of nurses are women and a little under half of doctors are women. However, by 2025, it is expected that the majority of doctors will be women. Māori and Pacific people are markedly underrepresented among health professionals.
There are two universities that train doctors (a six-year undergraduate course). Registered nurses are trained in three-year tertiary-level courses that are offered in both universities and technical institutes (now a single national institute). Nurse practitioners undertake advanced training and may have prescribing rights within their specialist field. New Zealand also has “enrolled” nurses who undergo an 18-month training programme and must practise under the direction and delegation of a registered nurse or nurse practitioner. Midwives have a separate four-year equivalent, pre-registration Bachelor of Midwifery programme, which can be completed over three years and is available in five centres in both universities and the national skills institute Te Pūkenga. Dentists complete five years of training; pharmacists and physiotherapists four years each.

**Provision of services**

Public (or population) health services in New Zealand, such as national screening and immunization programmes, are overseen by the MoH, which, prior to 1 July 2022, also had responsibility for directly funding and purchasing some national initiatives (e.g. well-child services). Prior to 1 July 2022, the MoH also directly funded 12 DHB-owned regional public health units (RPHUs), covering environmental and communicable disease control, health promotion and preventive services. DHBs in turn funded and supported many public health programmes, while a wide range of health providers also deliver such services to their local populations. Occupational workplace health and safety is overseen by a separate government agency, WorkSafe.

New Zealanders have a range of ways of keeping themselves well and may make use of a wide variety of non-funded services regularly (e.g. nutrition advice, physical activities, regularly visiting an alternative practitioner). People who feel unwell will first rest and may access advice from a national healthline and obtain over-the-counter medicines from pharmacists. They may also call for an ambulance or visit a publicly funded and provided emergency department (which are open 24 hours a day) or a privately owned after-hours clinic.

For further advice and treatment, people will visit a PHC provider, who might then organize further diagnostic tests, prescribe medicine or refer them to another PHC provider (such as a physiotherapist) or to a hospital specialist. Since 2001, PHC has been coordinated through PHOs, which received capitation funding for their enrolled populations, and which contracted GPCs and other providers to deliver PHC services. There are user charges for using general practice GPC services. The role of nurses – including advanced nurse
practitioners – is increasing over time. New Zealanders have relatively good access to PHC, but rates of enrolment with GPCs have been falling and there are quite high levels of unmet need, especially for Māori and Pacific peoples, those in more deprived areas, and for disabled people.

Most specialists are employed by publicly owned hospitals, but many also maintain their own private practices. Hospital outpatient and inpatient services are provided mainly by publicly owned hospitals. Maternity services are provided through a lead maternity carer, most of whom are midwives, working in publicly funded health providers or in independent practice. There are no charges for inpatient or outpatient treatment in publicly owned hospitals, or for maternity care. Patients are prioritized for access to publicly funded elective/planned services. People can also access services delivered in privately owned hospitals if they pay for care themselves or through private health insurance.

There are two main providers of ambulance services, staffed with paramedics and volunteers. One service is free and the other has user charges for some services. There is also a nationwide air ambulance service. Such services are funded by the ACC in the event of an emergency.

Pharmacists deliver services largely from independently owned community pharmacies, as well as from hospital pharmacies, with pharmacy services expanding over time. PHARMAC is the national government organization that decides, using decision-criteria, including cost-effectiveness, which medicines, vaccines and devices are to receive public funding, given its capped budget.

Accident-related rehabilitation services are funded by ACC; other services are funded by publicly funded health providers and delivered by publicly or privately owned providers. Long-term care can include disability support services, aged care (including home-based services and residential rest home services), and care for long-term conditions. Funding arrangements differ across these services, and services are delivered by a range of providers. There are some services to support family carers, and recurring legal cases over payment for those family members supporting people with disabilities.

Palliative care is funded in part by government, and delivered by privately owned, not-for-profit hospices, which rely on donations as well.

Funding from the government for mental health services has historically focused in particular on the estimated 3% of the population with severe
mental distress. Options for government-funded primary mental health care (other than medicines) have been limited but are now expanding.

Basic dental care is free for children under 18 years, but there is limited publicly funded dental treatment for adults, other than for emergencies.

Many forms of complementary and alternative care are available in New Zealand, delivered by a range of privately owned providers. Some are funded by ACC for those with accident-related needs.

There are a range of plans in place throughout the health sector to be used when disaster strikes. A review of a selection of major disasters and emergencies in New Zealand over the past 10 years suggests that the health sector has generally performed well during such events, including during COVID-19.

Principal health reforms

During the 20th century, the New Zealand government gradually picked up the overall financing of hospitals, which were progressively amalgamated into larger units as hospital care became more technologically driven and birth rates fell. The first Labour government’s (1935–1938) aim of a comprehensive and integrated public health-care system was never fully achieved, with compromises including fee-for-service funding for independent general practitioners (GPs); user charges for GP care, which rose over time as subsidies did not keep pace with costs (raising concerns about equity of access); and hospital specialists able to practise privately. Health funding and service delivery continued to be fragmented.

Since the 1980s, the New Zealand health system has undergone a series of reforms. From 1984, fourteen area health boards (AHBs) were established, funded on a population basis and responsible for funding and providing secondary and tertiary health care and public health services; PHC funding remained with the Department of Health.

In the early 1990s, a National Party government introduced separation of funding and provision of services with four regional health authorities responsible for purchasing all personal health and disability services for their regional populations. They could purchase services, using formal purchasing processes and contracts, from both public and private providers. Twenty-three public Crown health enterprises (CHEs) ran hospitals, community and public health services as commercial entities. PHARMAC, the government’s community drug-buying agency, was also established in the early 1990s, and still exists today. As a result of the reforms, New Zealand saw the formation
of independent practitioner associations of GPs to facilitate collective contracting, significant growth in the number of Māori health providers and in the scope of services they provided, and deinstitutionalization (particularly for mental health, disability and residential rest home services), with growth in the role of the private sector in delivering such services. Implementation of these reforms was costly and key aspects were very unpopular with both the public and with health professionals. As a result, CHEs became hospital and health services (HHS), which were no longer required to make a profit, and, in 1998, a single Health Funding Authority was formed to purchase services to provide greater national consistency.

These changes were short-lived, however, as a Labour–Alliance coalition government elected in 1999 introduced further reforms, returning to a model like that of the 1980s with AHBs. Thus, the New Zealand Public Health and Disability Act 2000 introduced 21 (later 20), majority locally elected, DHBs, responsible for planning and providing hospital and public health services for their regions. From 2002 on, 80+ PHOs (later 30) were established to coordinate PHC services for an enrolled population, funded on a capitation basis. Significant new funding initially reduced user charges and improved access to PHC.

The National Party-led government elected in 2008 kept the DHB model and focused on increased “frontline” services and reduced bureaucracy. It implemented a new National Health Board to plan and fund national health services, and a shared services agency to undertake administrative and support services on behalf of DHBs to reduce duplication. It sought improved collaboration between DHBs and reduction in the numbers of PHOs (down from over 80 to 30), and sought “better, sooner, more convenient”, and more integrated, services. However, the global financial crisis of 2007/2008 initiated a lengthy period of tight financial constraint on the health sector, and DHBs began to run up persistent deficits. During this time, other significant developments included the creation of a range of health targets, which evolved into a systems level measures (SLM) framework, used by new “alliances” (usually involving DHBs and PHOs but also others) to better integrate services.

The election of a Labour-led government in 2017 saw a dramatic change of policy, beginning with a major inquiry into mental health services. This resulted in the government introducing a NZ$ 1.9 billion funding boost for mental health services in 2019 and establishing an interim Mental Health and Wellbeing Commission (MHWC) in 2019, followed by the permanent Commission in 2021, to oversee and lead policy in the area.
The government initiated a major review of the health and disability system in 2018. It made a Draft of recommendations in 2020, most of which the government subsequently agreed to. These changes were introduced from 1 July 2022. The MoH is continuing to lead policy development, with a new Public Health Agency embedded within it to strengthen public health. DHBs have been abolished in favour of a single national organization, Health New Zealand (HNZ), to manage the day-to-day operations of the publicly financed and publicly owned health system, and to operate regional public health services. This was designed to make health service delivery more efficient, effective and consistent nationally. The Māori Health Authority (MHA) has been established to lead the strategic direction and funding of health services to Māori. This was part of measures to address inequities in health outcomes in New Zealand. PHOs will no longer have a formal place in the system and, instead, there will be a greater emphasis on locality networks, as part of plans to enhance the delivery of PHC throughout the country. A new agency, the Ministry of Disabled People (MoDP), has also been established to improve outcomes of people with disabilities and to deliver disability support services.

A major reform of New Zealand’s water services is also under way. In part, this is designed to improve the country’s drinking water standards following the worst outbreak of waterborne disease in the nation’s history.

Assessment of the health system

The New Zealand Public Health and Disability Act (2000) set the strategic direction and goals for the health and disability sector in New Zealand prior 1 July 2022, when it was replaced by the Pae Ora (Healthy Futures) Act. The Public Health and Disability Act required the responsible ministers to develop overall health and disability strategies for the country, originally the New Zealand Health Strategy (2000) and the New Zealand Disability Strategy (2001). Several other major strategies, such as the Primary Health Care Strategy (2001) (PHCS), He Korowai Oranga: Māori Health Strategy (2002), and the Pacific Health and Disability Action Plan (2002) sit below the statutory strategies. All set out key priorities and directions and most have been updated in recent years. A range of other action plans also exist for key parts of the health system, e.g. health of older people/healthy ageing; suicide prevention; and mental health. However, implementation of all these strategies and plans has not always been strong and there is often ad hoc reporting on progress.

Performance indicators were used in both PHC and secondary care to assess DHB and PHO performance against set targets. Recent targets have focused on keeping people out of hospital through measuring ambulatory sensitive
hospitalization and acute hospital bed days; patient experience; prevention and early detection of illness measured by amenable mortality rates; babies having a healthy start to life measured by babies living in smoke-free homes; and youth access to appropriate services.

There are recurring high-level goals across the strategies, action plans and targets that have been developed over the past twenty years. These include emphasizing more holistic conceptions of health and wellbeing; greater leadership and participation in decision-making, especially for Māori, but also for Pacific peoples and the disabled; a greater focus on equity; a stronger focus on prevention and PHC; greater integration; delivering timely care; and delivering more services closer to home, in part to reduce pressure on expensive hospital services. These often sit within a long-standing set of goals relating to the system acting as a public service, there to support the whole population’s health and wellbeing, while also emphasizing financial sustainability and overall expenditure control.

Overall, New Zealanders have very good coverage of their health and disability needs through publicly financed health services. User charges for PHC and co-payments for pharmaceuticals have been regularly identified as barriers to access. These charges did fall for a time when additional government funding was made available through the PHCS, but they have continued to rise, and cost is still a barrier for many. There are also some key gaps in coverage, which means some families may face higher overall costs than others.

New Zealand measures people’s experiences with hospital and PHC services. Generally, most people give high scores for the services they receive. People report issues in hospitals in terms of communication, and staff not involving family/whānau/someone close in discussions about their care. In PHC, people report that staff are not always knowledgeable about what they should do if they experience side-effects, that staff do not always discuss what is important with patients, and do not always make contact after a treatment or care plan is developed. There are often lower scores for Māori and Pacific populations.

Health inequities are a major issue in New Zealand. People of Māori and Pacific ethnicity, those with lower socioeconomic status, and disabled people have consistently poorer health status and poorer access to health and disability services. A long-standing goal of the health and disability system is to reduce such inequities. However, there is often insufficient focus on ensuring that key policies do indeed support their reduction. New Zealand needs to better recognize the needs of “new” New Zealanders, given that
Asian and Middle Eastern, Latin American and African populations have been growing in recent years. Differences in coverage between the government-funded health and disability system and the ACC, and differences in who makes claims to ACC, also raise significant equity issues in New Zealand.

International comparisons on health outcomes, health service outcomes, and quality of care give a mixed picture in terms of how New Zealand’s health and disability system performs compared with other countries. Overall, New Zealand does achieve good outcomes (in terms of life expectancy) from its health and disability expenditure compared with other OECD countries. OECD and Commonwealth Fund data suggest that New Zealand does well internationally on some key measures, such as adults’ rating of their own health, some key preventive measures, and in relation to care processes. New Zealand does less well in terms of cancer incidence, infant mortality and mental health, and the data suggest that New Zealand falls behind in terms of PHC care, which may keep people out of hospital.

The MoH reports annually on the state of public health in New Zealand. The report for 2019 showed continuing improvement in life expectancy and health expectancy; decreases in the rates of death from cancer and cardiovascular and cerebrovascular disease; a continuing reduction in smoking rates; and stabilizing obesity and diabetes rates. While New Zealanders are living longer, they are spending more time in poor health, while adults reporting their health as good, very good or excellent are reducing; rates of psychological distress are increasing; suicide rates remain higher; and communicable diseases remain an issue. However, in all cases, Māori (and, where reported, Pacific) outcomes were poorer than non-Māori. This inequity has been decreasing at least in life expectancy but remains a focus for improvement throughout the New Zealand health and disability system. For Māori, recent reports have emphasized the need for better honouring of Te Tiriti o Waitangi/the Treaty of Waitangi and a focus on building on key strengths, for Māori to find their own solutions. For Pacific peoples, recent reports have emphasized the need to implement new initiatives that are known to work, and to systematically reduce barriers across care pathways, while developing more holistic, integrated and comprehensive services, along with more authentic engagement with Pacific communities.

There is a good focus in New Zealand on improving quality. The establishment of the HQSC, which works collaboratively across the health and disability system, has resulted in some significant improvements in the quality of care.
A series of emergencies in New Zealand in 2016 and early 2017 called into question the efficacy of the country’s emergency management and response. As a result, a number of changes have been made to the emergency arrangements. A National Emergency Management Agency, charged with supporting communities to reduce the impact of emergencies across all hazards and risks, and to better respond to, and recover from, emergencies was established in 2019 within the Department of Prime Minister and Cabinet.

The worldwide pandemic of COVID-19 struck New Zealand early in 2020. New Zealand chose to go “hard” and “early” in its response, with one of the most stringent border closures and lockdowns internationally. During 2020, it largely succeeded in keeping cases and deaths low. However, when the Delta variant arrived in mid-2021, it proved difficult to continue this “elimination” strategy. The Omicron variant arrived in late 2021. With very high vaccination rates, restrictions began to be loosened in early 2022, and the number of cases and deaths has ballooned as a result, but still remain low in comparison to other countries. Māori and Pacific peoples were particularly affected by the virus in later 2021, and Māori and Pacific providers worked extremely hard to support their communities. The country has learned many lessons from the pandemic, and it is to be hoped that it is much more prepared for any future outbreaks, requiring a better-resourced nationwide public health response, and greater connection with community-based organizations (e.g. Māori- and Pacific-led providers), which are crucial in reaching key populations.

Assessing allocative and technical efficiency rigorously is difficult, but New Zealand does have a range of processes that aim to support efficiency. An overall set government budget seeks to contain costs and expenditure, while the government is also able to direct resources to key priorities and set targets to encourage providers to achieve key goals and objectives. A population-based funding formula that funded DHBs and capitation payments used for PHC both sought to keep costs down and encourage a focus on technical efficiency, although the continuation of fee-for-service user charges in PHC blunted such incentives somewhat.

A significant amount of publicly available data and information, including an Official Information Act that enables people to request government information, means that there is a high degree of transparency of the New Zealand health system. But there are significant gaps in our understanding of how the system performs and there can be long delays in data being reported. Accountability arrangements within the New Zealand health and disability system are complex. Much has been made in recent years
of the need to significantly improve accountability for a raft of areas (e.g. reducing inequities, maternity care); but formal accountability can be a blunt instrument and attention might be paid to better understanding how to successfully bring about change in a large and complex system.

**Conclusion**

Overall, New Zealanders have a high health status, but significant inequalities, particularly in relation to Māori and Pacific Island peoples’ health, have not closed over recent years, and must be more rigorously addressed. Bedding in reformed health and disability structures while also continuing to make improvements in health and independence are key challenges for the future.
Chapter summary

New Zealand is a Pacific nation of just over 5 million people.

Māori are the Indigenous people of New Zealand. They are of East Polynesian ancestry and are believed to have arrived in New Zealand in the late 13th century. In 1769, modern New Zealand was claimed for Great Britain by Captain James Cook. European settlement gradually followed.

The Treaty of Waitangi was signed in 1840 by numerous Māori chiefs and the British Crown, but there are important differences in the wording and interpretations of the English and Māori versions of the Treaty. There was widespread failure by the Crown to uphold the Treaty and consequently significant loss of Māori land and other economic and cultural resources. Since the 1970s, New Zealand has been striving for a more bicultural approach – so that Māori and Pākehā (a New Zealander who is descended from Europeans) exist on equal terms. In 1975, the Waitangi Tribunal was established to hear claims from Māori about breaches of the Treaty; the Tribunal makes recommendations to the government about recompense, including in relation to the health and disability system.

Since the signing of the Treaty in 1840, New Zealand has shifted from a predominantly Māori population and cultural heritage to one that is dominated by European cultural traditions. Today, the population is predominantly of New Zealand European ethnicity (70.2%), with significant Māori (16.5%), Asian (15.1%) and Pacific Island (8.1%) populations. About 20% of the population is aged 0–14 years, while the proportion of the population aged over 65 years (16%) is growing.

New Zealand is heavily reliant on foreign trade and, in common with the rest of the world, recently experienced a period of economic downturn due to the outbreak of the COVID-19 pandemic in 2020.

The Head of State is the British Sovereign. In September 2022, this became King Charles III. The Sovereign is represented in New Zealand by a Governor-General, who gives royal assent to all legislation. In practice, it is the New
Zealand parliament that enacts laws and governs the country. New Zealand has a unitary system of government, i.e. a single, central government that governs the whole country. New Zealand is a democracy with a parliament elected every three years under a mixed member proportional (MMP) representation system. The Labour party (centre-left) is currently the governing party. Local government consists of many regional and local territorial authorities, with a review of arrangements currently under way.

Local governments have their powers set by the Central Government, and are concerned with environmental and civil defence, as well as local infrastructure, building control, and public health inspections.

New Zealanders generally enjoy a high level of health status, according to international comparisons. Life expectancy is about 84 years for women and 80 years for men. The main causes of death are noncommunicable diseases, particularly cancer, ischaemic heart disease, cerebrovascular disease, and chronic lower respiratory diseases. Māori and Pacific Island peoples, those on lower incomes, and disabled people have lower overall health status than that of New Zealanders of European ethnicity, those on higher incomes and those who are not disabled. Asian peoples tend to have overall high levels of health. Less is known about the health and health needs of people from the Middle East, Latin America, and Africa.

In terms of natural and human-induced disasters, New Zealand has had recent earthquakes, a volcanic eruption, a major Campylobacter outbreak, mosque shootings, and the COVID-19 pandemic, each of which resulted in major injuries and illness and a loss of life (although the number of deaths from the Campylobacter outbreak are not certain). Major reforms to responsibilities for water are now under way, while New Zealand has had one of the strongest and most successful approaches to managing COVID-19, albeit at a significant economic cost.

1.1 Geography and sociodemography

New Zealand is situated in the southern Pacific Ocean, south-east of Australia (see Figure 1.1). The three main islands (North Island, South Island and Stewart Island) cover an area of 270 000 km², comparable to the size of Japan or the British Isles. New Zealand or Aotearoa (in Māori – “land of the long white cloud”) is more than 1600 km long with a temperate climate, although regional differences in climate exist. In 2022 the total resident population in New Zealand is 5 127 100 (Stats NZ, 2022a). The capital city is Wellington, but Auckland is the largest city with around one third of the
country’s population (World Population Review, 2022). There are three official languages: Te Reo Māori, English and New Zealand Sign Language.

Māori are the Indigenous people of New Zealand. They are of East Polynesian ancestry and are believed to have arrived in New Zealand in the late 13th century. They lived throughout the country, with key resources such as the land, lakes, rivers, sea, and forests sustaining them in good health (Wilson, 2020). Key groupings included whānau (a more complex version of “extended family” based on kinship relationships [Walker, 2011]), hapū (several whānau), and iwi (several related hapū). Iwi were the largest grouping, living usually in long-held locations (Taonui, 2005).

In 1642, Dutch voyager Abel Tasman became the first known European to find and chart New Zealand. In 1769, modern New Zealand was claimed for Great Britain by Captain James Cook, who outlined a map of the country. European settlement gradually followed, initially with whalers in the 1790s. It was during this term that the collective term Māori (originally meaning “ordinary” or “local”) began to be used, along with tangata whenua (people of the land) (Taonui, 2017).

During the 1830s, growing numbers of migrants began to arrive in New Zealand. In 1835, a Declaration of Independence was drafted by official “British Resident” James Busby, declaring New Zealand an independent state, governed by Māori chiefs. The Treaty was signed by 52 northern and 30 other chiefs (Ministry for Culture and Heritage, 2022), and was recognized by the then King of England (William IV) (Keane, 2012).
The later Treaty of Waitangi was signed in 1840 by 540 Māori chiefs and the British Crown. The Treaty sought to control increasing lawlessness, address...
Māori rights and ownership of land, and establish a British Governor. The three main Articles are: I, establishing a partnership along with the right of the Crown to govern; II, guaranteeing the right of Māori to full rangatiratanga (self-determination over their lands, villages and taonga [things held precious]), and III, guaranteeing Māori the same rights as non-Māori and at least equitable social outcomes. There are, however, important differences in the wording and interpretations of the English and Māori versions of the Treaty, particularly in relation to whether Māori would continue to have the right to manage their own affairs (Ministry for Culture and Heritage, 2022).

Since the signing of the Treaty in 1840, New Zealand has shifted from a predominantly Māori population and cultural heritage to one that is dominated by European cultural traditions. There was widespread failure by the Crown to uphold the Treaty and consequently significant loss of Māori land and other economic and cultural resources.

Contemporary New Zealand is becoming more ethnically diverse. In the 2018 Census, the most recent census conducted in New Zealand, those of European ethnicity accounted for 70.2% of the population, while Māori were 16.5%, Asian 15.1% and Pacific 8.1% (Stats NZ, 2021a).

From being the dominant population in 1840, Māori numbers fell dramatically after European colonization due to wars, epidemics, and the effects of cultural disintegration. Population numbers then recovered and have grown steadily since the 1950s. The Māori population is relatively young, with a median age of 25 years, compared to the total population’s median age of 37 years (Stats NZ, 2021b). The Māori population is projected to increase to 18% of the population by 2038 (Stats NZ, 2017).

Since the 1970s, New Zealand has been striving for a more bicultural approach – so that Māori and Pākehā (a New Zealander who is descended from Europeans) exist on equal terms. In 1975, the Waitangi Tribunal was established to investigate breaches of the Treaty of Waitangi and to make recommendations to government to provide recompense. Claims can now go back to 1840 (Ministry for Culture and Heritage, 2022). (For further discussion on the Waitangi Tribunal, which hears claims on breaches of the Treaty, including with respect to health and disability policy, see Section 6.1.6.2).

The population defined by European descent came predominantly from Great Britain and Ireland. The European population is relatively older, with a median age of 41 years, as against the general population’s median age of 37 years (Stats NZ, 2021c). Europeans’ proportionate share of the population is projected to continue to fall, reaching 66% by 2038 (Stats NZ, 2017).
Pacific peoples share a common migrant history, but many have retained the unique language and cultural characteristics of their islands of origin. The Pacific population consists of many distinct language and cultural groups. The Samoan community is the largest (48% of the Pacific populations), followed by Tongan (22%) and Cook Island (21%) (Stats NZ, 2021d; Stats NZ, 2021e; Stats NZ, 2021f). Pacific peoples have a youthful population structure, with a median age of only 23 years, in contrast to the general population’s median age of 37 years (Stats NZ, 2021g).

The largest proportion of Pacific peoples live in the Auckland region (64%), making Auckland the largest Polynesian city in the world. The Pacific population was initially predominantly composed of migrants (particularly from the 1960s onwards), but the majority (66%) are now New Zealand-born (Stats NZ, 2021g). The Pacific share of the total population is projected to rise to 10% by 2038 (Stats NZ, 2017).

The Asian community has grown significantly in New Zealand. This has been due to large migration numbers, with 77% of Asians in New Zealand having been born overseas (Stats NZ, 2021h). The two largest Asian ethnic groups are Chinese (35% of the Asian population) and Indian (34%) (Stats NZ, 2021i; Stats NZ, 2021j). The population is relatively young, with a median age of 31 years, in contrast to the general population’s median age of 37 years (Stats NZ, 2021h). As with Pacific peoples, the greatest proportion of Asians live in the Auckland region, with 63% living there compared to 33% of the general New Zealand population (Stats NZ, 2021h). The Asian share of the total population is predicted to continue to rise, reaching 22% by 2038 (Stats NZ, 2017).

Additionally, migration from other parts of the world has contributed to the cultural diversity of New Zealand. China, India and South Africa provide the most common sources of international immigrants (Stats NZ, 2020).

Table 1.1 shows selected demographic trends in New Zealand. Changing levels of immigration and fertility have influenced a change in the country’s demographic structure. In 2020, about 19% of the population was aged 0–14 years (down from 23% in 2000) and about 16% aged 65 years and above (up from 12% in 2000). The fertility rate (births per woman) for the total population remained essentially static for many years but decreased recently from 2.0 in 2015 to 1.6 in 2020. The crude birth rate per 1000 population for New Zealand decreased from 13.3 in 2015 to 11.3 in 2020.
Most New Zealanders are urban dwellers (87%) and just over a third are tertiary graduates. The growing proportion of older New Zealanders poses challenges for the future provision of health services.

**Table 1.1  Trends in population/demographic indicators, 2000–2020**

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</thead>
<tbody>
<tr>
<td>Total population (million)</td>
<td>3.9</td>
<td>4.1</td>
<td>4.4</td>
<td>4.6</td>
<td>5.1</td>
</tr>
<tr>
<td>Population, female (% of total)</td>
<td>50.9</td>
<td>50.0</td>
<td>50.9</td>
<td>50.8</td>
<td>50.9</td>
</tr>
<tr>
<td>Population aged 0–14 (% of total)</td>
<td>22.7</td>
<td>21.6</td>
<td>20.5</td>
<td>20.0</td>
<td>19.4</td>
</tr>
<tr>
<td>Population aged 65 and above (% of total)</td>
<td>11.8</td>
<td>12.1</td>
<td>13.1</td>
<td>14.7</td>
<td>16.4</td>
</tr>
<tr>
<td>Population growth (average annual growth rate)</td>
<td>0.6</td>
<td>1.1</td>
<td>1.1</td>
<td>1.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Population density (people per sq. km)</td>
<td>14.7</td>
<td>15.7</td>
<td>16.5</td>
<td>17.5</td>
<td>19.0</td>
</tr>
<tr>
<td>Fertility rate, total (births per woman)</td>
<td>2.0</td>
<td>2.0</td>
<td>2.2</td>
<td>2.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Birth rate, crude (per 1000 people)</td>
<td>14.7</td>
<td>14.0</td>
<td>14.7</td>
<td>13.3</td>
<td>11.3</td>
</tr>
<tr>
<td>Death rate, crude (per 1000 people)</td>
<td>6.9</td>
<td>6.5</td>
<td>6.5</td>
<td>6.9</td>
<td>6.4</td>
</tr>
<tr>
<td>Age dependency ratio (population 0–14 &amp; 65+: population 15–64 years)</td>
<td>52.8</td>
<td>50.6</td>
<td>50.5</td>
<td>53.0</td>
<td>55.8</td>
</tr>
<tr>
<td>Distribution of population (% urban population)</td>
<td>86.0</td>
<td>86.3</td>
<td>86.2</td>
<td>86.3</td>
<td>86.7</td>
</tr>
<tr>
<td>Tertiary degree (% of pop. aged 25–64)*</td>
<td>13</td>
<td>19</td>
<td>23</td>
<td>30</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: Health, Nutrition and Population Statistics (The World Bank, 2022a); *Tertiary Achievement and Attainment, Educational attainment in the population (Education Counts, 2021)

1.2 Economic context

New Zealand, due in part to geographical isolation, is heavily reliant on foreign trade as a driver of the economy and is therefore susceptible to fluctuations in international economic growth. New Zealand’s largest trade partners, by exports, are China (22.4%), Australia (16.4%), the United States of America (9.9%) and Japan (6.1%) (Central Intelligence Agency, 2021b).

Up to the 1980s, New Zealand had a highly regulated economy. The direction of economic policy turned dramatically with the election of the fourth Labour government in 1984. While in power, the Labour government introduced policies that aimed to liberalize the New Zealand economy. Economic reform included the deregulation of the financial system and a decrease
in government assistance programmes. Macroeconomic policies aimed to achieve low inflation and a sound fiscal position, while macroeconomic reforms were intended to open the economy to competitive pressures. Key reforms included floating the New Zealand dollar (NZ$), reducing trade protection, cross-sector deregulation, privatization and commercialization of government-owned enterprises, and the introduction of the Goods and Services Tax (GST) in 1987. During this period, the economy stagnated and then entered recession in the early 1990s. Economic reform continued after the election of the National party government in 1991, particularly in the labour market and welfare sectors. For most of the remainder of the 1990s, New Zealand enjoyed economic growth, apart from a brief recession in 1998.

The new millennium brought with it a change in the economic fortunes of New Zealand. During this period, New Zealand was a beneficiary of rapid global growth, particularly in China, which stimulated the price of commodities (Organisation for Economic Co-operation and Development [OECD], 2009). Accompanying high commodity prices were record low unemployment, high foreign investment, and a house price boom.

New Zealand has moved away from its traditional dependence on dairy, meat, and wool exports, as forestry, tourism, horticulture, fisheries, and manufacturing have become more significant, while also developing its agriculture and manufacturing industries to suit niche markets. As a proportion of gross domestic product (GDP), the services sector accounts for 72.8% of economic output, followed by the industry sector (21.5%) and agriculture (5.7%) (Central Intelligence Agency, 2021b).

Consistent with OECD trends, New Zealand experienced a period of economic downturn due to a global financial crisis. The economy entered recession in 2008 but began to recover from mid-2009. However, the recovery lost momentum from the second half of 2010 following the slowing global economy and the effect of two major earthquakes affecting New Zealand’s second largest city (Christchurch) in September 2010 and February 2011.

In the following years, the economy rebounded strongly driven by high international commodity prices and the rebuilding of Christchurch. The economy continued to perform well until the COVID-19 pandemic, which saw the borders closed for just over two years, leading to the collapse of international tourism (affecting the hotel, motel and hospitality industries hard), exports being affected by transport disruptions, a lack of migrant workers, and much economic activity being disrupted by lockdowns, restrictions, and changing employment and consumer behaviours.
Table 1.2 sets out selected macroeconomic indicators for New Zealand.

Thus, there was negative growth in the January–March and April–June quarters of 2020 (–1.5% and –10.3%, respectively), with the economy bouncing back during the July–September quarter of 2020 (by 13.9%). Overall, in the year to December 2020, the New Zealand economy shrank by 2.9%. By the end of June 2021, annual economic growth was back at 5.3%; however, a long lockdown period in Auckland again saw negative growth during the September 2021 quarter (–3.7%). By the end of December 2021, annual growth was at 5.6% (Stats NZ, 2022b).

Table 1.2  Macroeconomic indicators, 2000–2020

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>GDP (US$ million)</td>
<td>52 623</td>
<td>114 72</td>
<td>146 518</td>
<td>178 064</td>
<td>211 735</td>
</tr>
<tr>
<td>GDP, PPP (current international US$ million)</td>
<td>82 993</td>
<td>106 148</td>
<td>135 840</td>
<td>172 759</td>
<td>227 317</td>
</tr>
<tr>
<td>GDP per capita (current US$)</td>
<td>13 641</td>
<td>27 751</td>
<td>33 700</td>
<td>38 616</td>
<td>42 084</td>
</tr>
<tr>
<td>GDP per capita, PPP (current international US$)</td>
<td>21 514</td>
<td>25 677</td>
<td>31 222</td>
<td>37 480</td>
<td>44 658</td>
</tr>
<tr>
<td>Public expenditure (% of GDP)</td>
<td>NA</td>
<td>30.99</td>
<td>34.23</td>
<td>31.54</td>
<td>36.57</td>
</tr>
<tr>
<td>Tax revenue (% of GDP)</td>
<td>NA</td>
<td>30.31</td>
<td>26.15</td>
<td>27.42</td>
<td>27.50</td>
</tr>
<tr>
<td>Public debt (% of GDP)</td>
<td>NA</td>
<td>44.17</td>
<td>34.91</td>
<td>43.29</td>
<td>NA</td>
</tr>
<tr>
<td>Value added in industry (% of GDP)</td>
<td>23.59</td>
<td>23.94</td>
<td>21.18</td>
<td>21.16</td>
<td>NA</td>
</tr>
<tr>
<td>Value added in agriculture (% of GDP)</td>
<td>7.75</td>
<td>4.52</td>
<td>6.59</td>
<td>4.47</td>
<td>NA</td>
</tr>
<tr>
<td>Value added in services (% of GDP)</td>
<td>61.81</td>
<td>64.31</td>
<td>64.40</td>
<td>65.95</td>
<td>NA</td>
</tr>
<tr>
<td>Labour force (total) (million)</td>
<td>1.94</td>
<td>2.19</td>
<td>2.34</td>
<td>2.54</td>
<td>2.88</td>
</tr>
<tr>
<td>Unemployment, total (% of labour force)</td>
<td>6.13</td>
<td>3.81</td>
<td>6.56</td>
<td>5.41</td>
<td>4.60</td>
</tr>
<tr>
<td>Real interest rate</td>
<td>4.83</td>
<td>5.62</td>
<td>3.08</td>
<td>4.28</td>
<td>NA</td>
</tr>
<tr>
<td>Official exchange rate (NZ$ per US$)</td>
<td>2.20</td>
<td>1.42</td>
<td>1.39</td>
<td>1.43</td>
<td>1.54</td>
</tr>
</tbody>
</table>

Source: World development indicators [The World Bank, 2022b]
1.3 Political context

New Zealand is a liberal democracy with a parliamentary system of government, consisting of a single elected body known as the House of Representatives. Three branches of government – Parliament, the Executive, and the Judiciary – create, administer, and interpret the law. New Zealand does not have a formal written constitution. Instead, it draws upon various documents passed under the authority of the Queen and assorted Acts of Parliament from the United Kingdom (New Zealand Parliament, 2021). The Head of State is the British Sovereign, currently King Charles III, represented in New Zealand by a Governor-General who gives royal assent to all legislation. In practice, the powers of the Sovereign are limited, and it is the New Zealand Parliament that enacts laws.

In July 1993, New Zealand adopted the mixed member proportional (MMP) system of government, transforming the electoral system from one previously based on the British first-past-the-post system. Upon adoption of the MMP system, the total number of members of parliament (MPs) increased from 99 to about 120. Under MMP, an elector has two votes: one for an individual MP (in the geographical electorate where they live) and one for a political party; hence the use of the term “mixed member”. The party vote determines the number of seats in the House (Parliament) a party will hold, with Parliament made up of the electorate MPs who are voted in (representing geographical populations) plus list MPs as required to make up their party’s proportional entitlement. To gain seats in Parliament, a party must gain at least one electorate seat or 5% of the total party vote (Electoral Commission, 2021). Elections are generally held every three years.

By law, all people aged 18 years and over who are eligible to enrol as a voter must do so, although voting itself is not compulsory. New Zealand was the first country in the world to give women the vote in 1893.

New Zealand has two electoral rolls: the General Roll and the Māori Roll. Following each Census (generally held every five years), Māori in New Zealand are given the option of whether they want to register on the General Roll and thereby cast votes for candidates in their local general electorate, or on the Māori Roll, enabling them to cast votes in their local Māori electorate. Currently, there are 65 general electorates and seven Māori electorates.

There are two main political parties in New Zealand: the National party (centre-right) and the Labour party (democratic socialist). With the introduction of MMP in 1993, minor parties such as the Green Party and the Māori Party have had an increased influence over policy direction. Since 1996, virtually all governments have been coalition governments, led by either of
the two main parties – the National or Labour parties – with smaller parties in coalition, managed through a series of coalition agreements. The only exception was the 2020 election, which Labour won outright. Labour chose to govern alone, but did have an agreement with the Green party, with its two co-leaders having ministerial posts outside of Cabinet. Labour had 65 seats, National 33, the Greens 10, ACT (a right-of-centre party) 10 and the Māori party 2.

The local government sector of New Zealand is composed of 11 regional councils and 67 territorial authorities. Both regional councils and territorial authorities have legislative and regulatory roles; however, their powers are set by Parliament. Regional councils are primarily concerned with managing land, air and water resources, biodiversity, regional emergency management and civil defence preparedness, regional land transport planning and contracting for passenger services, and harbour navigation and safety, oil spills and other marine pollution.

Territorial councils are responsible for the provision of local infrastructure (including water, sewerage, storm water and roads), environmental safety and health, district emergency management and civil defence preparedness, building control, public health inspections and other environmental health matters, controlling the effects of land use, noise, and the effects of activities on the surface of lakes and rivers (Department of Internal Affairs, 2021a).

Local, territorial councils have been responsible for the fluoridation of the water in their local areas, with some councils not fluoridating the water. To remove this fragmented system and given the clear health benefits of water fluoridation, in 2021 the government announced that the Director-General of Health would take over the decision-making regarding water fluoridation around the country (Andelane, 2021). During 2022, further reforms were being discussed for local councils in New Zealand, while “Three Waters” reforms are planned to remove responsibility for drinking water, wastewater and stormwater from local councils and give them to four new statutory, publicly owned water services entities (see Section 6.2.2).

New Zealand is party to many international contracts and conventions relating to health and disability policy. For example, New Zealand is an active participant of the World Health Organization, including through the Regional Office for the Western Pacific, and including biennial meetings of Pacific health ministers. Additionally, through affiliation with the Commonwealth, OECD and the Commonwealth Fund, New Zealand maintains strong
correspondence with international health ministries and assemblies. Two treaties, the Framework Convention on Tobacco Control and the International Health Regulations (2005) directly concern health. The Framework came into effect in 2005 and seeks to regulate certain facets of the tobacco industry, including advertising and taxation [World Health Organization Framework Convention on Tobacco Control, 2022a], while the International Health Regulations (2005) is a global agreement binding 196 Member States and setting out measures to reduce health risks that cross borders [World Health Organization, 2022b].

1.4 Health status

New Zealanders enjoy a high standard of living by international standards; there are, however, significant, long-standing inequities, with the Indigenous Māori population, Pacific peoples, people on lower incomes, and disabled people having lower health status than other New Zealanders. This section reviews the overall health status of New Zealanders, key inequities, and some international comparisons; subsections consider a range of issues relating to key inequities.

1.4.1 Health status in New Zealand

Reductions in mortality mean that New Zealanders can now expect to live, on average, over 20 years longer than they did a century ago. Overall life expectancy for females is 83.9 years and for males is 80.3 years [see Table 1.3].

Table 1.3 Mortality and health indicators, 2000–2020

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<tbody>
<tr>
<td>Life expectancy at birth, total(^a)</td>
<td>78.6</td>
<td>79.9</td>
<td>80.7</td>
<td>81.5</td>
<td>82.1</td>
</tr>
<tr>
<td>Life expectancy at birth, male(^a)</td>
<td>76.1</td>
<td>77.9</td>
<td>78.8</td>
<td>79.7</td>
<td>80.3</td>
</tr>
<tr>
<td>Life expectancy at birth, female(^a)</td>
<td>81.3</td>
<td>81.9</td>
<td>82.7</td>
<td>83.3</td>
<td>83.9</td>
</tr>
<tr>
<td>Total mortality rate (per 100 000 adult males)(^b)</td>
<td>608.1</td>
<td>517.1</td>
<td>467.6</td>
<td>442.4</td>
<td>432.7 (2018)</td>
</tr>
<tr>
<td>Total mortality rate (per 100 000 females)(^b)</td>
<td>388.1</td>
<td>358.1</td>
<td>333.2</td>
<td>326.7</td>
<td>314.4 (2018)</td>
</tr>
</tbody>
</table>

\(^a\)Source: Health, Nutrition and Population Database (The World Bank, 2022a)
\(^b\)Source: Historical mortality (1948–2018), Mortality web tool (Ministry of Health, 2022a)
Table 1.4  Main causes and numbers of deaths, 2000–2018

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<tbody>
<tr>
<td>All cancer</td>
<td>7620</td>
<td>7970</td>
<td>8593</td>
<td>9617</td>
<td>9818</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>5970</td>
<td>5809</td>
<td>5391</td>
<td>5018</td>
<td>4674</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>2668</td>
<td>2587</td>
<td>2467</td>
<td>2467</td>
<td>2390</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td>1561</td>
<td>1600</td>
<td>1656</td>
<td>1818</td>
<td>1811</td>
</tr>
<tr>
<td>Other forms of heart disease</td>
<td>1242</td>
<td>1146</td>
<td>1304</td>
<td>1565</td>
<td>1903</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>802</td>
<td>839</td>
<td>768</td>
<td>838</td>
<td>902</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>347</td>
<td>382</td>
<td>478</td>
<td>765</td>
<td>669</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>459</td>
<td>515</td>
<td>534</td>
<td>531</td>
<td>626</td>
</tr>
<tr>
<td>Motor vehicle accidents</td>
<td>482</td>
<td>434</td>
<td>414</td>
<td>345</td>
<td>405</td>
</tr>
<tr>
<td>Assault</td>
<td>57</td>
<td>70</td>
<td>55</td>
<td>59</td>
<td>62</td>
</tr>
</tbody>
</table>

Source: Historical mortality (1948–2018), Mortality web tool (Ministry of Health, 2022a)

Premature mortality rates are declining; the rate of decline has slowed recently. Demographic change has been accompanied by an epidemiological transition, with a shift from communicable to noncommunicable diseases and those associated with an ageing population. The main causes of death are noncommunicable diseases, particularly cancer, ischaemic heart disease, cerebrovascular disease, and chronic lower respiratory diseases (see Tables 1.4 and 1.5).

Table 1.5  Detailed causes of death, total, Māori and non-Māori, 2018

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Total</th>
<th>Māori</th>
<th>Non-Māori</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate (per 100 000)</td>
<td>Number</td>
</tr>
<tr>
<td>All causes of death</td>
<td>33 316</td>
<td>370</td>
<td>3 838</td>
</tr>
<tr>
<td>All cancer</td>
<td>9 818</td>
<td>114</td>
<td>1 134</td>
</tr>
<tr>
<td>All circulatory diseases</td>
<td>10 306</td>
<td>104</td>
<td>1 117</td>
</tr>
<tr>
<td>All respiratory diseases</td>
<td>2 928</td>
<td>30</td>
<td>330</td>
</tr>
<tr>
<td>All external causes</td>
<td>2 205</td>
<td>35</td>
<td>407</td>
</tr>
<tr>
<td>Ischaemic heart diseases</td>
<td>4 675</td>
<td>48</td>
<td>501</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td>1 811</td>
<td>19</td>
<td>256</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>2 390</td>
<td>23</td>
<td>178</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>669</td>
<td>6</td>
<td>44</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>902</td>
<td>10</td>
<td>221</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>1 248</td>
<td>14</td>
<td>75</td>
</tr>
</tbody>
</table>
### Table 1.5  Detailed causes of death, total, Māori and non-Māori, 2018 (contd)

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Total</th>
<th>Māori</th>
<th>Non-Māori</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate (per 100 000)</td>
<td>Number</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>1 788</td>
<td>21</td>
<td>383</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>689</td>
<td>9</td>
<td>84</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>701</td>
<td>7</td>
<td>52</td>
</tr>
<tr>
<td>Melanoma of the skin</td>
<td>296</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>60</td>
<td>1</td>
<td>16</td>
</tr>
</tbody>
</table>

Note: Rates are age standardized.
Source: Historical mortality (1948–2018), Mortality web tool (Ministry of Health, 2022a)

Health loss is the gap between the current state of health of the population and that where everyone has a long life free from illness or disability. It is measured through disability-adjusted life years (DALYs), where one DALY represents the loss of one year of life lived in good health. The total number of DALYs in New Zealand is increasing, albeit at a slow rate (Table 1.6). But the age-standardized DALY rate, which takes into account population growth and ageing, is declining (Figure 1.2).

#### Figure 1.2  DALY count and age-standardized DALY rate, 1990 to 2019

Source: Health and Independence Report 2019 (Ministry of Health, 2020a)

Across the same period, healthy life expectancy increased by 5.6 years for males and 4.2 years for females (see Table 1.6). But the time spent in poor...
health has also increased. This is because life expectancy has increased at a faster pace than health expectancy. On average, New Zealanders are spending about a third of their life-years gained in poor health [Ministry of Health, 2020b].

Table 1.6  DALYs and healthy life expectancy, 1990 and 2019

<table>
<thead>
<tr>
<th>Measure</th>
<th>1990</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>DALYs (millions)</td>
<td>1.04</td>
<td>1.22</td>
</tr>
<tr>
<td>Healthy life expectancy, males (years)</td>
<td>63.3</td>
<td>68.9</td>
</tr>
<tr>
<td>Healthy life expectancy, females (years)</td>
<td>66.1</td>
<td>70.3</td>
</tr>
</tbody>
</table>

Source: Global Burden of Disease Collaborative Network (2020); Health and Independence Report 2019 (Ministry of Health, 2020a)

Table 1.7 shows trends in key maternal and child health indicators. They show decreasing birth rates between 2010 and 2019 for young mothers. Abortion rates have also fallen over this time. Perinatal, neonatal, post-neonatal and infant mortality rates generally fell between 2010 and 2015, but have moved around a bit since, although the 2019 rates are all lower than the 2000 rates. The under-5 mortality rate has consistently fallen since 2000. The maternal mortality rate is also declining slowly.

Table 1.7  Maternal and child health, 2000–2019

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth rate, women aged 15–19 years^a</td>
<td>28.2</td>
<td>29.0</td>
<td>18.6</td>
<td>14.9</td>
<td>13.4</td>
<td>12.8</td>
</tr>
<tr>
<td>Abortion rate, general^b</td>
<td>18.7</td>
<td>18.2</td>
<td>14.2</td>
<td>13.9</td>
<td>13.7</td>
<td>13.1</td>
</tr>
<tr>
<td>Perinatal mortality rate^c</td>
<td>9.5</td>
<td>10.1</td>
<td>8.4</td>
<td>9.1</td>
<td>9.3</td>
<td>NA</td>
</tr>
<tr>
<td>Neonatal mortality rate^d</td>
<td>3.8</td>
<td>3.6</td>
<td>2.8</td>
<td>3.3</td>
<td>3.0</td>
<td>NA</td>
</tr>
<tr>
<td>Post-neonatal mortality rate^e</td>
<td>2.5</td>
<td>2.0</td>
<td>1.5</td>
<td>1.4</td>
<td>1.4</td>
<td>NA</td>
</tr>
<tr>
<td>Under-5 mortality rate^g</td>
<td>7.4</td>
<td>6.1</td>
<td>5.5</td>
<td>5.2</td>
<td>5.0</td>
<td>4.9</td>
</tr>
<tr>
<td>Maternal mortality rate^h</td>
<td>12.0</td>
<td>11.0</td>
<td>10.0</td>
<td>9.0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Fully immunized rate for children [2 years]^i</td>
<td>NA</td>
<td>87.0</td>
<td>92.8</td>
<td>92.4</td>
<td>91.0</td>
<td>90.8</td>
</tr>
<tr>
<td>Fully immunized rate for children [5 years]^j</td>
<td>NA</td>
<td>70.0</td>
<td>82.8</td>
<td>88.6</td>
<td>88.0</td>
<td>88.0</td>
</tr>
<tr>
<td>Children born underweight rate^k</td>
<td>6.55</td>
<td>5.9</td>
<td>5.7</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Birth rate, women aged 15–19 years^a</td>
<td>28.2</td>
<td>29.0</td>
<td>18.6</td>
<td>14.9</td>
<td>13.4</td>
<td>12.8</td>
</tr>
</tbody>
</table>

Definitions and sources: Births and abortion rates are per 1000 women; mortality is per 1000 live births except for maternal mortality, which is per 100 000 live births; underweight is a percentage of all births (see Annex [Section 9.1 – Table 9.1] for further details and sources).
Key data on a range of health indicators are included in the Annex (see Section 9.1), used in this chapter to describe current health and disability status, and in Chapter 7 to assist in assessing the overall performance of the health and disability system. This includes data on baby and infant deaths, including differences by ethnicity; Health and Independence report data; and data from the New Zealand Health Survey.

Detailed data on baby and infant deaths show generally overall lower rates since 2009, but some recent increases, and significant inequities, especially for Māori and Pacific babies.

The Health and Independence Report for 2019 (Ministry of Health, 2020a) on the health status of New Zealanders (prior to COVID-19) provides in-depth data on health and disability status, including in relation to inequities for Māori and Pacific peoples and those living in areas of low socioeconomic status. The data show, for example, that life expectancy for Māori and Pacific people is five to seven years lower than for non-Māori and non-Pacific people; mortality rates are generally falling, especially in relation to cancer and cardiovascular and cerebrovascular diseases; rates of diabetes and obesity appear to be stabilizing, while rates of mental distress rise; smoking rates are falling; and communicable diseases remain an issue, with a large measles outbreak, especially among Pacific children, in 2019, and rheumatic fever rates (especially among Pacific peoples) increasing again since 2015.

The New Zealand Health Survey data from 2019/2020 (Ministry of Health, 2022b) also sets out details on trends and inequities on a range of measures, including new data on the disabled. Overall, the data show that most New Zealanders report their health as good, very good or excellent, but this is slowly trending downwards. Rates of key conditions (such as asthma, arthritis, and diabetes) are steady, while rates of chronic pain and psychological distress are rising. Rates of eczema in children may be falling. Rates of hazardous drinking are high. However, there are significant inequities, discussed more in depth below.

New Zealand has high rates of suicide compared with other countries, especially among young people. In the year to 30 June 2021, 607 people died by suspected suicide, compared to 628 the year before. This is a decrease of 21 deaths, and a drop in the suspected suicide rate from 11.8 deaths per 100 000 to 11.6. The suicide rate among Māori is markedly higher than for non-Māori, but it too declined from 19.8 per 100 000 people to 15.8 between 2020 and 2021. For Pacific populations, there was an increase in the suspected suicide rate from 7.2 to 9.6. More broadly, there was a decrease in suspected suicides for females and males in the 15–24 years age range, from 12.6 to
11.4 among females and 22.7 to 22.2 in males. For instance, in provisional 2020 figures released by the chief coroner, the suicide rate for Māori was 20.2 per 100 000 people compared to 12.1 for European. The Pacific rate was lower still, at 7.07 (Office of the Chief Coroner, 2021).

In terms of oral health, much – but not all – of the population’s water supply is fluoridated, and New Zealand provides free dental care for young people up to the age of 18 years. The 2019/2020 New Zealand Health Survey found that, overall, 6.9% of adults and 3.5% of children had had teeth removed due to decay in the previous year, while 45.1% of adults and 11.3% of children had had teeth removed due to decay during their lifetime (see [Ministry of Health, 2022b] and Annex [Section 9.1 – Table 9.4]).

In terms of immunization, free immunizations are available for babies, children, adolescents, and adults (see Section 5.1.3.2). The government has until recently set targets to ensure that high rates of immunization coverage are achieved (Ministry of Health, 2020c). Although immunization rates rose between 2010 and 2015/2017, rates have been falling slowly, and by the end of December 2019 (prior to COVID-19) had fallen to 90.8% overall for two-year-olds and 88% for five-year-olds (Ministry of Health, 2021a) [and Annex [Section 9.1 – Tables 9.2 and 9.3]]. The MoH works with PHC providers to maintain and increase immunization rates, especially among groups that have lower rates (Ministry of Health, 2020d).

The Health and Independence Report also notes that many underlying causes of ill-health lie beyond what individuals can control in their day-to-day lives, and even beyond the health and disability system’s influence. Addressing the socioeconomic determinants of health would both help reduce health inequities between groups and improve the health of all New Zealanders. Key concerns include the effects of poverty (just under one in seven children lives in a household that receives less than half of the median household income and Māori and Pacific children are disproportionately affected); damp housing (about 4% of homes always have visible mould, affecting Pacific peoples, Māori, and disabled people in particular) and household crowding (about one in ten New Zealanders lives in a crowded house, with a much higher rate for Pacific peoples).

1.4.2 Health status in New Zealand compared with other countries

The Human Development Index, a composite index measuring average achievement in three basic elements of human development (a long and healthy life, knowledge, and a decent standard of living), placed New Zealand 14th equal in the “very high human development” category in 2019 with a Human Development Index of 0.931. This compared with Norway (1) 0.957,
Australia (8) 0.944, United Kingdom (13) 0.932, Belgium (14), equal with New Zealand) 0.931, Canada (16) 0.929 and the United States (17) 0.926 (United Nations Development Programme, 2020).

The OECD produces international comparisons across key indicators relating to health. Its latest report (OECD, 2021), largely using 2019 data, shows that New Zealand performs close to the OECD average for life expectancy, avoidable mortality, and chronic disease morbidity, but better than average for self-rated health, and close to the OCED average for smoking, alcohol consumption and obesity risk factors. Areas where New Zealand does less well than the OECD average include cancer incidence – which is the second worst in the OECD, with Australia the worst – and cancer mortality; infant mortality; death by suicide and excess mortality from bipolar disorder and schizophrenia; and overweight adults. But New Zealand does better in relation to anxiety, adult self-rating of their own health as good or very good; melanoma five-year net survival; and mammography screening. Details are included in Annex (Section 9.1– 9.1.6).

New Zealand’s suicide rate at 12.0 per 100 000 members in 2019 of the population places it broadly in the middle of rates internationally. The highest rates were South Korea (24.6) and Lithuania (21.6) and the lowest rates were Turkey (4.4) and Greece (4.7). New Zealand’s rate was similar to Australia’s (12.3), but markedly higher than Canada (11.0) and the United Kingdom (7.3) (OECD, 2022a).

However, New Zealand has a very high rate of suicide for young people. A recent UNICEF report gave three-year rolling averages for suicide rates up to 2015 for those aged 15–19 years. New Zealand was second highest, at 14.9 per 100 000 youth. Only Lithuania was higher (18.2). Greece was the lowest (1.4). Australia (9.7) and Canada (9.0) had rates similar to each other, whereas the United Kingdom (3.7) was markedly lower (UNICEF, 2020).

1.4.3 The health of Māori

Māori health status has seen significant gains over recent decades; however, it continues to lag behind that of New Zealanders of European descent. Inequities stem from a range of factors, most notably the trauma associated with colonization, loss of land, racism, and discrimination (Waitangi Tribunal, 2019), lower socioeconomic status, and a range of health risk factors. Māori also face significant barriers to accessing health services, and significant inequities in terms of the use of and quality of care of health services.

Until the early 1980s, Māori life expectancy rapidly increased. After then, it was primarily static, while non-Māori life expectancy continued to rise. Since
the late 1990s, Māori life expectancy has been increasing at about the same rate as non-Māori, or even slightly faster. The trend has been for a narrowing gap, from 9.1 years in 1995–1997 to 8.5 years in 2000–2002, and to 8.2 years in 2005–2007. The gap between Māori and non-Māori life expectancy at birth had narrowed to 7.1 years by 2012–2014. In 2013, life expectancy at birth was 73.0 years for Māori males and 77.1 years for Māori females. By contrast, it was 80.3 years for non-Māori males and 83.9 years for non-Māori females (Ministry of Health, 2018a).

Māori have worse health outcomes than non-Māori for most health indicators. Table 1.6 shows higher rates of mortality for all causes other than colon cancer and skin melanoma. Data presented in the Annex (Section 9.1) show higher mortality rates for Māori, particularly for neonatal, post-neonatal and infant deaths.

Māori children also have higher rates of obesity, asthma, including severe asthma, eczema, and tooth removal. Māori parents are less likely to rate their child’s health as excellent, very good or good, and more likely to rate it fair or poor. Māori children are more likely to have teeth removed. Young Māori people have higher rates of chlamydia and suicide. Recently, there have also been growing inequities in childhood immunization rates (Figure 1.3 and 1.4), exacerbated by COVID-19 [see Section 5.1.3.2] (Health Quality and Safety Commission, 2019a; Ministry of Health, 2020a; Ministry of Health, 2022b; and Annex [Section 9.1 – Tables 9.1 and 9.2]).

Figure 1.3  Child immunization rates (%) at 2 years by ethnicity, 2010–2021

Source: National Immunisation Register (Ministry of Health, 2021a)
Figure 1.4  Child immunization rates (%) at 5 years by ethnicity, 2010–2021

Source: National Immunisation Register [Ministry of Health, 2021a]

For adults, there are higher mortality rates for Māori for ischaemic heart disease, stroke, all cancers combined and chronic respiratory diseases. Māori are less likely to say they have excellent, very good or good self-rated health, and more likely to say they have fair or poor self-rated health. They develop diabetes, for example, up to 10 years earlier than non-Māori, and more quickly have more serious disease, including cardiovascular disease and renal failure. Māori are more likely to have asthma, gout and chronic pain. Rates of psychological health are also worse for Māori, as are suicide rates. Oral health is significantly worse for Māori adults, and rates of disability and multiple disabilities are also higher for older Māori. Multimorbidity is common among Māori [see HQSC, 2019a; Ministry of Health, 2020a; Ministry of Health, 2022b; Ministry of Health, 2019a and Annex [Section 9.1–Section 9.1.2]].

There have been improvements in Māori health indicators over time, and the inequity between Māori and non-Māori in some areas has narrowed. These areas include lung cancer mortality rates, low birthweight rates and infant and child mortality rates (including both sudden unexpected death in infancy and sudden infant death syndrome mortality rates). However, in some cases, improvements may have occurred for Māori but there has been a greater improvement for non-Māori. This means there is now increased inequity between Māori and non-Māori outcomes in some areas. These include rates
for smoking, mortality for adults aged 35 years and over from all types of cardiovascular disease (Ministry of Health, 2019a).

Māori generally report high levels of wellbeing, despite challenging socioeconomic circumstances. In a recent survey, Māori were only a little less likely than NZ Europeans to rate their overall life satisfaction as high (7–10 on a 0–10 scale) (82% of Māori, 87.1% of NZ Europeans) and life as worthwhile (85.9% of Māori, 91.1% of NZ Europeans). In terms of family wellbeing, 84.4% of NZ Europeans rates this as high, compared with 76.7% of Māori. Māori also self-evaluated their health somewhat less, with 50% rating their health as very good or excellent, as compared to 59.4% of NZ Europeans (Stats NZ, 2021k).

A recurring key goal in New Zealand is to improve Māori health and reduce inequities in health. Most recently this has involved the development of key strategies to guide policy and practice, starting with the 2002 *He Korowai Oranga: Māori Health Strategy*, which sets the overarching framework guiding the government and the health and disability sectors to achieve the best health outcomes for Māori, with the overarching aim of *Pae Ora* – healthy futures for Māori (Ministry of Health, 2020e). More details on such strategies are set out in Section 2.3.7.

### 1.4.4 The health of Pacific Island peoples in New Zealand

Life expectancy for Pacific peoples living in New Zealand is more than six years lower, as compared to the rest of the population, and the gap has not reduced over time (Walsh & Grey, 2019). The proportion of all deaths considered potentially avoidable is twice as high in Pacific (47.3%) compared to non-Māori non-Pacific populations (23.2%) (Ryan, Grey & Mischewski, 2019).

A range of factors lead to significant poorer health for Pacific peoples than the non-Māori, non-Pacific populations. These include socioeconomic conditions (in particular, being more likely to live in areas of high deprivation, lower household incomes, higher unemployment rates and not having sufficient money to meet daily needs (Ryan, Grey & Mischewski, 2019; HQSC, 2021a). Poor access to health-care services, along with inequities in the use and quality of care of those services, are also issues contributing to the poorer health of Pacific peoples.

Inequities for Pacific peoples start early in life, and Pacific children have higher rates of asthma, dental problems, and ear and skin infections, and higher rates of teeth removal due to decay. Pacific children are disproportionately affected by infectious diseases, such as measles and
rheumatic fever. Immunization rates appear to lag early on in life, but by two and five years of age, Pacific children have rates of immunization that match those of other populations (see Figure 1.2 and 1.3). Pacific children are 3.3 times more likely to be obese compared with their non-Pacific counterparts. Young Pacific people have high and increasing rates of depression and increasing rates of suicide [see Annex [Section 9.1]; and Ryan, Grey & Mischewski, 2019; Ministry of Health, 2020a; Ministry of Health, 2020f; Ministry of Health, 2022b].

Pacific adults have disproportionately high rates of risk factors, such as obesity, smoking, alcohol use, physical inactivity, and psychological distress. Obesity rates for Pacific adults and children are the highest for all ethnic groups in New Zealand. Pacific adults are 2.5 times more likely to be obese compared with non-Pacific adults. Poor health outcomes and inequities for Pacific adults are also due to much higher rates of long-term conditions, such as gout, cardiovascular disease, diabetes and cancer, as well as to increasing multimorbidity. There is evidence also of earlier onset of long-term conditions such as diabetes. Inequities are well known but the gaps between Pacific and non-Māori, non-Pacific populations are not closing [see Annex [Section 9.1]; and Ryan, Grey & Mischewski, 2019; Ministry of Health, 2020a; Ministry of Health, 2020f; Ministry of Health, 2022b].

As with Māori, Pacific peoples living in New Zealand report reasonably high levels of wellbeing, despite challenging socioeconomic circumstances. In a recent survey, Pacific peoples were only a little less likely than NZ Europeans to rate their overall life satisfaction as high (83.6% of Pacific people, 87.1% of NZ Europeans) and life as worthwhile (86.7% of Pacific people, 90.1% of NZ Europeans). For family wellbeing, 82.2% of Pacific peoples rated this highly compared with 84.0% of NZ Europeans. But they self-evaluated their health significantly lower, with only 45.4% rating their health as very good or excellent, as opposed to 59.4% of NZ Europeans (Stats NZ, 2021f).

The government is committed to achieving equitable health outcomes for Pacific peoples living in New Zealand. This is at the heart of Ola Manuia, an action plan for the next five years, designed to address the health inequities Pacific communities face in New Zealand (Ministry of Health, 2020f). In several Pacific languages Ola Manuia means “living well or in wellness”. (More details on such strategies are set out in Section 2.3.8.)

1.4.5 Health of those with lower socioeconomic status

There is a strong focus on reporting inequities by socioeconomic status in New Zealand datasets. The New Zealand deprivation index measures the
socioeconomic deprivation of an area on a scale of 1 to 10. An NZDep 1 score indicates the area is in the least deprived 10% of areas in New Zealand, while NZDep 10 indicates the area is in the most deprived 10% of areas in New Zealand. The scores apply to areas, not individuals. Often, they are collapsed into quintiles (1–5, with 1 being the least deprived quintile) (Salmond, Crampton & Atkinson, 2007; Atkinson, Salmond & Crampton, 2019).

Looking at New Zealand Health Survey data for 2019/2020 (Ministry of Health, 2022b), Annex (Section 9.1 – Table 9.4), we see differences for those living in quintile 1 compared with those in quintile 5. Thus, those in quintile 1 have lower levels of excellent, very good or good self-rated health, and higher levels of fair or poor self-rated health for adults, although rates for children are similar to those in quintile 1. On all other measures, those in quintile 5 have higher rates of key conditions and risk factors, particularly in relation to smoking, being overweight or obese, gout, chronic pain, diabetes, as well as lower levels of dental health. They are also much more likely to run out of food often or sometimes and use food grants often or sometimes. Childhood immunization rates show similar inequities (Figure 1.5 and 1.6).

**Figure 1.5** Child immunization rates (%) at 2 years by socioeconomic status, 2010–2021

Source: National and DHB immunization data, National Immunisation Register (Ministry of Health, 2021a)
1.4.6 Disability and disabled peoples’ health

Disability surveys have been conducted in New Zealand following the censuses in 1996, 2001, 2006, and 2013. Information is collected on the prevalence, nature, and cause of disabilities among New Zealanders living in households and adults (aged 15 years and older) living in residential facilities, and the barriers people with disability encountered in daily life.

Disability is defined as long-term limitation (resulting from impairment) in a person’s ability to carry out daily activities. The 2013 survey (Stats NZ, 2014) found the following:

- Of the total population, 24% (1.1 million people at that time) had a disability, higher than the 20% reported in 2001.
- At 59%, people aged 65 years or over were much more likely to be disabled than adults under 65 years (21%) or children under 15 years (11%).
- Māori (32%) and Pacific people (26%) had higher disability rates than the European/Other (24%) and Asian (17%) populations. Māori and Pacific peoples also experience disability, on average, at younger ages, at age 40 years for Māori, 39 years for Pacific peoples, 45 years for Asian peoples, and 57 years for European/Other populations.
• Physical limitations were the most common type of impairment for adults. Eighteen percent of people aged 15 years or over, 64% of disabled adults, were physically impaired.
• Learning difficulty was the most common impairment type for children, with 6% of non-disabled children and 52% of disabled children having a learning difficulty.
• Just over half of all disabled people (53%) had more than one type of impairment.
• For adults, the most common cause of disability was disease or illness (42%). For children, the most common cause was a condition that existed at birth (49%).

The Welfare Expert Advisory Group (2019) report on the welfare system and people with health conditions or disabilities notes that Stats NZ surveys show that disabled people had lower wellbeing on several indicators, including overall life satisfaction, where 37.6% of disabled people rated their life satisfaction at the lower end (0–6) compared with 15.1% of non-disabled people. The report also notes the very low levels of disabled people who are working (22.3% in June 2018, compared with 70% of non-disabled people), with people with health conditions or disabilities making up the largest group (49%) of working age people receiving benefits (although this is regarded as likely to be an underestimate). The data also show recent increases in the proportion of people with mental health conditions within the working age population who are receiving benefits.

The New Zealand Health Survey (Ministry of Health, 2022b) collects information on the experiences of people with disabilities with the health and disability system. The 2019/2020 survey finds that disabled adults were less likely than non-disabled adults to have reported “good”, “very good”, or “excellent” health; more disabled people smoke; they are more likely to be overweight or obese and have raised blood pressure; they have higher rates of asthma, arthritis, chronic pain and diabetes; more likely to have had teeth removed; and experience higher rates of mental distress. They are less likely to have drunk alcohol in the previous year (see the Annex [Section 9.1 – Table 9.4] for further details).

In terms of overall wellbeing, disabled people aged 18–64 years were a lot less likely than the non-disabled to rate their overall life satisfaction as high (60.5% of disabled people, 86.5% of non-disabled) and life as worthwhile (73.0% of disabled people, 90.1% of non-disabled). For family wellbeing, 68.8% of disabled people rated this highly compared with 83.6% of non-disabled peoples. They also self-evaluated their health significantly lower, with only 18% rating their health as very good or excellent, as opposed to 60.3% of non-disabled people [Stats NZ 2021f].
1.4.7 Rural health

There are limited data on the differences between urban and rural population health, in part due to the use of different definitions of rurality. For example, there are differences between rural health services delivery and rural populations’ access to services, as some rural populations may have good access to urban-based health care (National Health Committee, 2010; Fearnley, Lawrenson & Nixon, 2016). The 2010 National Health Committee report found similar life expectancy for urban and rural populations, a gap between Māori and non-Māori life expectancy in both rural and urban areas, but that rural Māori had a lower life expectancy than urban Māori (National Health Committee, 2010). The Health and Disability System Review indicated that those living in rural towns have poorer health outcomes, particularly for rural Māori and disabled people (Health and Disability System Review, 2019).

1.4.8 Asian peoples’ health

As was noted in Section 1.1, the New Zealand population is becoming increasingly diverse, in particular, with growing numbers of people from Asia. However, each group covers a wide range of different peoples, e.g. “Asian” covers people from Afghanistan to Japan (Ministry of Health, 2006a). Although much data collected in New Zealand can differentiate within these groups, most often, data are reported in an aggregated way. There are no health strategies for these groups.

New Zealand Health Survey data for 2019/2020 (Ministry of Health, 2022b) show that Asian populations generally have very good health. Compared with European/Other populations, they have better self-rated health (as good, very good or excellent); lower rates of smoking; lower consumption of alcohol; lower rates of other health conditions; and better mental health across a range of measures. They do, however, have higher rates of teeth removal (see Annex [Section 9.1 – Table 9.4] for further details). Childhood immunization rates tend to be high (see Figure 1.3 and 1.4).

What detailed information there is available on specific Asian populations is now significantly out of date (Ministry of Health, 2006a). A 2012 report (Mehta, 2012), however, found that all have relatively young populations and that the key health issues for Asian people in Auckland were as follows:

- Among the Chinese (127 000 people in 2010): diabetes prevalence among older men and middle-aged and older women, diabetes in pregnancy, child oral health, cervical screening coverage, cataract extractions and terminations of pregnancy.
• Among Indian people (100 000 people in 2010): cardiovascular disease (CVD), diabetes (including during pregnancy), child oral health, child asthma, low birth-weight deliveries, terminations of pregnancy, cervical screening coverage, family violence, hysterectomies, cataract extractions and total knee joint replacements.

• Among Other Asian populations (84 000 people in 2010): stroke and overall CVD hospitalizations, diabetes (including during pregnancy), child oral health, child asthma, cervical screening coverage, terminations of pregnancy and cataract extractions.

Across all groups, language and lack of knowledge of the New Zealand health system were key barriers, along with cultural differences in assessment and treatment, lack of cultural competency among health professionals, stigma attached to health issues, concerns over lack of confidentiality, transport and cost issues.

Asian people living in New Zealand report reasonably high levels of wellbeing. In a recent survey, Asian people were only a little less likely than NZ Europeans to rate their overall life satisfaction as high (84% of Asian people, 82% of NZ Europeans) and life as worthwhile (84% of Asian people, 86% of NZ Europeans). For family wellbeing, 84% of Asian peoples rated this highly compared with 81% of NZ Europeans. But they self-evaluated their health significantly lower, with only 43% rating their health as very good or excellent, as opposed to 54% of NZ Europeans (Stats NZ, 2021k).

1.4.9 Other peoples’ health

There are growing numbers of people migrating to New Zealand from the Middle East, Latin America, and Africa (MELAA) (see Section 1.1). Where data are available, they are often reported on in an aggregated way, although the group covers a wide range of ethnicities. New Zealand Health Survey data do not report on MELAA separately. There are no health strategies for these population groups.

What detailed information there is available on specific MELAA populations is now significantly out of date. A 2010 report (Perumal, 2010) undertook a needs assessment for Auckland’s three DHBs on MELAA health. It found the following, compared with European populations:

• Among Middle Eastern people (14 000 in 2010): a young population with a large proportion of children, with many not conversant in English; a high proportion living in high deprivation areas with crowded houses; higher unemployment and benefit rates and lower mean incomes (in spite of similar qualifications). There were concerns
over rates of CVD, diabetes, and dental caries, along with pregnancy terminations, and low rates of breastfeeding.

- Among African people (11 000 in 2010): a young population, with a high proportion of people living in the most deprived areas; many living in more crowded circumstances; a high proportion of one parent households; higher unemployment and benefit rates and lower mean incomes (in spite of similar qualifications). There were concerns over high rates of diabetes, HIV/AIDS, tuberculosis, and pregnancy terminations.

- Among Latin American people (3000 in 2010): a more mobile, younger population, with high levels of qualifications but higher unemployment rates and lower mean incomes. There were concerns over high rates of diabetes, teenage deliveries, and pregnancy terminations.

Across all groups, key barriers to care were language and communication difficulties, health illiteracy, cost of care, a lack of cultural understanding by health service providers, and lack of trust and fear of Western models of health care.

1.5 Natural and human-induced disasters

1.5.1 Natural disasters

New Zealand is located on the Pacific “rim of fire” and, thus, is subject to seismic and volcanic activity on a regular basis. At their worst, these can lead to loss of life. The most significant recent earthquake occurred in Christchurch on 22 February 2011. The magnitude 6.3 earthquake killed 185 people and injured several thousand. The city was left badly damaged and is yet to be fully rebuilt. The earthquake was an after-shock of a magnitude 7.1 earthquake that had occurred more than five months beforehand. The 2011 earthquake was far more catastrophic due to it being shallower and nearer to the city (Te Ara, 2021).

The most significant recent volcanic eruption occurred on Whakaari/White Island, a small uninhabited island just off the east coast of the North Island, on 9 December 2019. There were 47 tourists and guides on the island at the time, most of the tourists being from an international cruise ship. The eruption killed 22 people on the island, with many of the survivors badly injured. Concerns were subsequently raised about the appropriateness of allowing 10 000 people a year to visit the active volcano. Indeed, 10 sulfur miners had been killed on the island in 1914 when part of the crater rim
collapsed. In November 2020, WorkSafe, New Zealand’s primary workplace safety regulator, laid 13 charges against tourism operators and others in light of the event; at the time of writing, the case is ongoing (WorkSafe, 2021).


The main agency involved in responding to natural disasters in New Zealand is the National Emergency Management Agency (NEMA), also known as Civil Defence. A government agency, NEMA undertakes precautionary measures prior to disasters, such as running publicity programmes advising the public how to protect themselves during emergencies, as well as coordinating the government’s response after emergencies, such as working with regional civil defence agencies, police, fire and emergency services, and the defence force (NEMA, 2022).

### 1.5.2 Environmental health

In general, New Zealand has very good drinking water standards. About 4.14 million New Zealanders (81.4% of the total population) received their water from registered drinking water supplies during 2019 (the remainder received drinking water from small community supplies and self-supplies, such as rainwater tanks) (Environmental Health Intelligence New Zealand, 2022).

Of the population on registered supplies, 95.2% were served with bacteriological-compliant drinking water, 80% with protozoal-compliant drinking water, and 99.1% with chemically compliant drinking water. Most people (78.6%) received drinking water that met all three requirements (Environmental Health Intelligence New Zealand, 2022).

However, in 2016, Havelock North water bores became contaminated with *Campylobacter*. Around 5000 of the town’s residents are thought to have become sick, with 45 hospitalized, and three deaths possibly linked to the outbreak. As a result of the Havelock North outbreak, and with local councils struggling to fund infrastructure replacement for wastewater and stormwater, a set of major reforms are under way, with a dedicated, national water regulator now in place that took over all aspects of water regulation from November 2021 (see Section 6.2.2 for more details).

Air pollution has major effects on the health of New Zealanders. In 2016, for instance, air pollution from human-made particulate matter was associated with an estimated 1277 premature deaths (27.2 per 100 000 people), 236 cardiac hospitalizations (5.0 per 100 000 people), 440 respiratory hospitalizations (9.4 per 100 000 people) and 1.49 million restricted
Environmental health responsibilities are split across the Ministry for the Environment, MoH (including 12 regional public health units under DHBs), and regional and local governments.

The Ministry for the Environment is the government’s primary advisor on environmental matters, working on issues relating to air quality, biodiversity, climate change, freshwater, hazardous substances and biotechnology, land protection and restoration, and marine, urban and waste issues. Much of its work is in conjunction with regional and local councils, which in turn are overseen by the Department of Internal Affairs.

Taumata Arowai – https://www.tauamataarowai.govt.nz/
Taumata Arowai will be the new water regulator for New Zealand drinking water and have an oversight role relating to the environmental aspects of wastewater and stormwater, commencing in 2021.

1.5.3 Human-induced disasters

1.5.3.1 Mosque shootings
The greatest human-induced disaster in recent New Zealand history occurred when a white supremacist murdered 51 people and injured 40 more at two mosques in Christchurch on 15 March 2019. The killer, an Australian who had moved to New Zealand in 2017, was sentenced to life imprisonment without possibility of parole. A Royal Commission of Inquiry into the killings found that, while the attack could not have been prevented, police had not done enough to identify white supremacist threats in New Zealand and there were inadequate checks of gun purchases (Royal Commission of Inquiry into the Terrorist Attack on Christchurch Mosques on 15 March 2019, 2020).

1.5.3.2 COVID-19
The primary health challenge facing all New Zealanders in the period 2020–2022 was COVID-19 (for detail, see Section 5.15.4). It is thought that the first case in New Zealand occurred on 21 February 2020 and was reported on 28 February 2020; the first death was on 29 March 2020. Particularly in 2020 and 2021, the government referred to New Zealand’s response to COVID-19 as being “hard” and “early”, with a view to stopping (“eliminating”) community transmission of the virus (Ardern, 2020). A wide range of agencies have been involved in the response to the pandemic (Cumming, 2021a). A number of
economic packages were also devised to support the economy and people’s livelihoods (Cumming, 2021a).

The core measures for controlling the virus were the closure of borders to most international visitors; compulsory managed isolation and quarantine (in specific hotels) for those permitted to travel to New Zealand; social distancing; hand sanitizing; contact tracing; and testing. An Alert Level Framework guided actions until late 2021 and involved a number of significant national and regional lockdowns at different points in time during 2020 and 2021. Vaccination began in February 2021, with a number of vaccination mandates put in place, e.g. health workers, teachers, and emergency and border workers.

In the first phases of the pandemic, between 28 February 2020 and 16 August 2021, New Zealand had been highly successful at restraining the virus’s effects, with only 2750 confirmed cases, and 26 deaths.

The Delta variant then entered the country, sending Auckland (the largest city) into a long lockdown period until towards the end of 2021; other districts also had shorter periods of lockdown. The aim of these 2021 lockdowns was to give time to increase vaccination rates.

As vaccination rates rose, a new COVID-19 Protection Framework “traffic light system” replaced the Alert Level Framework, providing those with vaccinations with more freedoms at the “green” level, and to those who were not vaccinated, with increasing limits on gathering at “orange” and “red” settings. From 3 December 2021, a large part of the North Island was at the “red” setting with the rest of the country at “orange”; all parts of the country except North Island (where vaccination rates were lower than elsewhere) went onto the orange setting on 31 December 2021.

The Omicron variant entered the community on 30 December 2021, moving the country to the highest, “red”, setting. New Zealand returned to the “orange” setting on 13 April 2022. New Zealand completely reopened its borders on 31 July 2022. Some weeks later, on 12 September, the traffic light system was abolished and the situations where masks must be worn were reduced to two instances – (1) in medical facilities (e.g. visiting GP or hospital) and (2) aged-care facilities. Also on 12 September, isolation requirements were reduced, such that those who contract COVID-19 must self-isolate for seven days (household contacts no longer had to isolate).

As of 27 September 2022, the MoH reported that New Zealand had had 1,779,476 cases of COVID-19, and 2,959 deaths (1,289 coded as being due to
COVID-19 with the remainder yet to be coded (Ministry of Health, 2022c). New Zealand’s death rate at 29 September 2022 was 592 deaths per 1 million population, meaning New Zealand had the 125th highest death rate per capita internationally. This was a lower death rate than many comparable countries, e.g. the United States’ death rate was 3235 (ranked 16), the United Kingdom 2765 (29) and Canada 1169 (89). However, Australia, on 573 (127), had a slightly lower rate than New Zealand (Worldometer, 2022).
2. Organization and governance

Chapter summary
New Zealand has a predominantly publicly funded, universal coverage health and disability system with services provided by publicly owned, privately owned and nongovernmental (voluntary or third sector [not-for-profit]) organizations.

The foundations for New Zealand’s health and disability system were laid in the late 1930s, with the passing of the Social Security Act 1938. However, regular reviews of the system emphasized the need for a greater focus on prevention and primary health care (PHC) services, concerns over rising user charges for PHC leading to significant barriers to access to PHC, fragmented service delivery across many health-care provider organizations and health professionals, and growing inequities in health and access to care. As a result, there have been seven major reforms of the system between the 1980s and 2020s.

The Ministry of Health (MoH) oversees the health system and is the lead advisor to the Minister of Health. Prior to 1 July 2022, the MoH also directly funded some services. A Health Quality and Safety Commission (HQSC) supports quality improvement.

Prior to 1 July 2020, 20 district health boards (DHBs) were responsible for planning and funding health and many disability services for their geographical areas. They were funded by, and their performance was managed by, the MoH. They owned and operated many hospital and community services (e.g. district nursing, mental health), and contracted for a range of PHC and community services (e.g. health promotion, mental health, disability support, home care and residential rest home care) from a range of privately owned organizations.

PHC is coordinated through primary health organizations (PHOs), which received capitation funding for their enrolled populations. Patients are free to enrol with a privately owned general practice (GPC) of their choice; the GPC then chose which PHO to join. PHOs are to have no formal place in the newly restructured health system.
Many PHC and community services are delivered by a range of privately owned service providers, many of which are non-government organizations (NGOs), which are not-for-profit. This includes an increasing number of Māori-led and Pacific-led service providers.

Most New Zealanders have a choice of GPC, although this may be limited in rural areas and there are now many practices with closed books. Most people access hospital services through their local DHB’s hospital, with usually no choice over hospital or specialists. Those with private health insurance or who pay privately for services have the choice to receive services from privately owned hospitals, although these are largely located in the main centres.

Recent governments have developed a number of overarching policy strategies for the health and disability system. This includes specific strategies for improving Maori and Pacific peoples’ health and wellbeing, and the wellbeing of disabled people. DHBs and PHOs have been held accountable for delivering on these strategies through a variety of mechanisms, such as annual plans and annual reports.

New Zealanders can purchase private health insurance that provides complementary service coverage for services typically not available through the publicly financed system (e.g. adult dental care); complementary coverage for the user charges paid for publicly financed services; and for supplementary services, such as faster access to elective/planned services, delivered by privately owned hospitals.

The accreditation process for health professionals is governed by the Health Practitioners Competence Assurance Act 2003. The 17 authorities created under the Act are responsible for overseeing practitioners of a particular profession or professions, including their registration, and managing complaints. A range of colleges is responsible for the training, examination, and recertification of health professionals. Many professional bodies advocate on behalf of their members and are engaged in collective bargaining on salaries and working conditions.

New Zealand has had several arrangements in place since the 1990s to set priorities, including national committees. This work now largely falls to the MoH. The Pharmaceutical Management Agency (PHARMAC) is the government agency responsible for deciding which medicines should be funded by government, and its role has expanded over time to include vaccines and medical devices.
Health and disability services (including medical, mental health, surgical, and obstetric services, aged care facilities, and other health-related services) are regulated by the Health and Disability Services (Safety) Act 2001 and associated regulations. These set standards, provide for certification, and establish a framework for the monitoring of compliance. Medsafe is an MoH business unit that regulates therapeutic products, including medicines and devices.

In addition to the information that health and disability organizations and health professionals provide, information for patients is provided nationally through the MoH, a national healthline service, regional disability information centres and by a large number of not-for-profit groups that support patients with particular health or disability conditions.

Since 1996, New Zealand has had a Code of Health and Disability Services Consumers’ Rights, and the office of the Health and Disability Commissioner (HDC) investigates complaints. Until recently, the HDC also included a Mental Health Commissioner; a separate Mental Health and Wellbeing Commission was established in 2021 to oversee the transformation of the mental health and addiction system. An Aged Care Commissioner has recently begun working from the HDC to oversee the aged care sector.

Consumer and/or community participation in the health system occurs at a number of levels in New Zealand. Prior to their disestablishment on 1 July 2022, DHBs included locally elected members. There are often advisory boards for particular initiatives or organizations, including for the MoH, PHARMAC and health-care providers, while some health-care providers have community governance. Consumers and communities are also involved in running a wide range of community organizations. The HQSC has a Partners in Care initiative to encourage the system to become more patient-centred and to take a co-design to service delivery.

2.1 Overview of the health system

The Central Government in New Zealand has overall responsibility for health and disability policy. The health and disability system provides universal coverage, and is predominantly publicly funded, with provision of services shared between a variety of public, private and voluntary sector agencies. Funding for government services is allocated to particular Votes: Vote Health is the main source of health and disability expenditure.

Total expenditure on health and disability services was NZ$ 20.3 billion in 2020/2021 (Ministry of Health, 2020g). The main source of funding for health
and disability care in New Zealand is public funding, largely through taxation. In 2018, 71% of expenditures were government funded through Vote Health. A further 10% of expenditure was funded by the Accident Compensation Corporation (ACC), which oversees a social insurance scheme covering New Zealanders for accident-related care (Health and Disability System Review, 2019). In 2018, private out-of-pocket payments made up 12.9% of expenditure. New Zealanders can also purchase private health insurance to supplement the services they can receive through the publicly financed system, but private health insurance contributed only 7.9% of expenditures in 2018 (Organisation for Economic Co-operation and Development [OECD], 2021).

Publicly owned hospitals provide most accident and emergency, secondary and tertiary medical care. The small privately owned hospital sector specializes mainly in elective/planned surgery, paid for by patients drawing on any private health insurance they might have or paying out of pocket. Independent medical, nursing, and allied practitioners provide many community-based PHC services. Privately owned providers also now dominate long-term care service delivery, much of which is publicly funded. A key player in health services delivery is the “third sector”, which refers to non-profit NGOs, a sector that has expanded rapidly since the mid-1980s. These providers offer community-based health promotion, primary health care (PHC), mental health, home care and disability support services, many of which are fully or partially publicly funded. The third sector includes union-based health services, and Māori- and Pacific-owned providers.

The main components of the New Zealand health and disability system as at June 2022 are shown in Figure 2.1. The historical development of the New Zealand health and disability system is explained in the following section, and then the roles and functions of the main organizations are given in detail.

2.2 Historical background

From the early days of European settlement in New Zealand, there has been mixed provision of health care services by the government, voluntary and private sectors. The first State hospitals were commissioned in 1846. Their services were free only to the Indigenous Māori population and to “indigents” (i.e. poor or needy people), but government health services became increasingly accessible to the general population and, by the 1880s, the government funded about three quarters of hospital care, including all mental health services for those with severe mental distress (Gauld, 2009). There were also private primary and secondary health-care services provided by medical practitioners who worked independently and were paid directly
by their patients. Voluntary provision included charitable work and “friendly societies”, and non-profit insurance schemes, which provided care for their contributing members (Gauld, 2009).

The Hospital and Charitable Institutions Act 1885 divided the country into 28 hospital districts (Hay, 1989), with local hospital boards responsible for raising half of the finance they needed (via patient charges, contributions from local authorities levied from rate-payers, and voluntary contributions) and the government contributing the remainder (Department of Health, 1969).

The Public Health Act 1900 created a Department of Public Health headed by a Chief Health Officer, and stipulated that those appointed as local district health officers were to be medical practitioners with “special knowledge of sanitary and bacteriological science” (Royal Commission on Social Policy, 1988). New Zealand thus set up a national department of health to oversee the health of the population earlier than other countries. The Department of Public Health gradually took on broader functions, merging with the Department of Hospitals and Charitable Aid in 1909 and eventually being renamed the Department of Health in 1920 (Dow, 1995).

By the mid-20th century, hospitals had become the key component in the health system. Advances in medical knowledge and technology meant that hospitals were able to offer effective treatment rather than just care, while caring for seriously ill people at home ceased to be the norm. Government funding of medical care gradually increased while patient fees made up a smaller share of revenue (Royal Commission on Social Policy, 1988).

**2.1.1 A national health care system – the 1930s and 1940s**

The first Labour government of New Zealand (1935–1949) substantially shaped the health-care system of today, setting up a welfare state in the years following the depression of the 1930s. The Social Security Act 1938 marked the introduction of universal entitlement to tax-financed and comprehensive health care. Free hospital treatment was provided for all (including inpatient and outpatient care in general hospitals, mental hospitals, maternity hospitals and sanatoria); medicines were made free; and benefits were introduced for X-ray and laboratory services and dental services for children aged under 16 years (McLintock, 1966).
The government originally also envisaged free PHC services, but general practitioners (GPs) insisted on remaining independent and, after lengthy negotiations, were subsidized by the government on a fee-for-service basis, rather than through capitation payments or salaries. The GPs’ view was that...
the subsidy attaches to the patient and is not a payment by the government to the practitioner. In addition to the government subsidy, GPs were also given the right to charge their own fees to patients (i.e. extra billing user charges). Some services, such as adult dental care and optometry, were still paid for privately (Department of Health, 1974). By 1947, however, New Zealand had set up a predominantly tax-funded health-care system that made most services available free to the user at the point of delivery, with a mix of public and private provision. However, the initial intention to develop a largely free-of-charge, integrated national health service was not achieved and, as a result, New Zealand’s health system continues to face problems arising from these arrangements to this day. Of most importance are the more limited role that PHC plays in New Zealand health care and the significant financial barriers to access to PHC that result from user charges, along with significant fragmentation of service delivery.

2.1.2 Developments from the 1950s through until 1980

Incremental, pragmatic adjustments to the health-care system continued over the next 40 years or so, with a series of reviews (Gauld, 2009). The 1953 Consultative Committee on Health Reform (the Barrowclough Committee) supported the establishment of additional private hospital beds (in line with the view of the National party government of the time), recommended that the Minister of Health (rather than individual hospital boards) have ultimate responsibility for hospital and health service organization (enacted in The Hospitals Act, 1957), and recommended reducing the number of hospital boards (although this recommendation was not implemented due to a change of government) (Gauld, 2009). A review of hospital and related services in New Zealand (Department of Health, 1969) also emphasized the need for more integrated health services and suggested amalgamations of the then 31 hospital boards, though again these did not occur.

With the 1972 election of a Labour government, a further review was undertaken by the Department of Health, resulting in the White Paper, A health service for New Zealand (Department of Health, 1974). This outlined principles for change, including the need for integration of health services, more emphasis on health promotion (in addition to the treatment of illness), and the equitable provision of health-care services on the basis of need rather than ability to pay (Department of Health, 1974). The White Paper proposed that 14 regional health authorities be established to coordinate all services in their geographical areas, and also suggested a split between the funding and the provision of services. Before any reforms could be enacted, however, there was a change of government, with the National party government taking office in 1975 and remaining there until 1984.
2.1.3 Reforms in the 1980s

The National party government set up a Special Advisory Committee on Health Services Organization, which proposed the establishment of 14 regional area health boards (AHBs) (Gauld, 2009). The government chose to pilot these in two areas and consult further with stakeholders rather than introduce them nationally all at once, before finally passing the Area Health Boards Act 1983, which allowed for the voluntary establishment of 14 AHBs (Gauld, 2009). These were formed between 1984 and 1989, during the period of the Labour government, which was elected in 1984.

This Labour government also undertook significant economic and public sector reforms, including the introduction of the State-Owned Enterprises Act 1986 (which restructured some government departments, separating trading activities into more business-like enterprises to promote improved performance); the State Sector Act 1988 (which introduced managerialism and performance objectives to State services), and the Public Finance Act 1989 (which reformed public financial management systems to incentivize the effective and efficient use of financial resources by government departments). The principles underpinning these major economic reforms were later reflected in changes in New Zealand’s health-care system during the 1990s.

During this period, the Labour government also commissioned two health policy reviews: the 1986 Choices for health care: report of the health benefits review (Scott, Fougere & Marwick, 1986) and the 1988 Unshackling the hospitals: report of the hospital and related services taskforce (Gibbs, Fraser & Scott, 1988). The former presented five options for the State’s funding role in health care, while the latter recommended separating the purchasing and provision of health care. At the time, these reforms were not enacted, but they provided the bases for later reforms.

2.1.4 Reforms during the 1990s

Not long after the last of the AHBs had been established, a National party government was elected in 1990 and set up a task force that recommended a split between the purchase and provision of health services (Upton, 1991). This was enacted through the 1993 Health and Disability Services Act. The Department of Health became a policy-focused Ministry of Health (MoH), losing most of its direct funding roles. Four regional health authorities (RHAs) were established and given a budget to purchase services from both publicly- and privately owned providers. RHAs would purchase all personal health services on behalf of their geographical populations. They were also given the funding to purchase disability support services; prior to this, many
disability services had been the responsibility of the social welfare sector. The provider arms of the 14 AHBs were converted into 23 Crown health enterprises (CHEs), which were to function as commercial entities; run hospitals, community and public health services; and return a surplus for reinvestment in health.

These reforms represented a major restructuring of the New Zealand health system. As such, they proved complex and expensive to implement, with one estimate that the reform process itself cost at least NZ$ 800 million (Gauld, 2009). The reforms were highly contentious, with many health professionals not in favour of the business or competitive focus of the model, while many disability advocates were concerned about the “illness” focus the health system might bring to their services.

The reforms would later be seen to have led to some gains – most notably, a clear focus for providers, improvements in information (including about the cost of services), the development of the PHARMAC to manage the national pharmaceutical budget, the increased development of by-Māori for-Māori and by-Pacific for-Pacific providers, the development of new meso-level primary health-care organizations (known as Independent Practitioner Associations or IPAs), and some acknowledged savings in pharmaceutical and laboratory spending.

The Core Services Committee (later the National Health Committee [NHC]) was also formed during this time, originally to determine “core” health services that would be publicly funded, later focusing on better management of waiting lists for elective/planned services and creating evidence-based guidelines to guide treatment and service delivery decisions.

However, there were many problems with the new system. There were major concerns over the cost of the reforms, poor purchasing practice, inconsistencies arising from having four RHAs, and the lack of competition in key areas of service provision (Gauld, 2009). There were also concerns that the major promised efficiency gains did not materialize with the most obvious being a major increase in the numbers of New Zealanders waiting for elective/planned surgery when reductions in waiting lists and times were originally promised.

The reforms were so contentious that the health and disability system was barely out of the news for a number of years, with a number of changes in the Minister of Health as the government tried to put the sector onto a surer footing. For a more detailed assessment of the reforms, see Chapter 6.
New Zealand’s first mixed member proportional (MMP) representation election in 1996 resulted in a coalition government of the National party and the smaller New Zealand First party. Difficulties with the purchaser–provider system and the influence of New Zealand First party saw a shift away from the quasi-market model approach to a national approach and a less competitive and more collaborative arrangement. The four RHAs were abolished on 30 June 1997. Their functions were transferred to a single health funding body, the Transitional Health Authority, which was renamed the Health Funding Authority (HFA) on 1 January 1998. As a single, national purchasing authority, the HFA continued the split between purchase and provision. It contracted with a range of providers for the provision of medical, hospital, public health, disability, and other health services, and was also responsible for purchasing postgraduate clinical training. Its other functions were to monitor the need for health services and to monitor the performance of providers.

At the same time, the CHEs were converted into 23 companies called Hospital and Health Services (HHS), which were relieved of the requirement to make a surplus (but were still expected to cover their costs and not to run deficits). They continued to run hospitals and related services, community and public health services, and were contracted to deliver these services by the HFA. These companies had independent legal and financial status and operated in a commercial legal framework.

2.1.5 Reforms during the 2000s

At the end of 1999, a Labour–Alliance party coalition government was elected and swiftly enacted the New Zealand Public Health and Disability Act 2000, which ushered in another major reorganization of the health and disability sector. Local governance was re-established by way of 21 district health boards (DHBs) to replace the HHS, and the HFA was disestablished, its purchasing role being split between the new DHBs and an expanded MoH. The MoH was [and remains] the main policy advisor to the Minister of Health, and also had some direct national purchasing responsibilities (e.g. for public health services and disability support services to those aged under 65 years – see Section 2.3.1). It was [and remains] responsible for developing national strategies, including an overarching New Zealand Health Strategy (King, 2000a) and an overarching New Zealand Disability Strategy (Minister for Disability Issues, 2001) to guide the health and disability system.

DHBs were responsible for planning and funding most health and disability services for their district. They also provide hospital and some community-
based services; i.e. removing the purchaser–provider split for such services that was established during the 1990s. DHBs did continue, however, to purchase and contract for PHC and a wide range of community-based services, from a wide range of private providers. PHC services were largely provided through privately-owned primary health organizations (PHOs), which were established from 2002 on. See Section 2.3 for more information on DHBs and PHOs.

In November 2008, the National party won the national election and led a coalition government with confidence and supply agreements with ACT, the Māori Party, and a United Future party. (In a confidence and supply agreement, minor parties in a coalition agree not to oppose the government in confidence or supply votes.) The National-party-led coalition did not seek to “restructure” the health system, but it sought various changes, building on its 2007 “Better, Sooner, More Convenient” (BSMC) election manifesto (New Zealand National Party, 2007) and a Ministerial Review Group report (Ministerial Review Group, 2009). This led to: establishing a National Health Board (NHB) as a business unit of the MoH to oversee DHBs, fund and plan specialist national services, and oversee infrastructure planning of IT, workforce and capital management; reorganizing the functions of the rest of the MoH; changing the functions of the NHC to focus on priority setting; establishing a separate national Health Quality and Safety Commission (HQSC) to oversee quality of care; establishing a shared services agency to undertake DHB back-office functions across DHBs (Health Benefits Ltd); encouraging Southland and Otago DHBs to merge; seeking mergers between PHOs, with a view to reducing the number of PHOs from the 80 in place in 2008; and encouraging the development of more integrated PHC service delivery through the establishment of new integrated family health centres (IFHCs).

The government also supported nine BSMC business cases, covering 60% of the population, to deliver large-scale changes and deliver care closer to home (Cumming et al., 2021). DHBs and PHOs typically worked more closely together through these business cases to plan and fund services, and their plans included developing IFHCs, developing more nurse practitioner- and nurse-led services and more multidisciplinary teams, and building more cooperation between PHC and hospital services. The business cases did not get new funding but were able to pool various PHO funding streams into a “flexible funding pool”, later rolled out throughout the country. The business cases became known as “alliances”.

Following its re-election in November 2011, the National party-led government shifted the focus of the public sector from outputs to results that
benefit families and communities. In 2012, the Prime Minister announced 10 high-level results to be achieved across the public sector. The MoH led the work on increasing immunization and reducing rheumatic fever cases among children.

From 2013 on, the government required each DHB to establish a District Alliance, to at the very least include PHOs, but also ideally to involve a range of other health-care providers. Alliances would work together to review key services and make recommendations to each DHB about improvement initiatives and resource re-allocations (Gauld, 2014).

The National party-led coalition government was returned to power in 2014. A major initiative included the introduction of a System Level Measures (SLM) Framework, to support local integrated care initiatives aimed at improving health outcomes and equity, across six key performance measures – four emphasizing integration (reductions in amenable mortality, total acute bed days, childhood ambulatory sensitive hospitalizations (ASHs), and improvements in patient experience of care) and two emphasizing health for two key populations (babies in smoke-free homes, and youth health services).

Since 2016, Alliances have focused on developing SLM improvement plans. The initiative was designed to encourage system integration (or collaboration) from the bottom–up through clinically led service improvements. It has supported more collaboration and small-scale initiatives, but by 2020 it was found that the results were mixed (Tenbensel et al., 2021).

In 2016, the government refreshed the New Zealand Health Strategy. The refreshed Future Direction (Minister of Health, 2016a) identified five key themes for the health and disability system, i.e. that it is people-powered; delivering care closer to home; offering value and high-performance; delivering through a “one team” approach; and “smart”. An accompanying Roadmap of Actions (Minister of Health, 2016b) focused on how the themes would be progressed over the next few years. A “Ministry on the Move” transformation programme saw both the NHB and the NHC disestablished.

At the end of 2017, a Labour-led coalition government, with the New Zealand First and Green parties, won the election. A Health and Disability System Review was established to review the system, to ensure it could:

- achieve better health and wellbeing outcomes for all;
- ensure improvements in health outcomes of Māori;
- ensure improvements in health outcomes of other population groups;
reduce barriers to access to health and disability services to achieve equitable outcomes for all segments of the population;

improve the quality, effectiveness, and efficiency of the health and disability system, including institutional, funding, and governance arrangements (New Zealand Health and Disability System Review, 2019).

An interim report was released in 2019 (Health and Disability System Review, 2019), and final report in 2020 (Health and Disability System Review, 2020). The government made announcements about the future health and disability system in April 2021. Chapter 6 provides more detail about these reports’ findings and the reforms in New Zealand, introduced on 1 July 2022.

2.3 Organization

2.3.1 Minister and Ministry of Health

The Minister of Health, with Cabinet approval, develops policy for the health and disability sector. The Minister is primarily supported and advised by the MoH and various ministerial advisory committees. The Minister of Health has overall responsibility for the health and disability system, with the MoH being the main advisor to the government on health and disability policy issues. As well as acting as the government’s principal advisor on health and disability policy, the MoH has a range of stewardship roles in the system, providing clinical and sectoral leadership, and with monitoring, regulatory and protection functions.

Until recently, the MoH also directly purchased/commissioned (funded and contracted for) a number of national services, including public health interventions (such as immunization or dealing with outbreaks of disease); disability support services for those aged under the age of 65 years; screening services (such as screening for breast cancer); maternity services; child health; ambulance services; and some workforce training (Ministry of Health, 2019b).

The Health Act 1956 sets out individuals’ roles and responsibilities to safeguard public health, including the roles played by the Minister of Health, the Director of Public Health, and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies, and the national cervical screening programme (Ministry of Health, 2021b).

The structure and funding of public health and disability services were set out in the New Zealand Public Health and Disability Act 2000. The Act established
DHBs and sets out the duties and roles of key participants, including the Minister of Health, ministerial committees, DHBs, and health sector provider organizations. The Act also set the strategic direction and goals for the country’s health and disability services. These included improving health and disability outcomes for all New Zealanders, reducing disparities by improving the health of Māori and other population groups, providing a community voice in personal health, public health, and disability support services and facilitating access to, and disseminating information for, the delivery of health and disability services in New Zealand (Ministry of Health, 2021b).

The MoH has a number of directorates. In June 2022, these included: system strategy and policy; corporate services; mental health and addiction; data and digital; DHB performance, support, and infrastructure; population health and prevention (including a National Screening Unit); office of the Director-General; Māori health; office of the chief clinical officers (medical, nursing, and allied health professions); health system improvement and innovation; disability; and health workforce (Ministry of Health, 2022d).

Key regulatory groups included the following:

- HealthCERT (http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-healthcare-services) is the group within the Ministry responsible for ensuring that hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001.

- The New Zealand Medicines and Medical Devices Safety Authority (Medsafe; http://www.medsafe.govt.nz) is the group within the Ministry responsible for administering the Medicines Act 1981 and Regulations 1984, which regulate therapeutic products in New Zealand. It applies a framework of controls, including pre-marketing approval of products and post-marketing surveillance, to ensure that the therapeutic products available can be expected to have greater benefits than risks if used appropriately.

The MoH also hosts a Departmental Agency, Te Aho o Te Kahu, the Cancer Control Agency. It reports directly to the Minister of Health. The Agency was established to provide strong central leadership of cancer control. It works with partners across the cancer continuum to prevent as many cancers as possible; ensure early detection and diagnosis; and provide high-quality treatment and care.
The MoH was reconfigured from 1 July 2022, maintaining its lead policy and regulatory roles, losing its purchasing roles to the new Health New Zealand (HNZ), and strengthening its public health responsibilities through a new, embedded Public Health Agency. A new Ministry of Disabled People (MoDP) is responsible for improving the outcomes of disabled people and for funding disability support services. The MoH retains responsibility for the health outcomes and health services for disabled people (see Chapter 6 for more detail).

2.3.2 Health Crown entities and agents

The Crown Entities Act 2004 established five categories of Crown Entity. The first of these statutory entities has three types, each of which includes health-related organizations.

- Crown agents (which must implement government policy when directed by the responsible minister) included the 20 DHBs (see Section 2.3.5), the Health Research Council of New Zealand, New Zealand Blood Service, PHARMAC and HQSC.
- Autonomous Crown entities (which must have regard to government policy when directed by the responsible minister) included Peke Waihanga – the New Zealand Artificial Limb Service.
- Independent Crown entities (which are generally independent of government policy) included the Health and Disability Commissioner and (from February 2021) the Mental Health and Wellbeing Commission.

Each of these health-related organizations is described briefly below.

**Health Research Council of New Zealand (HRC) – http://www.hrc.govt.nz**

The HRC is responsible for managing the government’s investment in health research. The Council is answerable to the Minister of Health, its ownership minister, and the Minister of Science and Innovation, who provides most of the Council’s funding through Vote Business, Science, and Innovation. The HRC’s functions include initiating and supporting health research; undertaking consultation to establish priorities in health research; advising the minister and administering funds in relation to national health research policy; fostering the recruitment, education, training and retention of those engaged in health research in New Zealand; promoting and disseminating the results of health research and ensuring the development and application of appropriate assessment standards by committees that assess health research proposals. The HRC received NZ$ 109 392 million in government revenue for the year ended June 2019 (HRC, 2019).
New Zealand Blood Service – http://www.nzblood.co.nz

NZBS ensures the supply of safe blood products through an integrated national blood transfusion process. All blood donations within New Zealand are voluntary.

Pharmaceutical Management Agency – http://www.pharmac.govt.nz

PHARMAC aims to ensure the best health-care value from the government’s expenditure on pharmaceuticals. It manages the Pharmaceutical Schedule of subsidized community medicines, working on behalf of publicly owned health providers to decide which medicines to fund, negotiating prices with pharmaceutical companies, setting subsidy levels and conditions, and ensuring that spending remains within budget. PHARMAC also plays a role in helping New Zealanders understand how to use their medicines optimally. Its role has expanded over time to include cancer medicines, contracting for the national influenza vaccine, managing a national immunization schedule, and managing hospital medicines and medical devices.


The HQSC was established in 2010 to work with clinicians and consumers to improve health and disability services, in particular, aiming to achieve the New Zealand Triple Aim of improved quality and safety and experience of care for people and their whānau; improved health and equity for all populations; and better value from public health resources (Health Quality and Safety Commission, 2022b).

The HQSC has a number of work programmes covering advance care planning, system safety, building leadership and capability, infection prevention and control, improved service delivery, mental health and addiction, trauma, national bowel screening, partners in care, and mortality review (Health Quality and Safety Commission, 2022b). Its work covers PHC, hospital care, and aged residential care, as well as mental health and addiction services. In recent years, it has also taken a strong interest in examining inequities in access to and use of services, across the life-course, for Māori and Pacific populations. It participates in the international “Choosing Wisely” work to improve quality by aiming to reduce harm from unnecessary and low-value treatment.

Its work includes monitoring and reporting on quality and safety, including through an Atlas of Healthcare Variation, signalling variations in access to and use of services throughout the country and across key population groups. The Atlas was designed to encourage discussion and debate and encourage improvements to be made at DHB and more local levels.
The HQSC also has an Adverse Events Learning Programme, supporting organizations to report, review and learn from adverse events. Adverse events are defined as: “An event with negative or unfavourable reactions or results that are unintended, unexpected, or unplanned. In practice this is most often understood as an event that results in harm or has the potential to result in harm to a consumer” (Health Quality and Safety Commission, 2022e). The process is underpinned by an emphasis on learning, a focus on systems, and restorative practice principles. Following a review in 2017, the HQSC aims to focus more on the lessons learnt and improvements made as opposed to reporting on the number of events. HQSC programmes aim to support the sector in making improvements over time.

Further details on a number of HQSC initiatives are included in Sections 2.9.5, 7.3.1 and 7.4.2.

There are four mortality review committees that sit under the umbrella of the HQSC:

- The Child and Youth Mortality Review Committee (https://www.hqsc.govt.nz/our-programmes/mrc/cymrc/) reviews the deaths of children and young people aged 28 days up to 25 years.
- The Perioperative Mortality Review Committee (https://www.hqsc.govt.nz/our-programmes/mrc/pomrc/) reviews deaths following any invasive procedure or any form of anaesthesia.

**Peke Waihanga – The New Zealand Artificial Limb Service – http://www.nzals.co.nz**

Peke Waihanga manufactures high technology medical devices – primarily artificial limbs – for individual patients with an integrated rehabilitation and coordination of care service.

**Health and Disability Commissioner – http://www.hdc.org.nz**

The office of the HDC was established to protect the rights of health consumers and disability services consumers and resolve complaints arising from the infringement of those rights. The rights of health and disability
services consumers in New Zealand are set out in the Code of Health and Disability Services Consumers’ Rights, available on the Commissioner’s website. The office now also hosts an Aged Care Commissioner.

**Mental Health and Wellbeing Commission (MHWC) – https://www.mhwc.govt.nz/**

The MHWC commenced on 9 February 2021, with the aims of ensuring better and more equitable mental health and wellbeing outcomes for people in New Zealand. Its key functions are to assess and report publicly on the mental health and wellbeing of people in New Zealand, the factors that affect people’s mental health and wellbeing, and the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing; to monitor services; and to advocate for those who experience mental distress or addiction.

**Ministerial advisory committees and councils**

The MoH provides secretariat support for a number of ministerial health advisory committees and councils, described in brief below.

**Advisory Committee on Assisted Reproductive Technology (ACART) –http://www.acart.health.govt.nz/**

ACART was established under the Human Assisted Reproductive Technology Act 2004. It formulates policy and advice specific to New Zealand for the regulation of assisted human reproduction. It is required to undertake extensive public consultation before issuing advice or finalizing guidelines.

**Ethics Committee on Assisted Reproductive Technology (ECART) – http://www.ecart.health.govt.nz/**

ECART is required to consider and determine applications for assisted reproductive procedures or human reproductive research and keep under review approvals previously given. It liaises with ACART and other relevant ethics committees on matters relating to assisted reproductive procedures and human reproductive research.

**National Ethics Advisory Committee – http://www.neac.health.govt.nz/**

The Committee’s statutory functions are to provide advice to the Minister of Health on ethical issues of national significance regarding health and disability research and services, to determine nationally consistent ethical standards, and to provide scrutiny for such research and services.

New Zealand has four ethics committees whose primary role is to provide independent ethical review of health and disability research and innovative practices to safeguard the rights, health and wellbeing of consumers and research participants, particularly those with diminished autonomy.

Radiation Safety Advisory Council

Under the Radiation Safety Act 2016, the Radiation Safety Advisory Council advises the government about matters relating to radiation safety.

### 2.3.4 Other government ministries

The health system depends upon a number of other government ministries and agencies, whose health- and disability-related activities are identified below.

The Accident Compensation Corporation (ACC) came into operation in 1974. It is a Crown Agent and provides comprehensive no-fault personal injury cover for all New Zealand residents and for visitors injured in New Zealand. Cover can include medical costs, compensation of up to 80% of weekly income, vocational and social rehabilitation, and death and funeral benefits (Further details on ACC are provided in Sections 3.3.1 and 5.7).

The Department of Corrections provides health-care services to prison inmates and those held in judicial custody.

The Department of Prime Minister and Cabinet (DPMC) supports the Executive, including Cabinet. Within it sit the Child Wellbeing and Poverty units, supporting the Prime Minister in her work on child poverty reduction. National Security coordination is also led from DPMC. It includes a new Implementation Unit, which tracks implementation of key initiatives (e.g. the 2019 mental health and addiction package). It also supports the integration of the government’s COVID-19 response. It currently also houses the Health Transition Unit, which is undertaking key roles in setting up the reformed health system in 2022.

The Ministry of Business, Innovation and Employment (MBIE) provides information and guidance to workplaces about occupational health and safety issues and managing hazardous substances; enforces workplace health and safety legislation; and works to reduce work-related death and injury rates. It is also responsible for the policy and investment functions for
research, science and innovation, including health research. It oversees the performance of the ACC.

The Ministry of Defence includes the provision of health-care services to Army, Navy and Air Force personnel.

The health-related activities of the Ministry of Education include tertiary training and education for doctors, nurses, dentists, and other allied health professionals.

The Ministry of Housing and Urban Development leads housing and urban development strategies, policies, and regulation. Kāinga Ora is the delivery organization, being the public landlord for government-owned housing and working with a range of agencies on issues relating to homelessness.

The Ministry of Social Development (MSD) carries out social sector policy, research, and evaluation for the government. Within MSD, the Office for Disability Issues provides policy advice on disability issues; promotes, monitors and reports on the progress of the New Zealand Disability Strategy; and ensures that the disability sector has a voice within government. Another MSD service, Work and Income, provides financial assistance and employment services for New Zealanders. Key benefits relating to health include supported living payments (for those unable to work due to ill-health or looking after a person with an illness or disability), disability support allowances, residential support subsidies (for those in residential rest home care), a winter energy payment, and a Community Services Card, which helps with some health-care costs for low- to middle-income New Zealanders.

The Ministry of Transport is the main policy advisor on transport issues. Waka Kotahi: New Zealand Transport Agency is the delivery agency responsible for transport infrastructure development and safety.

The Ministry for Primary Industries’ responsibilities cover regulatory processes related to a wide range of statutes. Those relevant to health include biosecurity regulations (encompassing pest and disease surveillance) and food policy and regulations.

The Ministry for Pacific Peoples, the Ministry for Women, and the Ministry of Youth Development (which is administered by MSD) may provide advice on health issues specific to these groups.

The Office of the Prime Minister’s Chief Science Advisor has the role of advising the Prime Minister on how science can inform good decision-making. It has played a key role in the COVID-19 response.
Sport New Zealand is a Crown Entity that promotes quality experiences in play, active recreation, and sport to improve levels of physical activity and wellbeing.

Stats NZ leads statistical data collection and integrity services for New Zealand. It oversees the collection of the five-yearly Census, along with a range of other data collections. It also hosts the Integrated Data Infrastructure, which allows data linkage across datasets.

Te Puni Kōkiri [Ministry for Māori Development] is the government’s principal adviser on Crown–Māori relationships; it also advises on policy issues affecting Māori wellbeing and development. Its primary responsibilities are to promote higher levels of achievement by Māori in education, training and employment, health, and economic resource development. It also monitors, and liaises with, other agencies that provide or have a responsibility to provide services for Māori.

The Treasury monitors and manages the financial affairs of the government and provides economic and fiscal policy advice. It provides support for ministers in balancing priorities through the Budget process and plays a role in assessing the efficiency and effectiveness of government agencies and their actions.

WorkSafe is a Crown Agent that was established in 2013 to lift health and safety performance in workplaces across New Zealand. It was established following a review into a 2009 Pike River Mine explosion, which killed 29 men. It aims to reduce injuries and deaths from workplace accidents and ill-health.

### 2.3.5 District health boards

The New Zealand Public Health and Disability Act 2000 created 21 DHBs, replacing the previous single HFA and the 23 HHS (Southland and Otago DHBs later merged into the Southern DHB in May 2010, leaving 20 DHBs). The DHBs covered geographically defined populations and were responsible for planning and funding services for their district, including PHC, secondary and tertiary health care, and aged care services. In order not to split smaller funding pools over many DHBs, and because of concerns that funding would be diverted to personal health services, funding for public health/ population health services remained the responsibility of the MoH. Similarly, funding for disability support services for those aged less than 65 years also remained the responsibility of the MoH, as a result of major concerns from the disability community that disability services would become “medicalized” if they were overseen by DHBs.
DHBs directly provided many secondary and tertiary health-care services, including community services related to secondary and tertiary care and community mental health services. They contracted provision for PHC and other community services, including aged care and mental health, from private for-profit and not-for-profit providers.

DHBs were Crown agents as defined by the Crown Entities Act 2004 (section 7(1)(a)), meaning that they were bodies established under an Act and had to implement government policy when directed by the responsible minister. DHBs were responsible to the Minister of Health for setting their strategic direction, for appointing their chief executive, and for their own performance. The DHBs were allocated resources to improve, promote and protect the health of the population within their district, and to promote the independence of people with disabilities.

DHBs (as organizations) were governed by DHB Boards, of which membership was intended to balance the need for community participation and skill mix. The local community elected seven members (at the same time as local government elections), and the Minister of Health appointed up to four members. In making appointments, the Minister considered those who can fill gaps on a board in terms of skills and experience. As such, the Minister could appoint people with financial or other experience in governing large organizations, or people from groups not represented among the elected members. At least two members of each DHB Board had to be Māori, with more members being Māori if the DHB served a large Māori community.

DHBs were expected to cooperate with adjoining districts in planning and delivering services, particularly where there were cross-DHB border issues, and where specialist services draw patients from a region larger than a single district. In addition, four “shared services agencies” undertook some collaborative work between specific DHBs (rather than replicating some functions within each DHB), including health service and funding planning, a range of information and analysis planning, and provider audits. NZ Health Partnerships, a subsidiary of all 20 DHBs, was established in 2015 to reduce DHBs’ costs through the efficient delivery of administrative, support and procurement services.

DHBs were expected to ensure that their communities can participate in board deliberations, were involved in planning, had access to information, were consulted on policies, funding, and performance outcomes, and had access to a full range of health services. DHB plans had to reflect the
health policies of the government and prudently manage assets owned by the Crown.

Under section 31 of the New Zealand Public Health and Disability Act 2000, if the Minister of Health was seriously dissatisfied with the performance of a board, the Minister could dismiss all the board’s members and replace them with a commissioner [who can, in turn, appoint up to three deputy commissioners]. The commissioner and any deputy commissioners held office only until those elected at the next election of board members take office.

DHBs were abolished as separate entities from 1 July 2022 and amalgamated into one national HNZ; the New Zealand Public Health and Disability Act 2000 was replaced by the Pae Ora (Healthy Futures) Act at the same time (see Chapter 6 for further details).

2.3.6 Primary health organizations

In February 2001, the Labour-led coalition government’s Minister of Health published the Primary Health Care Strategy (King, 2001), which outlined a new vision for PHC. PHOs were the new local structures designed to implement this new model of PHC. They were established as meso-level organizations, sitting between DHBs and PHC providers. Each PHO oversaw the provision of PHC services through its contracted providers, which are primarily GPCs. PHOs were required to be not-for-profit organizations and are expected to involve their communities in their governing processes, with all providers and practitioners involved in the organization’s decision-making.

PHOs were funded by DHBs to coordinate and oversaw the delivery of PHC services for their enrolled populations. In practice, patients enrolled with a GPC, which in turn joined a PHO. GPCs could choose whether to join a PHO, but if they chose not to join, they could not access higher levels of government subsidies to support PHC service delivery and to keep patient user charges low.

PHOs were funded by DHBs using several population-based, weighted capitation formulas. They received funding to support their management services roles, as well as funding to support service delivery. PHOs then funded GPCs, likely using the same funding formula.

In the 2000s, over 80 PHOs were established, varying considerably, particularly in relation to size, but also in relation to governance arrangements and how they saw their roles (Barnett, Smith & Cumming, 2009). Following Ministerial directions from 2009 on, the number of PHOs
fell from over 80 to 30. One DHB (South Canterbury) did not have any PHO, with the DHB fulfilling the PHO role. PHOs continued to vary widely in size and structure.

Under the 2022 reforms, PHOs will cease their formal existence within the health and disability system. However, as they play a key role in managing funding and providing support for GPCs, it is likely that they will continue to exist, albeit in a different form. Their role may be particularly important with respect to the new locality arrangements planned in the reformed system; indeed, some PHOs are playing a key role in the nine locality prototypes announced in April 2022. This is discussed later in Chapter 6.

2.3.7 Māori health services

Between 1900 and 1930, Māori were actively involved in shaping local health policies and delivering health services, with some tension between an approach based on Māori autonomy and self-determination, compared to an essentially monocultural medical model. Control was increasingly exerted by the State, however, so that the Department of Health eventually assumed full responsibility and health professionals (medical officers and district nurses) displaced Māori community leaders (Durie, 1994).

Whereas in earlier decades Māori men had led the drive for better public health, from 1931 to 1974, Māori women became more active with the establishment of the Women’s Health League (Te Rōpu o Te Ora) and the Māori Women’s Welfare League. These women liaised between a largely rural and conservative Māori society and a health sector dominated by institutions and health professionals. Māori women essentially were regarded as a support for professionals and as a community link for the mainstream health institutions (Durie, 1994). One indication of changing attitudes, however, was the repeal in 1964 of the 1907 Tohunga Suppression Act, which had forbidden traditional healers to practise.

Although slow to appreciate the links between culture and health, New Zealand began to face this issue from the late 1970s. A resurgence of interest in Māori language (te reo) and culture, combined with a reinterpretation of the Treaty of Waitangi, led to a reassessment of the values underlying health and social services. Different models for describing Māori health were debated; these took more account of cultural, social, and economic factors (Pomare et al., 1995).

In 1984, the Department of Health hosted a national conference with Māori (Hui Whakaoranga) to identify ways to address health inequities and to develop culturally relevant programmes. A Ministerial Committee was
set up as a result of the *hui* (meeting) to provide advice on Māori issues to the Department of Health, to be implemented through its Māori health resources unit (Te Wahanga Hauora Māori). The Department of Health began to incorporate Treaty principles into its management philosophy and to train its staff to respond in more culturally sensitive ways to the needs of Māori patients and their *whānau* (family). Although Māori health initiatives were under way in many Māori communities by the early 1990s, these depended on the goodwill of AHBs and were vulnerable to the sudden withdrawal of funds [Durie, 1994].

The government strategy for Māori health in the early 1990s, *Whaia te Ora mo te Iwi* [Department of Health & Ministry of Maori Development, 1993], outlined the following general policy directions:

- Greater participation by Māori people at all levels of the health and disability sector
- Priorities for resource allocation that take account of Māori needs and perspectives
- The development of culturally appropriate practices and procedures.

The restructuring of the New Zealand health system and the new purchasing arrangements in 1993 opened up more opportunities to Māori health-care providers [Ashton, 1996]. Māori community trusts were encouraged to provide services, to contract with other providers, and to develop alliances with local health and social service providers. The number of independent Māori health service providers increased tenfold from approximately 23 in 1993 to over 240 in 1998 [de Raad, 2003]. Many *iwi* (tribal) and urban-based health organizations now manage a range of health and disability services for enrolled populations, typically offering public/population health services, screening, PHC, well-child services and home support.

The New Zealand Public Health and Disability Act 2000, which established DHBs, required that DHBs:

- reduce disparities by improving the health outcomes of Māori and other population groups (section 3(1)b);
- involve Māori in decision-making and in the delivery of health and disability services (section 4);
- have Māori representation on the boards and their committees (section 29(4), 34–36);
- build the capacity of Māori to participate in the health and disability sector and to ensure that it responds to the needs of Māori (section 23(1)e).
In 2002, the government released *He Korowai Oranga: Māori Health Strategy* (King & Turia, 2002). The overall aim of the strategy was to achieve whānau ora: Māori families supported to achieve their maximum health and wellbeing. *He Korowai Oranga* has since been updated, with the overall goal of achieving “Pae Ora” – Healthy Futures, including mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments (Ministry of Health, 2020e).

To achieve the goal of “Pae Ora”, *Whakamaua: Māori Health Action Plan 2020–2025* (Ministry of Health, 2020i) sets out a range of outcomes and objectives for action. It includes key commitments to *Te Tiriti o Waitangi* and its principles, along with four main outcomes, four objectives, and eight priority areas for action.

The four main outcomes are as follows:

- *Iwi, hapū, whānau* and Māori communities exercise their own authority to improve their health.
- The health and disability system delivers more equitable outcomes for Māori.
- The health and disability system addresses racism and discrimination.
- Knowledge of the health and disability system is included and protected.

The four key objectives are as follows:

- Accelerate and spread the delivery of Kaupapa Māori and whānau-centred services.
- Shift cultural and social norms.
- Reduce health inequities and health loss for Māori.
- Strengthen system accountability settings.

The eight priority areas for action are:

- Māori–Crown partnerships.
- Māori leadership.
- Māori health and disability workforce.
- Māori health sector development.
- Cross-sector action.
- Quality and safety.
- Insights and evidence.
- Performance and accountability.
Whānau Ora has been another important initiative for Māori health. A Whānau Ora taskforce was established by the government in June 2009 to develop a whānau-centred approach to wellbeing. Following the Taskforce’s report (Taskforce for Whānau-Centred Initiatives, 2010), the 2010 Budget allocated $134 million of new funding for whānau ora over four years. Te Puni Kōkiri has the lead responsibility for the policy, supported by the ministries of Health and Social Development. The approach focuses on empowering whānau (families) as a whole (rather than individuals) to achieve their aspirations, so that whānau become self-managing, living healthy lifestyles, participating fully in society, confidently participating in te ao Māori (the Māori world), being economically secure and successfully involved in wealth creation, and living cohesive, resilient, and nurturing lives.

Since 2010, there have been two main phases of the Whānau Ora initiative. In the first phase, a Whānau Integration, Innovation and Engagement Fund was established to help whānau develop and implement plans to strengthen their connections, skills, and leadership in order to be more self-reliant; other funding supported provider capacity development; and integrated contracting and government support were established. Whānau ora navigators grew out of the initiative, supporting whānau to develop plans, assisting them in accessing services, and supporting providers to deliver whānau-centred services. In the second phase, funding was devolved to three independent Whānau Ora commissioning agencies – Te Pou Matakana (North Island), Te Pūtahitanga o Te Waipounamu (South Island) and Pasifika Futures (Pacific peoples) who work to build the capability of whanau, acting as brokers connecting whānau with initiatives to support their goals (Boulton et al., 2013; Smith et al., 2019).

The Whānau Ora initiative has been seen to be successful at improving the lives of those supported by the programme. The keys to Whānau Ora’s success have been the flexibility and responsiveness to meeting whānau priority needs (Boulton et al., 2013; Smith et al., 2019).

Rongoā Māori is a system of traditional healing practices based on ancient Māori cultural customs and beliefs, passed down through many generations, with the goal of uplifting the “mauri (life force) of the people and the land” (Mark, Chamberlain and Boulton, 2017). It takes a holistic approach to healing, focusing on wairua (spirit), hinengaro (mind), tinana (body), whānau (family), and mātauranga (education), aiming to influence all aspects of a person’s life but emphasizing the spiritual (Durie, 1998; Jones, 2000). It is a practice that has endured, in spite of being effectively outlawed through the Tohunga (Healer) Suppression Act 1907, eventually repealed in 1962.
Some Rongoā Māori is funded by the MoH, including mirimiri (massage), karakia (pastoral support) and whitiwhiti kōrero (cultural support) (Ministry of Health, 2022e). In 2017, some 15 contracts for 22 providers to a value of around $1.9 million were funded through the MoH. Other funding was through two DHBs and some PHOs, which employed traditional healers (Ahuriri-Driscoll and Boulton, 2019). Providers must meet particular standards (Ministry of Health, 2014a). It has been argued that the prescriptive nature of the standards and contracts means that many healers do not take up government funding (Mark, Boulton and Kerridge, 2019). The Waitangi Tribunal has described the level of funding as “wholly inadequate” given the burden of disease and poor health experienced by Māori and indicative of the Crown’s “lack of commitment to the idea that rongoā can make a difference” (Waitangi Tribunal, 2011).

2.3.8 Pacific peoples’ health services

Provider groups focused on Pacific peoples are traced back to the 1950s (Ministry of Health, 2003a), when there was high migration to New Zealand. A number of key welfare groups, such as PACIFICA Inc (a national organization for Pacific women) and the Pacific Health and Welfare Society were established in the 1970s (Ministry of Health, 2003a). West Auckland Pasifika Healthcare was established in 1989, followed by a number of other Pacific providers during the 1990s and 2000s. A Pacific Provider Development Fund was established by the MoH in 1998 (Ministry of Health, 2003a). The 2002 Pacific Health and Disability Action Plan set out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities (King, 2002). This plan was updated by Ala Mo‘ui, which set out the government’s priorities for Pacific people’s health in the period 2010–2014 (Minister of Health & Minister of Pacific Island Affairs, 2010). This, in turn, was further updated by Ola Manuia: The Pacific Health and Wellbeing Action Plan 2020–2025, the government’s new national plan for improving the health and wellbeing of the Pacific population in New Zealand. It is a tool for the health sector to use to inform the development of health policy and action (Ministry of Health, 2020f).

Ola Manuia (which in several Pacific languages means “living well”) sets out three high-level priority outcomes for Pacific peoples over the next five years:

- Pacific people lead independent and resilient lives.
- Pacific people live longer in good health.
- Pacific people have equitable health outcomes.

The number of Pacific providers grew from around 14 in 2002 to 39 by 2010 (Ryan, Beckford, and Fitzsimons, 2010); a 2015 report suggested there were
around 39 such providers (Allan & Clarke, 2018). Typically, they are small, not-for-profit organizations, delivering a range of PHC, health promotion and community services. Such providers have played a key role during the COVID-19 pandemic in supporting their communities.

2.3.9 Health insurance

Private health insurance companies in New Zealand insure people for complementary and supplementary services rather than providing comprehensive health cover. There is complementary coverage for services not funded by the government, such as adult dental care and optometry services. People can insure against some or all of the gaps between the government subsidy and the charges levied by providers on a range of health services (including GPC and prescription costs). Insurers also provide supplementary insurance to reimburse consumers for specialist visits and elective/planned surgery and other treatment by private hospitals and private specialists, in this way avoiding waits for specialist appointments and elective/planned surgery through the publicly funded health-care system, and having access to enhanced facilities, such as private rooms and choice of specialist.

Although a number of private health insurers provide cover in New Zealand, Southern Cross (a not-for-profit organization that owns a number of private hospitals around the country) is the largest. In 2007, it was estimated that private insurance was held by 38.4% of adults and 31.3% of children in 2006–2007 (Ministry of Health, 2008a) and it accounted for only 4.9% of total expenditure in 2009–2010 (Ministry of Health, 2012a).

The percentages of people covered has fallen in recent years, with reported private health insurance coverage falling to 34.9% of adults in 2019/2020 (1,424,000 adults). Coverage is, however, uneven, with slightly fewer women than men (34.4% vs 35.4%), older people (28.3% of 65- to 74-year-olds and 21.1% of those aged 75 years and over), Māori (22.6%), Pacific (18.9%) and those living in the most deprived neighbourhoods (17.9%) having insurance (Ministry of Health, 2022b). Private health insurance is now estimated to cover around 7.9% of total health expenditures (see Section 3.1).

2.3.10 Other

The Health Practitioners Competence Assurance Act 2003 covers 17 health profession authorities: Chiropractic Board, Dental Council, Dietitians Board, Medical Council of New Zealand, Medical Radiation Technologists Board, Medical Sciences Council of New Zealand, Midwifery Council, Nursing Council of New Zealand, Occupational Therapy Board, Optometrists and
Dispensing Opticians Board, Osteopathic Council, Paramedic Council, Pharmacy Council, Physiotherapy Board, Podiatrists Board, Psychologists Board and Psychotherapists Board. These Councils and Boards register professionals, set standards, promote education and training, and manage complaints. A range of colleges are then responsible for the training, examinations, and recertification of professionals. There are then also professional bodies that advocate on behalf of their members. Some of the main medical and nursing organizations are noted below.


The Medical Council of New Zealand’s roles include registering doctors to practise in New Zealand, setting standards for doctors’ conduct and competence, giving guidance on medical practice issues, and promoting the education and training of doctors.


The New Zealand Medical Association is the country’s pan-professional medical association and represents all disciplines within medicine, including specialists, GPs, doctors in training, and medical students. The Association is active in political and media issues concerning medical practitioners, and maintains close relationships with related health associations, New Zealand Medical Students Association, and the Medical Assurance Society. It publishes *The New Zealand Medical Journal*. In May 2022, it was announced that the Association is being disestablished.

**Council of Medical Colleges – [https://www.cmc.org.nz/](https://www.cmc.org.nz/)**

A Council of Medical Colleges supports 15 medical colleges; some are joint colleges with Australia.


The Royal New Zealand College of General Practitioners is the professional body and educational lead for GPs and rural hospital doctors in New Zealand.


General Practice New Zealand is the representative body for general practice, with membership made up of those providing general practice and other PHC services to local populations.
The Nursing Council of New Zealand is the statutory authority that governs the practice of nurses. The Council is responsible for setting and monitoring the standards of nurses to ensure public safety under the Health Practitioners Competence Assurance Act 2003.

The College of Nurses is a professional body representing New Zealand nurses of all specialities. The College provides commentary on policy issues that affect the nursing profession and publishes the journal *Nursing Praxis in Aotearoa New Zealand*.

The New Zealand Nurses Organisation is a professional and industrial organization representing nurses, midwives, students, *kaimahi hauora* (Māori health workers), health workers and allied health professionals. Services provided by the Organisation include education development, scholarships and grants, legal services, indemnity insurance, and other professional services.

Other key organizations include the following:

- Te Kaunihera o Nga Neehi Māori o Aotearoa, the National Council of Māori Nurses – [http://maorinursescouncil.nz](http://maorinursescouncil.nz)

### 2.4 Decentralization and centralization

The Minister of Health is responsible for determining national health and disability strategies and negotiating Crown Funding Agreements to fund agreed services. The MoH plans nationwide service frameworks, but since the health reforms brought about by the Act, the responsibility for purchasing...
and providing most health and disability services, guided by the national health and disability strategies, was devolved to the 20 DHBs (apart from some national services, such as disability support services for people aged under 65 years and public/population health services, which remain under the control of the MoH).

An evaluation of the 2001 health reforms found overall support for the NZPHDA model, with key strengths identified as its local focus, the ability to involve the community in decision-making and the ability to be locally responsive (Cumming, 2007). However, there were also a number of weaknesses with the model, including perceived dual accountabilities to both local communities and Central Government (albeit board members were learning to manage these), and the large number of DHBs covering the country’s small population (though forced amalgamations would not be supported).

There were also concerns about too much control and “interference” in boards’ decision-making by the Ministry and Minister of Health, and the failure to devolve public health funding and funding for disability support services for those aged under 65 years to DHBs. The researchers concluded that many informants believed that the DHBs have insufficient autonomy and would like greater devolution of decision-making, although some of those working at the Central Government level considered that some centralized decision-making is necessary to promote national consistency and ensure accountability for Central Government funding (Cumming, 2007).

Similar matters arose in relation to New Zealand’s PHOs. A key issue was the respective roles of DHBs and PHOs, which were often unclear, and whether PHOs were expected to be purchasers or providers of PHC services (Smith & Cumming, 2009a; Smith & Cumming, 2009b). The number of PHOs was also raised as an issue, given the small size of the New Zealand population; however, from a high of 80 in 2009, many PHOs amalgamated to reduce the number to 30.

Ongoing concerns over the performance of the health and disability system during the 2000s resulted in a major review of the system between 2018 and 2020. The findings from the review and the government’s response are set out in Chapter 6.

2.5 **Policy and planning**

The MoH is the lead policy advisor on health and disability services. DHBs played a major role in allocating resources, both to their own service
departments, but also to a range of other service providers with whom they had service delivery contracts, including PHOs and a range of NGOs. PHOs led the allocation of resources to PHC. Some research has explored decision-making in DHBs (Coster, 2004; Mays, Cumming & Tenbensel, 2007), with key concerns over the centralized nature of much health and disability decision-making in New Zealand (see Chapter 6).

New Zealand has had a number of arrangements in place since the 1990s to assist in setting priorities across the health sector. In the early 1990s, the government established the Core Services Committee, later the National Health Committee (NHC) to determine an explicit “core” of services that would be publicly funded (see Sections 2.1.3 and 2.1.4). However, the NHC rejected the approach of establishing an explicit list of such services and instead focused on identifying key principles for allocating resources, improving priority-setting processes for elective/planned surgery and management of waiting times, and developing guidelines to support decision-making and improve effectiveness, for a time through a not-for-profit New Zealand Guidelines Group (which ceased to exist in 2012). PHARMAC was also established during this time to prioritize and manage New Zealand’s pharmaceutical budget (see Section 5.6).

In the late 1990s, the HFA also worked on an improved priority-setting process, based around programme budgeting and marginal analysis, incorporating cost–effectiveness analyses, and considering equity, Māori health, and acceptability principles (Ashton et al., 2000).

Following on from the establishment of the DHBs in 2000, joint work by the MoH, DHBs and the NHC resulted in guidance for DHBs around decision-making and later a 2006 Service Planning and New Health Intervention Assessment (SPNIA) framework for collaborative decision-making. The framework was intended to help DHBs and the MoH assess and make service changes that required a collective decision (covering new health interventions and service reconfigurations), and to ensure that individual DHB decisions did not compromise other DHBs.

The 2009 Ministerial Review Group report found that the SPNIA framework had been difficult to implement due to its governance structure (split between the Ministry and DHBs) and lack of influence over funding decisions (Ministerial Review Group, 2009). The review group therefore recommended that a single national agency, removed from both the ministry and DHBs, be responsible for prioritizing eligibility for funding of all significant new diagnostic procedures and treatment interventions, and proposed reconfiguring the NHC to take on this role (Ministerial Review Group, 2009).
The government accepted this recommendation and the NHC was refocused in 2011 with a mandate to assess non-pharmaceutical technologies, services, models of care and programmes, applying consistent standards of assessment across the country and avoiding duplication (NHC, 2011). Assessing and prioritizing pharmaceuticals continued to be PHARMAC’s responsibility. The review group also recommended that PHARMAC become responsible for medical devices (see Section 2.8.4).

From 2012 on, the NHC was developing programme budgets to identify areas of high and fast-growing expenditures; using “mega-analyses” to focus on assessing interventions across a disease state; developing a number of levels of evidence-based analyses to suit particular decisions; establishing key criteria for decision-making; developing a specialist team to undertake analyses; and establishing international linkages to make the best use of resources in its work.

The NHC was aiming to provide advice that would result in savings of $30 million (2012–2013), $45 million (2013–2014) and $60 million (2014–2015) (NHC, 2012). However, it was abolished in 2016 and its work incorporated into the MoH.

Health technology assessment work is now spread across a number of agencies, including the MoH (e.g. the National Screening Unit provides advice on screening programmes, National Screening Unit, 2021), as well as PHARMAC in relation to medicines, vaccines and devices (see Section 5.6). Some DHBs also had more formal health technology assessment committees and/or processes, e.g. Auckland DHB (Munn, 2014).

### 2.6 Intersectorality – health initiatives outside the health-care sector

See Section 2.3.4 for the range of agencies involved in health and disability policy and services.

### 2.7 Health information management

#### 2.7.1 Information systems

See Section 4.1.4 on Information technology.

#### 2.7.2 Information management system for emergencies

See Section 1.5 on Natural and human-induced disasters.
2.8 Regulation

In New Zealand, the Central Government is responsible for the overall direction and policy-setting for health-care services and, in particular, for publicly funded services.

Governments can exert regulatory leverage over the health system in four ways: funding, legislation, administrative authority, and professional authority (Healy & Braithwaite, 2006). Regulation, narrowly defined, is the promulgation of rules, often by a specialist public agency, accompanied by mechanisms for monitoring and enforcing compliance. A broader definition uses the term to mean “governance” in the more general sense of steering the flow of events (Healy & Braithwaite, 2006). Here, the focus is on a range of governance arrangements within the New Zealand health sector, which set the rules for the way in which key health-sector activities are undertaken in New Zealand.

2.8.1 Regulation and governance of third-party payers

Under section 8 of the New Zealand Public Health and Disability Act 2000 (replaced by the Pae Ora (Healthy Futures) Act in 2022), the Minister of Health was responsible for setting out a health strategy to provide a framework for the government’s overall direction for the health sector.

The refreshed New Zealand Health Strategy (Minister of Health 2016a) is a national policy statement that sets the agenda for government action on health. It specifies eight fundamental principles, which should be reflected across the health sector.

These principles are given below:

- Acknowledge the special relationship between Māori and the Crown under the Treaty of Waitangi.
- Provide the best health and wellbeing possible for all New Zealanders throughout their lives.
- Improve the health status of those currently disadvantaged.
- Ensure collaborative health promotion and disease and injury prevention by all sectors.
- Provide timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.
- Ensure a high-performing system in which people have confidence.
- Actively involve people and communities at all levels.
- Think beyond narrow definitions of health and collaborate with others to achieve wellbeing.
Building on these principles, the MoH developed five themes to guide policy (Minister of Health 2016a):

- People-powered, such as ensuring that people understand their care and can make informed decisions
- Closer to home, such as providing care as close as possible to where people live and work
- Value and high performance, such as striving for equitable health outcomes for all New Zealanders
- One team, such as using the health and disability workforce in the most effective, flexible way
- Smart system, such as taking advantage of the opportunities of new technology.

Ensuring compliance with health legislation and regulations is a responsibility of the MoH. The Ministry is also responsible for funding services on behalf of the government and monitoring the performance of public hospitals. The Ministry has been required to report annually on the implementation of the New Zealand Health Strategy (Minister of Health, 2010).

A number of processes were used to review the performance of DHBs and hold them to account. These follow processes set for all government agencies, and included:

- Enduring letters of expectations – setting out more general expectations, including the need to engage with Māori, deliver strong performance and achieve value for money.
- Annual letters of expectations – setting out the government’s strategic priorities and specific expectations for Crown entities.
- Three-yearly statements of intent and annual statements of performance expectations – setting out each entity’s strategic intentions and medium-term undertakings, outlining how the entity’s funding will be allocated across services and determining performance targets and indicators. Entities are accountable to Parliament through these documents.
- Output agreements – which are the principal agreements between the Minister and each entity. It covers each entity’s specific agreed performance and details funding and key aspects of the Ministry’s relationship with the entity. DHBs’ Output Agreements are known as Crown Funding Agreements.
- Annual reports – setting out each entity’s performance in achieving the goals, indicators and targets contained in its Statement of Intent.
DHB funding was determined by a population-based funding formula that tries to recognize relative need fairly (see Section 3.3.3).

PHOs were the local structures for coordinating primary health-care services. The first PHOs were established in July 2002, and by the end of 2008 there were 80 PHOs around the country. DHBs worked with local communities and provider organizations to establish PHOs in their regions. The number of PHOs was reduced to 30, as a result of the government during the 2010s encouraging amalgamations to improve performance and reduce costs and duplication. A set of minimum standards applied to PHOs. They had to be not-for-profit, work with local communities, iwi and enrolled populations, and involve a wide range of providers in their governance arrangements.

A PHO performance programme that ran from 2006 until the late 2010s set key targets that PHOs had to meet. Funding for PHOs was determined by a weighted capitation-based funding formula that supported first contact services, with additional funding for services to improve access, health promotion, “Care Plus” services (for people with high health needs), and very low-cost access (VLCA) payments (to keep charges low). PHOs also received payments to fund the management services they provide. In addition to the funding GPCs received from the PHO they belonged to, GPs were free to charge patients a user charge for the services provided. However, PHOs had to notify DHBs of their providers’ standard consultation user charges and, where the DHB considered any annual increases unreasonable, they could refer them to a fee review committee to consider.

From 2013 on, each DHB was also required to establish a District Alliance, to at the very least include PHOs, and ideally a range of other providers. Alliances have, since 2016, focused on developing SLM improvement to encourage system integration. Plans were submitted and reviewed each year by the MoH (Sharma, 2021).

### 2.8.2 Regulation and governance of providers

In New Zealand, health and disability services (including medical, mental health, surgical and obstetric services, aged care facilities, and other health-related services, whether public or private) are regulated by the Health and Disability Services (Safety) Act 2001 and associated regulations. These set standards, provide for certification, and establish a framework for monitoring
of compliance. Health providers are required to demonstrate compliance with the relevant standards to gain and retain their accreditation.

### 2.8.3 Regulation and planning of human resources

Prior to 1 July 2022, within the MoH there has been a Health Workforce Directorate, a team responsible for national coordination and leadership on workforce issues in the health sector. The Health Workforce Advisory Board worked in partnership with the directorate to provide strategic oversight for the health workforce. The Board comprised representatives from the health sector, including Māori and Pacific peoples.

The Directorate advised the government on workforce development and regulation, collects workforce data and intelligence, and invests in training. It provides funding to support new graduate nurses, midwives, pharmacists, and doctors to move into the workforce, it subsidizes the cost of specialist training for doctors (general practice) and supports the postgraduate training of nurses, midwives and others. This support is designed to ensure that the health system has the right people to provide the safest care and best outcomes for the country’s population (Ministry of Health, 2022d).

The accreditation process for registered health professionals (see Section 2.3.10) is governed by the Health Practitioners Competence Assurance Act 2003. A range of responsible authorities were established under the Act to be responsible for overseeing practitioners of a particular profession or professions (see Table 2.1).

Each responsible authority must describe its profession(s) in terms of one or more scopes of practice and prescribe qualifications for every scope of practice. Health practitioners must work within their scope of practice when performing a health service that is part of their profession, although scopes of practice may overlap between different professions. Authorities also register practitioners and issue annual practising certificates. Registered practitioners must have the prescribed qualifications, be competent to practise within their scope and meet certain requirements to be fit for registration. An authority must not issue an annual practising certificate unless it is satisfied the practitioner is competent (see Section 2.9.3 regarding complaints procedures).
Table 2.1  Responsible authorities currently established under the Health Practitioners Competence Assurance Act 2003

<table>
<thead>
<tr>
<th>Profession</th>
<th>Responsible authority</th>
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<tbody>
<tr>
<td>Chiropractic</td>
<td>Chiropractic Board</td>
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<tr>
<td>Dentistry, dental hygiene, clinical dental technology, dental technology,</td>
<td>Dental Council</td>
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<td>dental therapy and oral health therapy</td>
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<tr>
<td>Dietetics</td>
<td>Dietitians Board</td>
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<tr>
<td>Medical Laboratory Science, Anaesthetic Technology</td>
<td>Medical Sciences Council of New Zealand</td>
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<tr>
<td>Medical Imaging and Radiation Therapy</td>
<td>Medical Radiation Technologists Board</td>
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<tr>
<td>Medicine</td>
<td>Medical Council of New Zealand</td>
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<tr>
<td>Midwifery</td>
<td>Midwifery Council of New Zealand</td>
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<tr>
<td>Nursing</td>
<td>Nursing Council of New Zealand</td>
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<tr>
<td>Occupational Therapy</td>
<td>Occupational Therapy Board</td>
</tr>
<tr>
<td>Optometry and optical dispensing</td>
<td>Optometrists and Dispensing Opticians Board</td>
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<tr>
<td>Osteopathy</td>
<td>Osteopathic Council</td>
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<td>Paramedics</td>
<td>Paramedic Council</td>
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<td>Pharmacy</td>
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<td>Physiotherapy</td>
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<td>Psychology</td>
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<td>Psychotherapy</td>
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2.8.4  Regulation and governance of pharmaceuticals, medical devices and aids

The New Zealand Medicines and Medical Devices Safety Authority (Medsafe) is the MoH’s business unit responsible for the regulation of therapeutic products. Medsafe administers the Medicines Act 1981 and Medicines Regulations 1984. Included in its remit is the regulation of medicines, related products, herbal remedies and controlled drugs used as medicines. Medsafe also administers a post-market system for regulating medical devices supplied in New Zealand. The objective of the medicines’ legislation is to manage the risk of avoidable harm associated with the use of medicines. The legislation is designed to ensure that:

- medicines meet acceptable standards of safety, quality and efficacy;
- personnel, premises and practices used to manufacture, store and distribute medicines comply with requirements designed to ensure that products meet acceptable standards right up till they are delivered to the end-user;
• information about the selection and safe use of medicines is provided to health professionals and consumers.

Medsafe is responsible for applying a framework of controls designed to ensure that the therapeutic products available in New Zealand are those that can be expected to maximize therapeutic benefits and minimize risks. This is achieved through the pre-marketing approval of products and post-marketing surveillance. In New Zealand, new medicines cannot be marketed without the approval of the Minister of Health (or delegate). Data that satisfactorily establish the quality, safety and efficacy of the product, for the purposes for which it is to be used, must be submitted to Medsafe for evaluation before marketing consent can be granted.

Once Medsafe approval has been granted for the marketing of a pharmaceutical, the sponsor (usually the manufacturer) may apply to PHARMAC to have it assessed for listing on the Pharmaceuticals Schedule (i.e. to receive a subsidy). While PHARMAC is not strictly a regulatory body, it is a powerful player in the health sector as it provides advice to the government on which pharmaceuticals should be subsidized and negotiates with suppliers to obtain supplies on favourable terms (see Section 5.6 for further information about Medsafe and PHARMAC).

New Zealand has a post-market system for regulating medical devices supplied in New Zealand. Medical device manufacturers are required to notify details of their medical device to a database operated by Medsafe. The Director-General of Health has the right to request information about the safety of devices and to remove products from the market for up to one year should safety concerns arise. There is no pre-market approval process for medical devices supplied in New Zealand.

2.8.5 Health technology assessment

See Section 2.5 Policy and Planning.

2.8.6 Regulation of capital investment

See Section 4.1.1 Capital stock and investments.

2.9 Patient empowerment

2.9.1 Patient information

Information is provided to patients from a wide variety of sources. The many health professionals and organizations delivering services are a major
source of information. In addition, there are a number of national sources of patient information.

The MoH provides information about various aspects of New Zealand health services on its website (http://www.health.govt.nz) along with links to other information sites. For example, there is information about a range of health conditions and their treatment, and what to do in a health emergency (see https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services).

There is a government-funded, free, 24-hour telephone service, Healthline, which provides health advice. The service is staffed by registered nurses, paramedics and health advisors. It has been providing advice on COVID-19 and COVID-19 vaccinations during the pandemic.

Disability information is available through 22 regional disability information centres, a free telephone service and a national website (see https://www.thefederation.nz/).

A large number of not-for-profit groups, usually grouped around health conditions, also exist to provide support and information to patients and, in some cases, act as advocates for patient services. Examples include the Cancer Society, the Mental Health Foundation, Health Navigator, Burnett Foundation, Alzheimers New Zealand, Plunket (for child care), IHC (which provides services to people with intellectual disabilities and their families), CCS Disability Action (a partnership organization working with disabled people) and the Disabled Persons Assembly (an umbrella organization representing people with disabilities, the organizations involved in advocacy on their behalf and service providers). Consumer New Zealand (along with other media) also has a role to play in providing health information.

2.9.2 Patient choice

Patients are free to enrol with a GPC of their choice, although this can be limited in some geographical areas where there is a shortage of key providers. In many parts of the country,GPCs may also have closed their books to new patients, similarly due to staff or funding shortages. GPCs then chose to join a PHO. Patients could be enrolled with only one PHO at a time; they would be asked to enrol when they choose to register with a particular GPC. Patients could still use other doctors or health providers but will be charged as a “casual patient” for such visits (at a higher rate than care received from the GPC they are registered with).
A recent paper using MoH administrative data showed that enrolment rates have been decreasing, from 95% in 2015 to 93% in 2018 and rising again to 94% in 2019 (Irurzun-Lopez, Jeffreys & Cumming, 2021). However, rates of enrolment vary across the population, with slightly lower overall rates of enrolment for Māori (91% vs 94% for New Zealand Europeans in 2019); young people aged 15–24 years (85% in 2019) and younger adults aged 25–44 years (91% in 2019); and those in more deprived areas (90% in the most deprived quintile, 88% in the next most deprived quintile, compared with 97% in the least deprived quintile).

Rates also varied across DHBs, compounding variations in ethnicity, age and deprivation; for example, the lowest rates were found for Māori at 74%; for young people and younger adults (67% and 74%, respectively); and for the second least deprived quartile (79%), all in Auckland DHB (Irurzun-Lopez, Jeffreys & Cumming, 2021).

A person could choose to dis-enrol from a GPC, and hence a PHO, at any time. A PHO could terminate an individual’s enrolment only if there was genuine concern that the relationship between the patient and the practitioner was severely compromised and having given appropriate notice and a reason for termination (Ministry of Health, 2018b). Enrolment could not be terminated or refused on the basis of health status, anticipated need for health care or any other form of discrimination as defined in the Human Rights Act 1993. If a PHO terminated or refused enrolment, it had to offer to help the person find another suitable provider (Ministry of Health, 2018b).

Patients have some choices relating to hospital care. Most services are provided through publicly owned providers, and intensive care and a range of other services are available only through the publicly owned services (e.g. transplants, long-term mental health care). However, within the publicly owned system, they do not usually have a choice of either specialist or hospital but will be referred by their GP to the nearest service, which will allocate appointments with the available specialists. Those who can afford to pay for private secondary care or who have health insurance will have the choice to receive services from the private sector if they wish; however, patient choice of private providers may be limited as private providers are largely located in the main centres and may not be available in provincial and rural areas.

### 2.9.3 Patient rights

The office of the Health and Disability Commissioner (HDC) was established under the Health and Disability Commissioner Act 1994, with the purpose “to promote and protect the rights of health consumers and disability services
consumers, and, to that end, to facilitate the fair, simple, speedy, and
efficient resolution of complaints relating to infringements of those rights”
(Section 6). This is achieved through the implementation of a Code of Health
and Disability Services Consumers’ Rights, which applies to all health and
disability services in New Zealand, and which carries legal force. The Code
includes 10 rights of consumers and duties of providers, as follows:

1. Right to be treated with respect
2. Right to freedom from discrimination, coercion, harassment and
   exploitation
3. Right to dignity and independence
4. Right to services of an appropriate standard
5. Right to effective communication
6. Right to be fully informed
7. Right to make an informed choice and give informed consent
8. Right to support
9. Right in respect of teaching or research
10. Right to complain.

Under right 10, providers must have complaints procedures and must
facilitate “the fair, simple, speedy, and efficient resolution of complaints”
(Health and Disability Commissioner, 2021, para. 1). Consumers may
complain directly to a provider or use the services of the Health and Disability
Commissioner, including their independent advocates.

The HDC included a Mental Health Commissioner until the establishment of
the Mental Health and Wellbeing Commission (MHWC) in February 2021. The
HDC continues to consider and assess complaints relating to mental health
and addiction services, while the MHWC oversees the transformation of the
mental health and addiction system.

An Aged Care Commissioner has recently been established to oversee the
aged care sector, to provide older people and their families/whānau with
confidence in the quality and safety of aged care services.

Consumers may also complain to health practitioners’ professional bodies.
Under the Health Practitioners Competence Assurance Act 2003, where such
complaints affect a consumer, they must be promptly referred to the Health
and Disability Commissioner (section 64). In addition, Professional Conduct
Committees can consider complaints to determine whether they are related
to competence or discipline issues, and recommend appropriate action,
which can be to review the practitioner’s competence, fitness to practise, and/or scope of practice; refer the matter to the police; or counsel the practitioner (section 80).

The Privacy Act 2020 (which replaced the Privacy Act 1993) exists to promote and protect individual privacy. The Act includes 13 information privacy principles to guide the way personal information can be collected, used, stored and disclosed. The Health Information Privacy Code sets out the specific applications of the Privacy Act to the health sector. Organizations are required to have procedures to deal with complaints about breaches of privacy, and failure to comply with the Code can result in penalties for both organizations and individuals.

2.9.4 Complaints procedures (mediation, claims)

See Section 2.9.3 above.

2.9.5 Public participation

Consumer and/or community participation in the health system occurs at a number of levels in New Zealand. For instance, at the MoH level, until recently, the Ministry’s Disability Directorate funded disability support services for people with a long-term physical, intellectual and/or sensory impairment that requires ongoing government support to enhance their health and wellbeing and advises the government on the disability policy and ensuring that disabled people receive the health-care services they need. In its decision-making, the Directorate obtained input from a consumer consortium, comprising disabled people and/or family or whānau representatives (Ministry of Health, 2022f). The MoH has had consumers involved in a number of advisory committees and for developing key strategies and action plans and involves community leaders in work based in particular communities.

The HQSC has a Partners in Care initiative to encourage the system to become more patient-centred and to take a co-design to service delivery. It has a consumer advisory group and network to support its activities, which include responding to consumers, promoting consumer–provider partnerships, and improving health literacy and building capability.

At the DHB level, consumers and/or community members could become elected or appointed board members and could be appointed by the board to serve on its mandated advisory committees (the community and public health advisory committee, disability support advisory committee and hospital advisory committee). Public voting for DHB members took place
every three years alongside local body elections. DHBs were also engaged in the HQSC programme, Partners in Care, including collating information for a health quality and safety marker. Some DHBs also had their own health consumer councils.

PHOs had to demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO was responsive to its community.

Many community-led (e.g. Māori, Pacific, disability, etc.) providers will be either community-owned and governed or will involve consumers and/or communities in their work. There are also many NGOs representing consumers in the health and disability sectors.

### 2.9.6 Patients and cross-border health care

There is no information available on the numbers of New Zealanders who might travel abroad for medical treatment, although individuals occasionally do seek care elsewhere. Some DHBs made occasional and temporary use of specific services, such as radiotherapy during a period of staff shortages. DHB specialists could also apply to the MoH Special High Cost Treatment Pool for funding of one-off treatments not otherwise funded by the public health system. This can include treatment that is available only outside New Zealand, as well as treatment offered only by private hospitals (Ministry of Health, 2021c).

All residents in New Zealand, including visitors, are eligible for ACC services if they receive an injury within New Zealand. Other publicly funded health services are restricted to New Zealand citizens, permanent residents who have lived in New Zealand for two years or more, Australian citizens and permanent residents who have intended to live or have lived in New Zealand for two years or more, people on work permits and eligible to be in New Zealand for two years or more, and some other categories, including refugees. There are also reciprocal arrangements with Australia and the United Kingdom, covering necessary care (but not PHC).

New Zealand citizens living in the Cook Islands, Niue and Tokelau who visit New Zealand are eligible for publicly funded services (Ministry of Health, 2022g). The government’s international aid and development programme funds health assistance for citizens living in the Cook Islands, Niue and Tokelau (Ministry of Foreign Relations and Trade, 2021; Adam Smith International, 2015).
3. Financing

Chapter summary

In 2020, New Zealand ranked 18th in the Organisation for Economic Co-operation and Development group of countries (OECD) for health expenditure as a percentage of GDP at 9.7% (the same as the OECD average). Health expenditure as a percentage of GDP rose from 7.5% in 2000 to 9.7% in 2000. However, New Zealand health expenditure per capita at US$ 4469 in purchasing power parity (PPP) in 2020 was below comparable countries, such as the United Kingdom (US$ 5019), Australia (US$ 5627) and Canada (US$ 5828).

New Zealand finances health care primarily through government sources (80.1% in 2020), largely through the Ministry of Health (MoH), with the balance coming from the Accident Compensation Corporation (ACC) to fund injury-related services; direct payments by service users; and private health insurance. The total appropriation for health spending in the 2021–2022 government budget was NZ$ 24 398 million, an increase of NZ$ 1167 million or 5% over actual expenditure in 2020–2021.

Most health services funding was until recently allocated to District health boards (DHBs) (66.3%), with DHBs funded through a population-based funding formula. DHBs then provided a wide range of hospital and community services themselves, as well as funding privately owned providers through service agreements for primary health care (PHC), community, rest home and home care services.

The New Zealand health and disability system provides universal access to a broad set of health and disability support services. In addition, 35% of the population holds complementary and supplementary private health insurance (representing 7.9% of total health expenditure).

Outpatient and inpatient hospital services, including maternity services, are free of charge for service users. Following the introduction of the Primary Health Care Strategy in 2001, capitation funding has replaced fee-for-service funding of general practice (GPC) services, but service users continue to pay extra billing user charges. Most adult prescriptions have a co-payment of
NZ$ 5 per item. Basic dental services are free for children and young adults to the age of 18 years; adult dental care and optometry are paid for privately. Long-term care is funded both publicly and privately.

The State-run ACC provides injury compensation through a fully comprehensive, no-fault insurance scheme. ACC is funded through employer, employee, self-employed and car-licensing levies. It also provides funding to the MoH for accident-related care costs incurred by public hospitals and pays private providers for approved treatment for accident-related care.

A mix of payment mechanisms are in place for health workers. Salaries are used to pay many workers – doctors, nurses, allied health staff, management – working for both publicly and privately owned health provider organizations (e.g. staff in DHBs, as well as staff in GPCs, pharmacies, rest homes, or working for home care providers). Medical specialists working in the privately owned sector are paid on a fee-for-service basis, while midwives are paid via a case-based arrangement per trimester of care. Owners of GPCs might be paid via a range of mechanisms, such as capitation, salary, or fee-for-service payments. Pay equity is a significant issue for the health sector, with recent settlements for care and support workers and upcoming settlements for nurses and midwives.

3.1 Health expenditure

In 2020, New Zealand ranked 18th in the Organisation for Economic Co-operation and Development (OECD) for health expenditure as a percentage of GDP, at 9.7% (the same as the OECD average) (Figure 3.1). New Zealand’s share is less than three comparable nations, Australia (10.6%), the United Kingdom (12.0%) and Canada (12.9%).

Figure 3.1 Health expenditure as a percentage of GDP in selected countries, 2020

Source: Health expenditure and financing (OECD, 2022b)
As with comparable countries, New Zealand’s health expenditure as a percentage of GDP has trended upwards since 2000 (Figure 3.2), rising from 7.5% in 2000 to 9.7% in 2020. However, New Zealand’s share began to drop markedly in the later 2010s. Although New Zealand’s share rose recently in response to the COVID-19 pandemic, the spike in spending was more pronounced in Canada and the United Kingdom.

**Figure 3.2 Health expenditure as a percentage of GDP in selected countries, 2000–2020**

New Zealand health expenditure per capita at US$ 4469 in purchasing power parity (PPP) in 2020 was below comparable countries, such as the United Kingdom (US$ 5019), Australia (US$ 5627) and Canada (US$ 5828) (Figure 3.3).

**Figure 3.3 Health expenditure as US$ PPP per capita in selected countries, 2020**

Source: Health expenditure and financing (OECD, 2022b)
The New Zealand government is a relatively large player in the county’s health sector. In 2020 the New Zealand government accounted for 80.1% of total health expenditure in the country (Figure 3.4). This was lower than the United Kingdom (82.8%), but notably higher than Canada (75.0%) and Australia (71.5%).

**Figure 3.4** Public sector health expenditure as a percentage of total health expenditure in selected countries, 2020

![Bar chart showing public sector health expenditure as a percentage of total health expenditure in selected countries, 2020.](chart)

Source: Health expenditure and financing (OECD, 2022b)

Between 2000 and 2020, real total health expenditure per capita in New Zealand rose from US$ 2108 to US$ 3890 (Table 3.1). Total health expenditure increased from 7.5% of GDP to 9.7%. While the New Zealand economy grew across most of the period in real terms, in 2020 the economy shrank by 2.1% as a result of the COVID-19 shock to the economy. The government’s share of the total expenditure on health rose from 78.0% to 80.1% and private expenditure’s share dropped accordingly from 22.0% to 19.9%.

Total appropriations for health spending in the 2021–2022 Crown [government] Budget were NZ$ 24 398 million, an increase of NZ$ 1167 million or 5.0% from actual expenditure in 2020–2021 (The Treasury, 2021). Government funding for health has increased significantly since 2019–2020 in response to the COVID-19 pandemic, with new funding to support/strengthen public/population health services, testing/tracing, Healthline, health-care providers, new medicines to treat COVID-19, and for the vaccine and vaccine programme. In addition, the government is providing initial funding in 2021–2022 to implement a new health system as part of Health and Disability System Reform, including funding a national public health delivery agency and a Māori Health Authority (MHA), as discussed elsewhere in this monograph (see Chapter 6).
Table 3.1 Trends in health expenditure in New Zealand, 2000–2020

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure (US$) PPP per capita (constant prices)</td>
<td>2108</td>
<td>2699</td>
<td>3242</td>
<td>3501</td>
<td>3890</td>
</tr>
<tr>
<td>Total health expenditure as % of GDP</td>
<td>7.5</td>
<td>8.3</td>
<td>9.6</td>
<td>9.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Mean annual real growth rate in GDP</td>
<td>4.3</td>
<td>3.2</td>
<td>1.8</td>
<td>3.7</td>
<td>-2.1</td>
</tr>
<tr>
<td>Public expenditure on health as % of total expenditure on health</td>
<td>78.0</td>
<td>79.7</td>
<td>81.2</td>
<td>79.0</td>
<td>80.1</td>
</tr>
<tr>
<td>Private expenditure on health as % of total expenditure on health</td>
<td>22.0</td>
<td>20.3</td>
<td>18.8</td>
<td>21.0</td>
<td>19.9</td>
</tr>
</tbody>
</table>

Sources: aHealth expenditure and financing (OECD, 2022b); bReal GDP, Reserve Bank of New Zealand (2022)

Details on where government health expenditure will be allocated in 2021/2022 are given in Table 3.2. The majority of funding (two thirds) would go to the 20 DHBs around the country, with approximately another quarter to health and disability services funded directly by the MoH (such as well-childcare, health promotion, and disability services for those aged under the age of 65 years). The structure of funding will change in 2022/2023 as the new public health sector model is implemented (see Chapter 6).

Table 3.2 Intended government health expenditure by service and budget category, 2021/2022

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>NZ$ million</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Board funding (including for hospital care, aged care, mental health services, primary care and pharmaceuticals)</td>
<td>16 188</td>
<td>66.3</td>
</tr>
<tr>
<td>Health and Disability Services, managed by the MoH</td>
<td>5 764</td>
<td>23.6</td>
</tr>
<tr>
<td>Capital investment</td>
<td>1 631</td>
<td>6.7</td>
</tr>
<tr>
<td>Support, oversight, governance, and development of the health and disability sectors</td>
<td>815</td>
<td>3.3</td>
</tr>
<tr>
<td>Total</td>
<td>24 398</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Vote Health (The Treasury, 2021)

3.2 Sources of revenue and financial flows

Figure 3.5 shows the sources of New Zealand’s health funding, as percentage shares, for 2020. Government funding accounted for 80.1% of total funding. The remainder came from the private sector.
Figure 3.5  Percentage of total expenditure on health according to source of revenue, 2020

![Figure 3.5](image)

Source: Health expenditure and financing (OECD, 2022b)

Historical data are presented in Table 3.3. This includes the most recent disaggregated data for private expenditure available. As the table shows, the government’s share of the funding has trended upwards, as has voluntary health insurance. The share of out-of-pocket expenses has trended down.

Table 3.3  Sources of revenue as a percentage of total health expenditure, 2000–2018

<table>
<thead>
<tr>
<th>Source</th>
<th>Year 2000</th>
<th>Year 2005</th>
<th>Year 2010</th>
<th>Year 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>General government</td>
<td>78.0</td>
<td>79.7</td>
<td>81.2</td>
<td>79.5</td>
</tr>
<tr>
<td>Out-of-pocket payments</td>
<td>15.4</td>
<td>14.1</td>
<td>12.0</td>
<td>12.9</td>
</tr>
<tr>
<td>Voluntary health insurance</td>
<td>6.6</td>
<td>6.3</td>
<td>6.9</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Source: Health expenditure and financing (OECD, 2022b)

Figure 3.6 shows the financial flows within the New Zealand health system, as at June 2022. Key points (clockwise in the document starting at 12 noon) are as follows:

- Most funding flows from the population through general taxation into the Central Government, through to the MoH. This Central Government funding is called Vote Health.
- The MoH (Vote Health) funds a range of non-DHB providers, including PHARMAC, and a range of health and disability providers. However,
most Vote Health funding was allocated to the 20 DHBs. DHBs then delivered their own services and fund a range of privately owned providers through service agreements. In July 2022 the DHBs were abolished (see Chapter 6).

- Service users pay some extra billing user charges for PHC services, with the user charge level set by the GPCs themselves; most New Zealanders would also pay NZ$ 5 per prescription item as a co-payment.

- Those living in New Zealand may also purchase private health insurance; usually, those using services directly pay providers for privately funded care and apply to the insurer for reimbursement, but in some cases the insurer will have an arrangement with a specialist or private hospital where the insurer pays the provider of the service directly; people may also pay for private care out of their own pockets.

- New Zealanders pay property rates (a local government tax), which in part funds local government agencies that provide health services, such as the provision of clean drinking water and the safe removal and disposal of household sewage and waste.

- ACC is funded through employer, employee, self-employed and car-licensing levies. ACC provides funding for accident-related care delivered by publicly owned hospitals and pays private providers for approved treatment for accident-related care.

- The government funds a range of other State agencies that provide health services, including the Ministry of Social Development (health care for veterans and for administering the Community Services Card programme), the Department of Corrections (health care for those in custody), the Ministry of Education (including training professionals such as doctors, nurses and clinical psychologists) and the Ministry of Business, Innovation and Employment (including ensuring a safe, healthy workplace for New Zealanders).
Figure 3.6  Financial flows in the health sector, June 2022

Source: Briefing to the Incoming Minister: Part B: The New Zealand Health and Disability System – handbook of organisations and responsibilities (Ministry of Health, 2020h)
3.3 Overview of the statutory financing system

3.3.1 Coverage

The New Zealand health-care system provides New Zealand citizens universal access to a broad set of health services. Several other groups are also entitled to some services. For example, under reciprocal health agreements signed with Australia and the United Kingdom, citizens are entitled to certain health services of the country they are visiting as defined in the terms and conditions of the respective Health Benefits Act. Thus, the Health Benefits (Reciprocity with Australia) Act 1999 allows Australian temporary visitors the same medical treatment as a New Zealand citizen if deemed necessary by a registered medical professional. New Zealand citizens are entitled to reciprocal health benefits in both Australia and the United Kingdom. Others entitled to care include permanent residents who have lived in New Zealand for two years or more, those on work visas of 2 years or more, children up to the age of 17 years of those eligible, some interim visa holders and students, and refugees. All those in New Zealand are covered by ACC, regardless of their immigration status, for accident-related care [Ministry of Health, 2021d].

Entitlement to free health care was originally defined through the Social Security Act 1938. However, it was not until 1947 that a tax-funded health system, delivered through both public and private systems, was made universally available to New Zealand citizens. Currently, with substantial public financing, all New Zealanders have access to extended health-care services, including PHC services, public/population health services, inpatient/outpatient medical and surgical hospital care, maternity services, mental health services, listed-prescription drugs, dental care for children and young adults aged up to 18 years, and disability support services (including home care, and residential rest home and hospital care).

Many health services are provided free of charge to service users in New Zealand. There are no charges for accident and emergency care, day patient, and outpatient care delivered through publicly owned hospitals. Co-payments were introduced for both inpatient and outpatient hospital treatment in the early 1990s but proved to be extremely unpopular. Inpatient charges were quickly dropped, and outpatient charges were removed in 1997.

Most maternity services are also free of charge; most women obtain primary maternity services through independent midwives, and have their babies delivered in hospitals. Some specialized services for non-high-risk pregnancies might be charged for (e.g. specialist obstetrician care).
Traditionally, governments have only partially subsidized PHC services in New Zealand, leaving service users to pay extra billing user charges for each visit. In the early 1940s, government subsidies covered around two thirds of total GPC fees (Department of Health, 1974); this fell to around 50% by the mid-1960s (Sutch, 1966), and the subsidy was virtually worth nothing by the early 1990s for many adults (including beneficiaries, those with chronic conditions and pensioners), with a higher rate for children and young people (Scott, Fougere & Marwick, 1986). Subsidy arrangements were changed in the early 1990s, with government funding then targeted towards those with lower incomes and/or higher needs.

The Community Services Card (CSC) was introduced in February 1992 to provide health-care subsidies for individuals on low-to-middle incomes. Additionally, a person may be eligible for the CSC if they receive income support such as sickness benefit or unemployment benefit, or if the family income is below a certain threshold.

The High-Use Health Card (HUHC) was originally introduced to assist people who were not eligible for a CSC but had ongoing health problems requiring frequent doctor’s visits (12 or more in the previous year). Funding is now rolled into the capitation rates for PHC for those enrolled with a particular GPC.

In the early 1990s, about half of the population was entitled to a subsidy card, with the subsidy for adults (then $15) covering about one third to two fifths of the average charge. At that time, the majority of adults paid the full costs of GPC services themselves (or from private insurance) (Cumming & Mays, 2011; Cumming, Mays & Gribben, 2008) as those without a CSC paid the full cost of their GPC services. Higher subsidies were introduced in 1997 for children, with a view to enabling free PHC (for standard visits) for children aged less than 6 years, although GPCs continued to be free to set their own user charge rates.

The system was changed again in 2002, when New Zealand adopted a largely capitation-based system of financing PHC and re-introduced universal subsidies for PHC (see Section 3.7.1). The extent of government financing was dependent upon factors such as age, gender, HUHC status, and rural workforce retention; as well as ethnicity and deprivation for some specific initiatives. The system has evolved over time, and now also includes additional payments to GPCs for those receiving ongoing intensive care (Care Plus), and for VLCA practices (those with 50% or more of their enrolled population who are Māori, Pacific or from low-income areas), which are then
required to keep the user charges that people pay below a certain threshold (in 2021, $0 for those aged 13 years and under; $13 for 14- to 17-year-olds; and $19.50 for those aged 18 years and over). In December 2018, CSC status was introduced into the capitation funding formula, providing higher subsidies for those with CSCs. GPCs then set the extra billing user charge levels they charge service users for each visit. The free PHC childcare arrangements have also extended over time, covering after-hours services from 2011 on; those aged under 13 years from 2015 on; and those aged under 14 years from 2018. Accordingly, standard PHC may be delivered free of charge (for many children under the age of 14 years) or partially subsidized by the government.

Currently, the CSC card is available to those are aged at least 16 years, are a New Zealand citizen or resident, and earn no more than specific annual before-tax income levels (ranging from about NZ$ 30 000 for a single person to about NZ$ 100 000 for a family of six) (Work and Income, 2022a).

The CSC can be used to offset the cost of:

- visits to a health practitioner (such as a GPC), where a person is enrolled at their practice (including for dependent children aged 14–17 years);
- ACC visits to a GPC, if the person is accidentally injured. Those eligible do not need to be enrolled at the practice;
- prescription fees;
- fees for after-hours health practitioner visits;
- glasses for those under 16 years;
- emergency dental care provided by hospitals and approved dental contractors;
- travel and accommodation for treatment at a public hospital if the person has been referred to outside their area (at least 80 km away for adults and at least 25 km for children);
- home help.

Overall, most GPC visits and prescription charges are free for children under 14 years. People with a CSC or in a VLCA GPC pay no more than $19.50 for a standard visit with a doctor or nurse. People aged 14–17 years, who have a parent or caregiver with a CSC, or who are enrolled in a VLCA GPC, are charged no more than $13. There are no caps on the user charges other people may pay, although there is a fees’ review process if user charges rise beyond an annually set figure (see Section 2.8.1).
The New Zealand Government subsidizes medicines through the State-owned PHARMAC. Pharmaceuticals are free for inpatients, and, from the mid-2000s, other people paid a maximum of NZ$ 3 per item on the pharmaceutical schedule from pharmacies; this charge rose to NZ$ 5 in January 2013, although there is no charge for children under 14 years. However, prescriptions for a non-schedule or partially subsidized medicine incur an additional charge. Once an individual or family has collected 20 new prescription items in a year, they are eligible for a pharmaceutical subsidy card and do not have to pay any more prescription charges for a year. Some evidence suggests, however, that not all those eligible for free prescriptions get their medicines free, as pharmacies do not work with a national information system and family members’ information is also not linked together well (University of Otago, 2012). In 2021, pharmaceutical sales totalled NZ$ 1777 million (OECD, 2022b).

There is publicly funded dental care available for those aged up to 18 years of age; but adult dental care is paid for by adults themselves. Adults with CSCs may be able to get emergency treatment (e.g. pain relief or extractions). Those on benefits may be entitled to welfare payments to support some dental care.

There are some services delivered by nongovernment organizations (NGOs), which may be partly funded by the government, along with donations, and sometimes user charges. For example, Plunket is a national organization delivering childcare to new mothers and their babies and is supported by both government funding and donations. Ambulances are another example, although ACC pays for accident-related services; in all but the Wellington region, the ambulances may have a user charge that service users have to pay for non-accident-related care (e.g. hospital transport).

Medical aids and prostheses are free of charge for children under 16 years. For adults over 16 years, the government fully subsidizes medical items required for employment or educational training purposes. If the medical aid or prosthesis is required as a result of injury and is deemed necessary after assessment by one of the limb centres of Peke Waihanga – Artificial Limb Service, ACC will usually cover the cost of the item. Support for those with hearing or sight issues may also be available, especially to those with these issues since childhood and/or who hold CSCs.

In terms of home care, there is a needs-assessment process that determines if people are able to receive support (e.g. for cleaning) to continue to live in their own homes as they age. Publicly funded residential rest home care has three tests. First, it is only available to those assessed to have sufficiently high needs. Second, it is available to those with assets below a certain level...
(for those aged 65 years and over, currently $236 336); others have to pay until their asset values fall beneath the maximum. Third, an income test is also applied, which determines how much a resident will pay towards the cost of their care. Rest home care is now delivered via privately owned providers, both for-profit and not-for-profit.

There is no defined list of benefits for health care in New Zealand. New Zealand government decision-making over many years has resulted in the range of services available today. Whether or not a particular service will be available in a particular location will also be determined by service facility capacity – for example, there is a formal points system for accessing elective/planned services, and the level of points needed to be eligible for publicly funded care – which has to be delivered within set timeframes – can differ across the country and change over time.

Although the New Zealand health system covers a wide range of services, there are some significant, long-standing gaps, including adult dental care, optometry services, and counselling for mental distress (although new mental health services in GPCs are currently being rolled out). At times, there may be pilots or trials or funding to support such services in some parts of the country. Some funding is available through work and income to support health-care costs (dental costs, optometry services, including glasses/lenses, or other health-care costs) for those on lower incomes and with few assets. Those with ongoing disabilities and who earn less than specified limits (e.g. just over $1000 a week for a couple) can apply for a disability allowance to help cover regular health-care costs, including counselling.

One area where there is a stronger legal framework that governs the range of services to be provided is through the ACC. Injury compensation is provided by the State-run ACC, established in 1974 under the Accident Compensation Act 1972. Through a fully comprehensive insurance compensation scheme, ACC provides no-fault insurance for accident-related injuries and disabilities. The ACC has the responsibility for establishing and operating an insurance-based scheme to rehabilitate and compensate people who suffer personal injury. To meet this responsibility, ACC directly purchases primary care, emergency transport, community and referred services, and non-urgent (elective/planned) treatment for patients directly from public and private hospitals, and ancillary services for people with injuries from accidents. Under the Accident Insurance Act 1998, ACC was briefly exposed to competition and employers were required to purchase health insurance for employees from competing insurers to cover work-related and non-work-related injuries. A change in government in 1999 quickly reversed those
legislative changes, reintroducing most of the provisions of the Accident Compensation Act.

In 2018, total ACC expenditure on health was $2171 million, which was 10% of total health expenditure (Health and Disability System Review, 2019). In addition to covering medical and rehabilitation expenses, depending on the type of injury sustained, ACC will provide an income of 80% of the injured person’s pre-injury income, as well as any specialized equipment required for daily activities.

Finally, around 35% of adults in New Zealand hold private health insurance, which supplements rather than competes with the publicly funded system. In 2018, health insurance accounted for 7.9% of total health-care expenditure (see Table 3.3).

3.3.2 Collection

New Zealand’s health-care system is financed predominantly through general taxation. In 2020, public sector financing accounted for 80.1% of total health expenditure (see Fig 3.5). All other funding was from private sources, including out-of-pocket payments and voluntary health insurance.

New Zealand citizens contribute to health-care revenue through general taxation based mainly upon pay-as-you earn income tax, corporate tax, and a Goods and Services Tax (GST, a form of value-added tax on goods and services). A portion of general taxation is allocated to the government health system budget each year. The second compulsory contribution is through the ACC, paid through a mix of taxation and levies.

Taxation in New Zealand is collected at both the central level, through the Inland Revenue Department, and at the local and regional levels by local and regional governments. New Zealand has a progressive form of income taxation, based on a four-tier system, with PAYE rates ranging from 10.5% to 39%. In addition, an ACC levy of 1.39% per $100 of income is charged with a maximum of $1820 per year (Inland Revenue Department, 2022). Local taxes are collected in the form of property taxes, known as “rates”, at the discretion of local governments. Rates are based on land valuation and capital improvements to the land and can only be collected by local or regional bodies – not the Central Government. Corporate taxation is now set at a rate of 28%. Additionally, New Zealand has GST, introduced in 1986, which was originally 12.5% but increased to 15% in October 2010.

New Zealand Government tax revenue as a percentage of GDP was 32.2% in 2020, a little under the OECD average of 33.5%. This means New Zealand was
ranked 24th out of 38 OECD countries in terms of tax as a percentage of GDP in 2020 (OECD, 2022c).

ACC receives income from five sources:

- Employers pay a premium based on their total payroll and on the relative safety/risk involved in the type of work performed – the employer’s work record also influences the premium level.
- Earners pay a premium based on their total earnings, collected as pay as you earn income tax.
- Motor vehicle owners and drivers, where the premium is included in the annual vehicle registration fee and an excise duty component on petrol sales.
- An annual government payment, using money collected through general taxation, to cover people who are not earning an income.
- Investment earnings from respective account reserves.

There are also tobacco excise taxes. The most recent figures available are that these taxes raise around NZ$ 1.5 billion each year (just under 2% of government’s consolidated fund) (Ministry of Health, 2016a), but this is not automatically returned to the health sector. There are also duties on alcohol, with around NZ$ 725 million collected in 2019 (Figure NZ, 2022).

### 3.3.3 Pooling of funds

The structure of New Zealand’s health and disability sector as at June 2022 is illustrated in Figure 2.1.

All Vote Health expenditure flows through the MoH, from where funding is divided into two key categories: departmental spending and non-departmental spending. Allocation of resources is performed by the MoH after negotiation of budget appropriations with The Treasury, and the annual budget statements from key ministers, led by the Minister of Finance. Departmental appropriations refer to those funds required for the functioning of the MoH, for example, administration and performance monitoring costs. Non-departmental appropriations are designated for the purchase of health services from providers. Figure 3.7 shows departmental operational spending (i.e. the MoH) in 2020–2021, with nearly a third of funding going on information technology; a quarter on sector leadership and services; a fifth on purchasing services directly (that is, not through the DHBs), and the remainder comprising policy advice, managing legislation, administering contracts and responding to COVID-19.
Figure 3.7  Ministry of Health’s departmental operational expenditure, 2020/2021

- Information technology and publication of data (30.5%)
- Health sector planning, incl. governance of health sector Govt entities (23.5%)
- Purchasing services for the public and health and disability sector (20.1%)
- Policy advice (9.8%)
- Implementing and enforcing health-related legislation (8.2%)
- Administering contracts (5.4%)
- Coordinating health response to Covid-19 (2.5%)

Source: Vote Health (The Treasury, 2021). Note: Total expenditure was NZ$ 349 million in 2020/2021.

Figure 3.8 shows the non-departmental operational expenditure. Three quarters of funds went through DHBs. The remaining funding was spent on services that were directly purchased by the MoH.

The boards of each DHB were responsible for planning, maintaining and managing the resources of their respective DHBs appropriately. DHBs received public funds to deliver and purchase health services for a geographically defined population. DHBs were responsible for the delivery of health services to their geographical areas through their provider arm, commonly their own hospital, or through contracts with other hospitals. DHBs also allocated funds through service agreements to providers such as PHOs, pharmacists, laboratories, other private providers, community trusts and private hospitals.

DHBs had high financial autonomy from the MoH, reserving the right to maintain cash surpluses over successive financial years. Additionally, DHBs could keep accounts with, and borrow from, private banks and markets. However, DHBs were directly responsible to the Minister of Health (through the MoH) and had to undertake priority work as set out each year in a
“letter of expectations” and meet service specifications and performance targets. At times, a portion of the received funds was also earmarked for specific services.

**Figure 3.8 Ministry of Health’s non-departmental operational expenditure, 2020/2021**

![Pie chart showing expenditure breakdown]

- DHB funding (75.7%)
- Other disability support funding (8.2%)
- Other public health funding (5.4%)
- Planned care interventions (2.5%)
- Primary health care strategy (1.7%)
- Covid-19 response (1.1%)
- Maternity services (1.1%)
- Other (4.4%)

*Source: Vote Health (The Treasury, 2021). Note: Total expenditure was NZ$ 20 284 billion in 2020/2021.*

DHBs were funded using a population-based funding formula. The following factors were taken into consideration in the formula:

- The DHBs’ share of the projected New Zealand population, weighted according to the national average cost of the health services used by different demographic groups (age, gender, ethnicity, and socioeconomic status).
- An additional policy-based weighting for unmet need that recognizes the different challenges DHBs faced in reducing disparities between population groups.
- A rural adjustment and an adjustment for overseas visitors, each of which redistributed a set amount of funding between DHBs to recognize unavoidable differences in the cost of providing certain health and disability support services.
New Zealand, like some other OECD nations, has (since 2002) largely adopted capitation as a method for allocating funds for PHC. Funding for PHOs was divided into different categories, and each capitation payment is based on the number of enrollees within different population subgroups (see Section 3.7.1).

Although PHOs were funded on a capitation basis, how they distributed funding to GPCs was up to them. Research found that most funded practices on the same basis as the PHOs received funding (i.e. via capitation), but that individual practitioners continued to be paid through a variety of means. A GPC might have had one or more GP owners as well as GPs who worked there but had not “bought into” the practice. In a survey of 99 GPCs, 82% of non-owners reportedly received their income via a fixed payment (e.g. a salary), but around a third of non-owners received at least some income based on the number of patients seen or fees earned. Among practice owners, the list size affected payments for 52% of respondents, and payments made according to patients seen (59%) and fees earned (69%) were even more prevalent for this group (note that multiple responses were possible so the totals add to over 100%) (Smith & Cumming, 2009a).

### 3.3.4 Purchasing and purchaser–provider relations

Prior to the mid-2022 reforms, the main purchasers within the New Zealand health and disability system were the MoH, DHBs, and PHOs, along with ACC. As noted earlier, all Vote Health funding flowed through the MoH, and most was distributed to DHBs, via a population-based funding formula.

Until mid-2022, the MoH contracted directly for a range of national services, including public/population health services (immunization, outbreaks of disease), some screening services, disability support services for those aged under 65 years, well-childcare, ambulances, maternity care (midwives), Māori health services, and postgraduate education and training. Many contracts were renegotiated with the same providers year after year. The MoH could contract selectively for some services (e.g. specific initiatives such as the current Healthy Families initiative).

DHBs provided a wide range of services themselves, but they also contracted for a range of PHC and community services, from both for-profit and not-for-profit providers. Such contracts would include those for PHOs, as the funding flowed through DHBs, although there was a national contract governing PHO funding, as well as for home care and residential rest home services, and services from NGOs, e.g. community mental health services for those with serious mental health distress. As with the MoH, many contracts were renegotiated with the same providers year after year, but DHBs could also selectively contract. For example, they might have contracted out some
elective/planned services to privately owned hospitals to ensure that they 
meet set targets each year.

PHOs received their funding from DHBs on the basis of a nationally agreed 
contract, but in turn had back-to-back contracts with GPCs.

ACC is also engaged as significant purchaser of health-care services. 
It provides funding to Vote Health for accident-related services through 
publicly owned providers, but also contracts for a wide range of services 
from, for example, physiotherapists, and privately owned hospitals (so as 
to deliver timely care and reduce the time off work people might otherwise 
have as a result of injury; with ACC paying income compensation, it is to 
their advantage to contract for faster delivery of care through privately 
owned hospitals).

3.4 Out-of-pocket payments

3.4.1 Cost-sharing (user charges)

Public funding covers PHC visits, prescription drugs, maternity services, 
specialist consultations and hospital care. However, out-of-pocket payments 
(payment at the time of care) are still required, for example, in filling 
prescriptions and health care provided in PHC settings by GPCs. These out- 
of-pocket payments are set by GPCs themselves and vary by age and location, 
and according to whether or not the GPC accepts VLCA or CSC funding, 
which pays a higher capitation rate but requires user charges to not exceed a 
particular limit [see Section 3.3.1].

Private out-of-pocket payments provided 15.4% of total health financing in 
2000, declining after that as the funding from implementation of the Primary 
Health Care Strategy led to reductions in co-payments (OECD, 2022b). In 
2018, out-of-pocket expenses accounted for 12.9% of total health sources of 
funding (OECD, 2022b). The major components of out-of-pocket payments 
are aged care (27%), pharmaceuticals (24%) and oral health (22%) (Health 
and Disability System Review, 2019). Since the introduction of capitation 
and additional funding under the Primary Health Care Strategy, extra billing 
user charges for GPC visits for many people initially fell (Cumming and 
Gribben, 2007). They have, however, crept back up slowly over time: one 
comparative analysis showing them at $24 in 1996/1997, $35 in 2002/2003 
and in 2006/2007, $38 in 2022/2012 and reaching median user charge of $39 
in 2016/2017 (Jeffreys et al., 2020) [see also Chapter 6].

Private health insurance companies commonly reimburse the majority of 
costs for those people that include such coverage in their policies; if the
patient has an excess associated with their policy, the insurer bears most of the cost, but a portion is still contributed by the patient.

Public hospital accident and emergency, medical and surgical services are provided free of charge, leaving PHC as the major setting for out-of-pocket payments.

Older people in residential nursing care may be eligible for a means-tested subsidy; those with assets over a particular level will pay for care themselves until their asset values fall below the relevant maximum (see Section 5.8.2).

Details of user charges for health services are summarized in Table 3.4.

Table 3.4  User charges for health services, 2022

<table>
<thead>
<tr>
<th>Health service</th>
<th>Type of user charge</th>
<th>Exemptions and/or reduced rates</th>
<th>Cap on</th>
<th>Other protections</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPC visit/PHC</td>
<td>Extra billing</td>
<td>Children under 14 years (free care); HUHC; VLCA; CSC</td>
<td>VLCA and CSC</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient specialist visit</td>
<td>None</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
</tr>
<tr>
<td>Outpatient prescription</td>
<td>None</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
</tr>
<tr>
<td>Medicines</td>
<td>Co-payment</td>
<td>Children under 14 years; Prescription subsidy card holders (20+ items per annum for a family)</td>
<td>$5 per item</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient stay</td>
<td>None</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
</tr>
<tr>
<td>Dental care</td>
<td>Full cost for adults, no charge &lt;18 years</td>
<td>Not app</td>
<td>Not app</td>
<td>Some emergency care for adults is free in DHBs</td>
</tr>
</tbody>
</table>

HUHC= high-use health card, VLCA= very low-cost access, CSC= community services card
Source: Author

3.4.2  Direct payments

Those living in New Zealand pay directly for a number of health-related items not discussed above, such as over-the-counter medicines, and elective/planned services delivered in a private hospital.
3.4.3 Informal payments
Informal payments are not known to be an issue in New Zealand.

3.5 Voluntary health insurance
Private health insurance is configured to both complement and supplement the well-established publicly funded system rather than directly substituting for services supplied through government-funded programmes and agencies. Thus, it provides complementary services – cover for services largely excluded from public funding (e.g. adult dental care, optometry services); complementary cover – for user charges for PHC; and supplementary services – offering faster access to services and enhanced facilities.

Under section 48 of New Zealand’s Human Rights Act 1993, an exception allows discrimination regarding the insurance’s terms and conditions on the grounds of sex, disability, and age. Such discrimination must be based on actuarial or statistical data (upon which it is reasonable to rely, relating to life expectancy, accidents or sickness) or, where no such data are available in respect of persons with a disability, reputable medical or actuarial advice or opinion, upon which it is reasonable to rely.

In addition, life insurance companies offer lump sum payments to cover medical expenses for people diagnosed with a terminal illness or disability.

3.5.1 Market role and size
Given its limited role in New Zealand, private health insurance accounts for only 7.9% of total health-care expenditure (2018 figures, the most recent available), which is broadly in line with other OECD countries (Health and Disability System Review, 2019). Nevertheless, the trend has been upwards since 2000, when health insurance accounted for 6.6% of total health expenditure (see Table 3.3).

Two main types of health insurance are offered in New Zealand: comprehensive policies that cover both PHC user charges and hospital services, and hospital-only policies that cover specialist and hospital care. Within these two broad types of policies, New Zealanders can choose which specific services they want coverage, e.g. dental care, optician services and glasses/contact lenses, physiotherapy, nutrition, hearing tests, and clinical psychology consultations.

Packages also differ in the proportion of co-insurance costs (e.g. 10%, 20%) those insured pay for themselves, the maximum schedule fee for a particular service, and the annual total reimbursements they are covered for. Those
insured can also agree to pay an “excess” or deductible, e.g. the first $100 from each claim, to reduce premiums.

Health insurance membership has been trending downwards (see Figure 3.9). Coverage was at a high of nearly 50% in 1990 (OECD & ILIS, 2009), and then fell as tax deductions were removed and a fringe benefit tax began to apply where employers offered coverage.

The proportion of the population covered by private health insurance, which varies considerably by age group and income, was 34.7% of New Zealand adults in 2021. Coverage is uneven, with a lower percentage of older people (27.3% of 65- to 74-year-olds and 15.8% of those aged 75 years and over), Māori (21.7%), Pacific (18.3%) and those living in the most deprived neighbourhoods (18%) having insurance (Ministry of Health, 2022b).

Unlike other countries such as the United States of America, most private health insurance in New Zealand is sold on an individual basis, although employers are encouraged to offer insurance to their employees, usually with a discount available to acknowledge that membership is being obtained through a group. But unlike other countries, packages are not tailored for individual employers.

**Figure 3.9** Percentage of adults with private health insurance cover, 2012–2021

*Source: New Zealand Health Survey (Ministry of Health, 2022b)*
3.5.2 Market structure

New Zealand’s private health insurance industry is dominated by one major player: Southern Cross Health Insurance, which has 62% of the market (Southern Cross Medical Care Society, 2021). The Financial Services Council, a professional association which represents, among others, health insurers, lists five health insurers.

Southern Cross also has a separate Health Trust, which runs hospitals, travel insurance and, increasingly, PHC clinics, usually with discounts available for medical care society members.

3.5.3 Market conduct

See Section 3.5.4 – Public regulation of voluntary health insurance.

3.5.4 Public regulation of voluntary health insurance

There is no specific health-policy-related government regulation of private health insurance in New Zealand. General regulation for insurers as businesses and in relation to health and disability consumer rights apply, but, unlike other countries (such as Australia, Canada or the United States of America), New Zealand does not regulate acceptance of members, premiums, premium increases or insurance packages. There are human rights rules that allow health insurers to charge varying premiums based on, for example, age and gender, but only if the differences are reasonable and are justified based on actuarial data.

In the past, health insurance premiums were tax deductible, but this is no longer the case. The industry regularly lobbies government for rebates, on the grounds that health insurance coverage is declining, and that the government faces increased costs as a result (i.e. where people no longer have insurance coverage and instead obtain care through public funding). The Treasury has rejected the call for such rebates, in part due to concerns over the deadweight losses that would occur (i.e. providing rebates for those who would choose to have insurance anyway), the potential for health insurers to capture increased profits, the uncertainty over the extent to which increased health insurance enrolment actually does reduce public sector costs, as well as gaps in the case put forward by the industry (The Treasury, 2004).

It is recognized that the public sector picks up the costs of, for example, laboratory and radiology tests undertaken for those who are receiving related private services paid for by their health insurance. Research has shown that those with private health insurance use more PHC and specialist services than those without such insurance. It has also been shown not to reduce the
probability of using public hospital services but does seem to reduce use of outpatient services. It was estimated that the public sector was therefore paying an extra $40–$100 million annually in additional services delivered as a result of private health insurance in New Zealand (Blumberg, 2006).

The industry continues to lobby for support, such as via subsidies or compulsory enrolment in health insurance (see, for instance, New Zealand Institute of Economic Research, 2014).

With little public regulation of the industry, private health insurers set their own terms and conditions around insurance policies and premiums. They may reject patients and many policies exclude pre-existing conditions for at least several years, if not forever. In previous years, particular premiums applied for large age ranges (e.g. children, young people, adults, those 65 years and over), but there has been an increasing trend for premiums to be set within smaller age bands, and for those in the older age group to face significant premium increases, as the market for insurance has become more competitive.

3.6 Other financing
There are no other significant sources of funding for health.

3.7 Payment mechanisms

3.7.1 Paying for health services
New Zealand has universal, though not full, PHC funding. Prior to the Primary Health Care Strategy and the development of PHOs, GPCs were part-funded by the government largely on a fee-for-service part-subsidy basis, and they charged people an additional extra billing user charge. Although GPs see the government subsidy as accruing to the service user, the system was set up so that the service users pay only the extra billing amount to the GPC and the GPC claims the government subsidy from the government.

Originally set up in the 1940s, until the early 1990s, the universal government subsidy generally failed to keep pace with rising GP fees and, as GPs have always had the right to set their own user charges, New Zealanders had been paying an ever-increasing proportion of the GP fees themselves. In the early 1990s, the low universal subsidy was replaced with targeted subsidies for those with CSCs, and those without CSCs paid the full GP fee. This system continued until the introduction of the Primary Health Care Strategy; in 2002, government subsidies for PHC increased and once again became universal (see Section 3.3.1).
The population health focus of the Primary Health Care Strategy saw a shift away from a government fee-for-service subsidy to a capitated model of funding, with PHC funding now allocated through PHOs. There were originally three main public funding streams for primary care: first level services; services to improve access (SIA); and health promotion.

First level services have a capitation-based formula that provided the bulk of PHO funding. It funded PHOs to provide or purchase first-contact services, such as GP or practice nurse consultations for enrolled populations. PHOs were originally funded at two levels. “Access” PHOs or GPCs, defined as those serving high-needs populations (more than 50% of their enrolled population were Māori, Pacific Islanders or people living in the most deprived areas), received higher subsidies for all those enrolled. In 2002, Access PHOs’ entire enrolled populations started being capitation funded. Capitation funding for interim PHOs’ enrolled population was progressively rolled out between 2003 and 2007 for successive age groups. By July 2007, all eligible New Zealanders were covered by capitation funding subsidies, provided they were enrolled with a PHO. First level funding is passed on to GPCs by the PHOs.

Those not enrolled in a PHO were not eligible for the new, higher levels of government funding for PHC. However, they were eligible for some funding if they held a CSC or HUHC. Similar arrangements held for those receiving services outside of the practice they are enrolled with.

SIA funding was available for all PHOs to reduce inequities for those populations that were known to have the worst health status: Māori, Pacific people and those living in New Zealand Deprivation index (NZDep) 9 to 10 decile areas. SIA funding was for new services or improved access to existing services, and is paid on a capitation basis, with the highest rates for those who are Māori and Pacific and who live in NZDep 9/10 areas.

Health promotion funding was paid for health promotion activities carried out by PHOs, and was also paid on a capitation basis, again with the highest rates for those who are Māori and Pacific and who live in NZDep 9/10 areas. Both were additional to the main PHO capitation funding for FL services.

SIA and health promotion funding was paid to PHOs, who had to then work with DHBs to develop a plan for the use of the funding. Some funding could be held by PHOs if they themselves delivered particular services; other funding had to be passed on to GPCs for the services they provide.
There was additional capitation funding, which was not weighted for high-needs groups:

- For rural workforce retention, from 2002 (weighted by a rural ranking score).
- In the form of Care Plus, which became available in 2004, to support those with long-term conditions (a single capitation amount for up to 5% of a practice’s population, designed to replace the HUHC).
- For PHO management services.

There was also a VLCA scheme, introduced in 2006, whereby participating practices received additional funding in return for a cap on the level of user charges. Originally, this was available to any GPC that signed up, but in 2009, the rules were changed and the only new GPCs that could join were those with 50% or more of their populations being high need (i.e. Māori, Pacific, or NZDep 9/10). The 2021 maximum charge for an enrolled child and young person 0–13 years was NZ$ 0; for a young adult 14–17 years NZ$ 13; and for an adult NZ$ 19.50. Capitation rates differ by age and by the holding of a CSC.

In addition to the capitation funding, GPCs retain the right to charge a patient an extra billing user charge. In general, funders have had limited control over PHC user charges for enrolled patients. As new funding was rolled out in the 2000s, the government became concerned that not all the new funding was being used to reduce user charges and they set out a framework requiring a certain proportion of the new funding to be used to reduce co-payments (Cumming & Mays, 2011). This has now developed into a process where annual acceptable increases in PHC user charges are determined by an independent body (based on increasing costs and increases in the capitation payments from government), with publicly owned health providers able to refer GPCs to an Independent Fee Review Committee if the increases go beyond the annual acceptable increase. Thus, the roll out of PHO capitation did create some oversight over charges for standard consultations during normal business hours. The annual statement of allowable user charges increases guides how much practices can increase their standard consultation user charges.

New Zealanders are required to pay a co-payment of NZ$ 5 for each prescribed item that is on the pharmaceutical schedule. Prescriptions for children under 14 years are free. Once a service user and/or their family have collected 20 prescription items in a year, they should receive a Pharmaceutical Subsidy Card, entitling them to free prescriptions for the remainder of the year (see Section 3.3.1).
DHBs were not only responsible for funding and ensuring the provision of PHC services but were also directly manage public hospitals. There had sometimes been a separation in the purchasing/funding and provision roles within the DHB [with hospitals called the “provider arm” of the DHB]. Publicly owned hospitals provide comprehensive free-of-charge health services. DHBs were funded via a global budget, using a series of complex weighted population-based funding formulas that vary across services (Penno et al., 2012). Many individual hospital services were paid using a case- and complexity-based diagnostic-related group approach. Specialist mental health services were publicly funded, with each DHB required to ring-fence a portion of their appropriated funds for the delivery of such services, and the amounts increased each year to account for population and cost growth.

Long-term care in New Zealand is funded publicly for those who meet both needs and asset tests. Payments are made on a fee-for-service basis, according to the level of care being provided. Service users pay a contribution towards these costs depending on their income. Publicly owned health providers are responsible for purchasing the publicly funded services from privately owned providers.

As in most OECD countries, the privately owned sector dominates the delivery of dental care services. In 2021, it was estimated that total expenditure on dental care was NZ$ 1.1 billion, of which 91% was paid out of pocket. The remaining 9% was public financing, mainly through school-based dental services (3 News, 2020).

### 3.7.2 Paying health workers

In New Zealand, hospital physicians are salaried when working in the publicly financed health-care system. They charge on a fee-for-service basis when working in private practice. Specialist physicians commonly devote their services to both publicly financed and privately financed services (including privately owned) hospitals, and therefore can receive both modes of income. Accordingly, physicians’ remuneration depends on both speciality and mode of employment. Physicians working for a publicly owned health provider usually earn between NZ$ 155 000 and NZ$ 219 000 per year. Those working in the private sector earn more, with the best paid earning up to NZ$ 600 000 per year (Careers, 2022a).

As shown earlier, GPCs are funded by government on a capitation basis, along with fee-for-service user charges. GPCs can be owned by GPs themselves but are increasingly corporately owned. Qualified GPs can earn
between NZ$ 145 000 and NZ$ 210 000 a year. Senior GPs and those who own private practices can earn more than NZ$ 200 000 a year (Careers, 2022b).

Most nurses are paid on a salaried basis, whether working in hospitals, PHC or in residential rest homes. With respect to hospital nurses’ remuneration, the annual income of a graduate registered nurse working at a publicly owned health provider is about NZ$ 60 000 a year. Registered nurses with three to seven years’ experience usually earn NZ$ 68 000 to NZ$ 83 000 per year. Senior registered nurses with more experience and responsibility usually earn NZ$ 85 000 to NZ$ 136 000 per year (Careers, 2022c). PHC nursing salaries have typically been lower than those in hospitals, and the conditions of employment are not as generous (e.g. with respect to study leave).

New midwives employed on salaries by publicly owned health providers usually begin their careers at NZ$ 65 000 a year, whereas midwives with up to five years’ experience usually earn NZ$ 69 000 to NZ$ 84 000, and senior midwives can earn NZ$ 87 000 to NZ$ 138 000. Self-employed midwives, paid under a case-payment arrangement per trimester of care, by contrast, usually earn $80 000 or more (Careers, 2022d).

The government is currently engaged in ensuring that there is pay equity for women. Previous settlements in 2017 were established for care and support workers, and a nursing settlement for around 40 000 public sector nurses is nearing conclusion (Ministry of Health, 2022h; New Zealand Nurses Organisation, 2021). Negotiations have also begun for a settlement with midwives (TAS, 2021).

Dentists’ income depends on their experience, where they work, and the size and location of their practice. Dentists can earn between NZ$ 114 000 and NZ$ 254 000 a year (Careers, 2022e). Dental assistants can earn NZ$ 46 000 to NZ$ 61 000, depending on experience (Careers, 2022f).

The level of pay for pharmacists depends on experience and level of responsibility. Pharmacy interns (that is, graduates completing their registration year) usually earn an average of NZ$ 43 000 a year. After that, staff pharmacists can earn an average of NZ$ 82 000. Finally, charge pharmacists (that is to say, those who manage a pharmacy) can earn an average of NZ$ 86 000 (Careers, 2022g).

By way of comparison, the median annual salary in New Zealand in 2022 was about NZ$ 62 000 (Stats NZ, 2022c).
Table 3.5 below summarizes the payment mechanisms in place in 2022.

**Table 3.5 Provider payment mechanisms, 2022**

<table>
<thead>
<tr>
<th>Service</th>
<th>Ministry of Health</th>
<th>Other ministries</th>
<th>Local health authority</th>
<th>Private/voluntary health insurers</th>
<th>Cost-sharing</th>
<th>Direct payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>-</td>
<td>FFS</td>
<td>C</td>
<td>-</td>
<td>FFS</td>
<td>-</td>
</tr>
<tr>
<td>Ambulatory specialists</td>
<td>-</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td>Hospitals</td>
<td>DRG</td>
<td>B</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>DRG</td>
<td>B</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dentists</td>
<td>FFS</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>FFS</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>-</td>
<td>-</td>
<td>FFS</td>
<td>-</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td>Public health services</td>
<td>-</td>
<td>-</td>
<td>S</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social care</td>
<td>-</td>
<td>-</td>
<td>PD</td>
<td>FFS</td>
<td>FFS</td>
<td></td>
</tr>
</tbody>
</table>

Notes: B=budget, FFS=fee-for-service, C=capitation, DRG=diagnostic-related group, PD=per diem, S=salary

Source: Author.
4. Physical and human resources

Chapter summary

In 2018, the Ministry of Health (MoH) concluded that district health boards (DHBs) operated with an accumulated underinvestment in assets and that many believed DHBs’ assets to be in a poor condition and not fit for purpose. The same year, the Minister of Health announced the government’s intention to address the poor state of health infrastructure in the country.

All DHBs had to maintain an asset management plan and report annually on capital intentions through the District Annual Planning process. Prioritizing capital funding and investment in the health sector and advising the ministers of health and finance on these matters was the role of the Capital Investment Committee (CIC), a part of the MoH.

Overall, acute care hospital bed capacity has been reduced in recent years and average lengths of stay have been falling over time. Medical equipment and devices are regulated for use in New Zealand. DHBs could make decisions regarding purchasing capital assets, up to set limits.

In 2021, New Zealand had 16.62 magnetic resonance imaging (MRI) units per million population and 44.99 computer tomography (CT) scanners per million population. Compared to Australia, the one comparable country for which data are available, New Zealand’s MRI rate is a little higher than that of Australia, but far lower for CT scanners.

New Zealand hospitals have multiple information technology (IT) systems, and general practices (GPCs) are also highly computerized. Electronic messaging is extensively used, including for sending referrals, payment claims, laboratory and pathology results, and hospital discharge summaries. E-prescribing has increased significantly in recent years and grew further during the COVID-19 pandemic. There are, however, significant issues with digital and data systems and information, which have been slow to be rectified. Infrastructure planning of IT in early 2022 is a role of the MoH.

New Zealand’s health and disability sector employs around 220,000 people, or 8.5% of the total workforce. It is the largest sector employer in the country. Just over a third have until recently been employed in DHBs, with DHBs
often the largest employers in their region. Clinical staff, employed directly in caring for people, make up 66% of the workforce. Personal carers and assistants (at 23% of the workforce), nurses and midwives (at 21%) are the largest groups of workers. There are over 30 000 allied health workers across at least 43 groups delivering care.

In 2021, there were 3.53 physicians, 10.91 nurses, 0.56 midwives, 0.52 dentists, 0.72 pharmacists and 1.14 physiotherapists per 1000 population. New Zealand has a relatively high proportion of migrant doctors and nurses. In 2020, 42.4% of New Zealand’s doctors and 28.6% of its nurses were foreign-trained. The rate at which New Zealand-trained doctors move overseas has reduced in recent years – of late, all New Zealand-trained doctors have remained in the country two years after graduating and 93% five years after graduating.

Gender representation in the health workforce varies significantly depending on the profession. Over 90% of nurses are women and a little under half of doctors are women. However, by 2025, it is expected that the majority of doctors will be women. Māori and Pacific people are markedly underrepresented among health professionals.

There are two universities that train doctors (a six-year undergraduate course). Registered nurses are trained in three-year tertiary-level courses that are offered in both universities and technical institutes (now a single national institute). Nurse practitioners undertake advanced training and may have prescribing rights within their specialist field. New Zealand also has “enrolled” nurses who undergo an 18-month training programme and must practise under the direction and delegation of a registered nurse or nurse practitioner. Midwives have a separate four-year equivalent, pre-registration Bachelor of Midwifery programme, which can be completed over three years and is available in five centres in both universities and the national skills institute Te Pūkenga. Dentists complete five years of training; pharmacists and physiotherapists four years each.

4.1 Physical resources

4.1.1 Capital stock and investments

4.1.1.1 Current capital stock

In 2018, the Ministry of Health (MoH) concluded that district health boards (DHBs) operated with an accumulated underinvestment in assets and that many believed DHBs’ assets to be in a poor condition and not fit for purpose. Work through 2018/2019 indicated investments of $14 billion for buildings and infrastructure and $2 billion for information technology (IT) were needed
over the next 10 years. The same year, the Minister of Health announced the government’s intention to address the poor state of health infrastructure, beginning with a national stocktaking of selected DHB assets (Ministry of Health, 2020j).

Publicly owned tertiary level-hospitals in New Zealand are located in Auckland City (the largest in New Zealand, providing highly specialized care as well as tertiary and secondary care services), South Auckland, Hamilton, Wellington, Christchurch and Dunedin; with other secondary hospitals in Kaitaia, Whangarei, North Shore, Waitakere, Tauranga, Rotorua, Whakatane, Hawke’s Bay, Taranaki, Gisborne, Whanganui, Palmerston North, Wairarapa, Hutt Valley, Nelson, Blenheim, Ashburton, Timaru, Southland and the West Coast. Some health centres in smaller communities may also have subacute units and health centres delivering, for example, day patient or maternity care services (Ministry of Health, 2020j). A map is provided at Ministry of Health (2022i).

4.1.1.2 Investment funding

After 2009, all DHBs were required to maintain an asset management plan and to report annually on capital intentions through the District Annual Planning process. DHBs were also required to work regionally and include capital planning in their regional strategic plan. DHBs’ business cases were expected to include a regional perspective and regional support.

As of 2017, all DHBs had to produce long-term investment plans. Asset management planning involved a review of current assets and the financial burden of a proposed project, and medium- and long-term asset assessments. All projects required a business case, a standalone document that assumed the reader had no prior knowledge of the proposed project. All business cases had to comply with The Treasury’s Better Business Case Process (The Treasury, 2022a).

DHBs could make decisions regarding the purchase of capital assets, up to set limits. Projects requiring significant investment required ministerial support. The approval of both the Minister of Health and the Minister of Finance were required for all capital investments that required new Crown equity, as did investment in projects that total more than $10 million (The Treasury, 2018).

Prioritizing capital funding and investment in the health sector and advising the ministers of Health and Finance on these matters is now the role of the CIC, a part of the MoH. CIC uses a set of criteria to assess and prioritize proposals (Ministry of Health, 2021e).
4.1.2 Infrastructure

The MoH and publicly owned health providers are responsible for most publicly owned health infrastructure costs, within their annual budget provided by the government. Many providers will raise some funds from donations to pay for special equipment and, although rarely, major buildings (e.g., the new Children’s Hospital in Wellington had a significant sum provided by one donor). Privately owned hospitals and privately owned health-care facilities are responsible for maintaining their own infrastructure. Both publicly and privately owned hospitals and health clinics are bound by identical legislation.

Publicly and privately owned hospitals, rest homes, residential disability care facilities and fertility providers must provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001. Certification of these organizations is overseen by HealthCERT, a division of the MoH. HealthCERT administers and enforces relevant legislation, reviews audit reports and manages legal issues relating to health-care providers. Standards are based on the Health and Disability Sector Standards and the Ngā Paerewa Health and Disability Services Standard [Ministry of Health, 2022j]. Medical equipment licensing is overseen by Medsafe.

New Zealand has reduced its overall bed capacity over the past few decades. One reason for this reduction in overall hospital beds was the shift of long-stay cases out of hospitals into either nursing homes or to treatment or care in the community. This applies particularly to population groups such as dependent older people, people with mental health distress, and those with physical or intellectual disabilities. A second reason is the push for greater cost-effectiveness in hospitals and hence shorter hospital stays and higher occupancy rates. A third reason is changes in patient management and treatment methods. A fourth reason is a focus on enhancing PHC services with a view to keeping people out of hospital [see Chapter 6].

Figure 4.1 shows the number of acute care beds, psychiatric beds and long-term care beds per 1000 population, 2009–2019 (the most recent comparable data available). Acute care hospitals dominate the mix, with well over 2 beds per 1000 people across the period. Psychiatric beds, while a much lower rate, have increased somewhat of late, rising from 0.14 beds per 1000 at the start of the period to around 0.3 by the end. Data on long-term care beds only goes back to 2014 and has remained static across the period, at around 0.03 beds. (If we consider solely the population aged 65 years and over, the rate of long-term care beds for the period is around 0.2 per 1000 each year.)
Figure 4.1  Mix of beds per 1000 population, 2009–2019

Source: Organisation for Economic Co-operation and Development (OECD) Health data (OECD, 2022b). Note that there are no data for long-term care before 2014.

Figure 4.2 presents the average number of days in hospital for all causes, 2010–2018 (the most recent data available). New Zealand data are presented alongside data for three comparable countries. From 2001, New Zealand had the longest average stay, peaking at 10.5 days in 2006. Since then, New Zealand’s average stay has trended down and was overtaken by Canada in 2014. In 2018 New Zealand’s average number of days in hospital was 6.7.

Figure 4.2  Average number of days in hospital in selected countries, 2000–2018

Source: OECD Health data (2022b). Note that one data point has been estimated – United Kingdom 2017.

Figure 4.3 shows the number of beds in acute hospitals per 1000 population, 2009–2019 (most recent figures available). The only comparable figures
available are for Canada since 2009. Across the period, New Zealand had a notably higher rate of acute beds than Canada, with 2.41 beds per 1000 in 2009, rising to a high of 2.83 in 2012. Since then, the rate has decreased appreciably, with New Zealand having 2.55 beds per 1000 population in 2019.

**Figure 4.3 Beds in acute hospitals per 1000 population in selected countries, 2009–2019**

![Chart showing beds per 1000 population in selected countries from 2009 to 2019 for Canada and New Zealand.]

**Source:** OECD Health data (2022b)

### 4.1.3 Medical equipment

DHBs were responsible for purchasing public hospital consumables, including new medical equipment. In 2004, the National Health Committee reviewed DHB decision-making about new health interventions (NHC, 2005, 2006). They found a complex decision-making environment, including political factors, funding constraints, risk minimization and the sub-specialization of medicine. Hospitals had a variety of decision-making processes, with strong clinical input but often poorly related to prioritization processes.

In the 2009 Ministerial Review Group report, it was recommended that PHARMAC expand its work to include prioritization of medical devices, and this is now part of PHARMAC’s work programme (PHARMAC, 2011). The devices PHARMAC now funds include interventional cardiology items (such as stents and catheters), beds and mattresses (including birthing beds and paediatric beds) and respiratory products (such as flow meters and breathing filters). A range of new products is under consideration, including for audiology and ophthalmology (PHARMAC, 2022).

Privately owned hospitals are free to purchase any medical equipment they require, as long as the equipment meets regulatory approval.
In 2021, New Zealand had 16.62 magnetic resonance imaging (MRI) units per million population and 44.99 computer tomography (CT) scanners per million population (Table 4.1). Regarding MRI units, New Zealand’s rate is a little higher than one comparable country for which data are available – Australia (14.96). Regarding CT scanners, New Zealand’s rate is far less than that for Australia (69.43).

### Table 4.1 MRIs and CT scanners per 1 000 000 population, 2021

<table>
<thead>
<tr>
<th>Item</th>
<th>Per 1 000 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI units</td>
<td>16.62</td>
</tr>
<tr>
<td>CT scanners</td>
<td>44.99</td>
</tr>
</tbody>
</table>

*Source: OECD Health data (2022b)*

For regulation of medical devices, see Section 2.8.5.

#### 4.1.4 Information technology

The percentage of the New Zealand population with access to the Internet is 92%. This is higher than for Australia (90%), but lower than for Canada (97%) and the United Kingdom (95%) (The World Bank, 2022c; all figures 2020). There are concerns over a range of groups in New Zealand that have less access to key digital technologies, including by geography, ethnicity, disability, social housing, and income status (Digital Inclusion Research Group, 2017; Grimes & White, 2019).

Health information management and technology have become increasingly important in New Zealand. The first ministerial strategy for health information was published in 1991, and the New Zealand Health Information Service was established the following year, its projects including the establishment of a National Health Index (NHI, a unique patient identifier), a national minimum dataset (which gathers national data on public and private hospital discharges), and the collection of national statistics (Gauld, 2004).

New Zealand hospitals have reasonably well-developed information technology (IT) and data systems. GPCs are also highly computerized: practices and a large proportion of other health-care providers have been using electronic medical records software since 1992 (Jha et al., 2008). E-prescribing rates had also been increasing over time since 2016, with major increases following the arrival of COVID-19 in New Zealand (Ministry of Health, 2021f).

Electronic messaging is now extensively used, including for sending referrals, payment claims, laboratory and pathology results, and hospital
discharge summaries. Almost all electronic messaging in the New Zealand health sector uses services provided by HealthLink, which is a privately owned company and part of the Dublin-based global health-care technology business collective, Clanwilliam Group (HealthLink, 2022).

Sharing health information is aided by a person’s NHI number. This is a unique number assigned to every person who uses health care in New Zealand. It accurately identifies people and links them with the right health records, facilitating good decision-making and helping to plan, coordinate and provide health and disability services across New Zealand.

The collection and sharing of health information associated with the NHI is governed by the Privacy Act and Health Information Privacy Code (Ministry of Health, 2021g).

There are, however, major key issues relating to digital record-keeping and delivery of health services using digital technology in New Zealand (Health and Disability System Review, 2019; Health and Disability System Review, 2020). DHBs, for example, use multiple systems, many of which are old and are customized, requiring substantial work to maintain and upgrade. GPCs also use a range of different systems. NGOs often rely on paper-based records. As a result, not all health records are able to be shared across all health-care providers, with information often collected in silos in different formats.

Not all provider contracts include the responsibility to share data extensively. GPC and PHO data, for example, are not routinely shared. As a result, there is no national PHC dataset, which severely limits the ability to evaluate reforms and track trends over time.

Existing systems are also vulnerable to cyber security attacks – not only in terms of information being stolen but scanners, lifts, lights and air-conditioning have also been identified as vulnerable. Indeed, in 2021, Waikato DHB was the subject of a cybersecurity theft, which shut down services for several days and weeks and required significant rebuilding of information (Asghar, 2021).

There have been four strategies on digital and data issues since 2001; they have, however, not been well implemented for a range of reasons, including frequent leadership changes; a complex system; unclear roles and responsibilities; lack of collaboration; top–down projects not being well received or considered fit for purpose; limited training and emphasis on change management; and minimal resourcing for transformation. Spending
on IT in health is likely to be significantly lower than in other comparable countries (Health and Disability System Review, 2020).

A Digital Health Strategic Framework guides work in this area at present (Ministry of Health, 2021h). However, changes in key roles may occur with the health and disability system reforms introduced on 1 July 2022 (see Chapter 6).

### 4.2 Human resources

#### 4.2.1 Health workforce trends

New Zealand’s health and disability sector employs around 220,000 people, or 8.5% of the total workforce. It is the largest sector employer in the country. Just over a third are employed in DHBs; and, indeed, DHBs were often the largest employers in their region. Clinical staff, employed directly in caring for people, make up 66% of the workforce. Personal carers and assistants (at 23% of the workforce), nurses and midwives (at 21%) are the largest groups of workers (Health and Disability System Review, 2019).

New Zealand has experienced some rises in the number of health professionals per 1000 population in recent years (Table 4.2). This is particularly the case with physicians, which have seen an increase of 35% since 2010. Other increases over that time period were physiotherapists (19%), pharmacists (14%) and nurses (8%), whereas midwives saw no change and dentists saw a fall of 12%.

<table>
<thead>
<tr>
<th>Health workers</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>2.11</td>
<td>2.62</td>
<td>3.03</td>
<td>3.53</td>
</tr>
<tr>
<td>Nurses</td>
<td>9.03</td>
<td>10.06</td>
<td>10.22</td>
<td>10.91</td>
</tr>
<tr>
<td>Midwives</td>
<td>NA</td>
<td>0.56</td>
<td>0.56</td>
<td>0.56</td>
</tr>
<tr>
<td>Dentists</td>
<td>0.55</td>
<td>0.59</td>
<td>0.62</td>
<td>0.52</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>NA</td>
<td>0.63</td>
<td>0.67</td>
<td>0.72</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>0.84</td>
<td>0.96</td>
<td>1.02</td>
<td>1.14 (2020 figure)</td>
</tr>
</tbody>
</table>

*Source: OECD Health data (2022b)*

The distribution of health practitioners, especially GPs, receives considerable public attention. People in rural areas have reduced access to GPs and PHC services compared to people living in non-rural areas (see Section 5.3.1).
The number of medical graduates per 100 000 in the population has trended up steadily over recent years. In 2000, New Zealand had 7.41 medical graduates per 100 000 in the population, 7.18 in 2005, 7.29 in 2010, 8.7 in 2015 and, finally, 10.37 in 2020 (OECD, 2022b). The number of nursing graduates per 100 000 in the population has also trended up markedly. In 2000, there were 31.78 nursing graduates per 100 000 population, 31.69 in 2005, 33.42 in 2010, 45.82 in 2015, albeit dropping back to 40.90 in 2020 (OECD, 2022b).

The rise in physicians per 1000 in New Zealand has improved the country’s relative position internationally in recent years. Figure 4.4 shows that New Zealand’s rate was second only to Australia in 2000 but then declined, before rising markedly since 2012, compared to Canada and the United Kingdom. Australia remains higher, however.

**Figure 4.4  Number of physicians per 1000 population in selected countries, 2000–2020**

![Chart showing the number of physicians per 1000 population in selected countries, 2000–2020.](chart)

*Source: OECD Health data (2022b)*

New Zealand is relatively well served by nurses (Figure 4.5). For most of the period since 2005 [the earliest comparable figures], New Zealand has had a relatively high rate of nurses per 1000 population. Again, however, Australia has an even higher rate.
In terms of midwives (Figure 4.6), New Zealand has fewer than Australia, and more than the United Kingdom (there are no data for Canada). The number of midwives per 1000 population in New Zealand was fairly flat across the period. In 2009, New Zealand had 0.57 midwives per 1000 population; by 2013 this figure was effectively the same (0.56). In 2013, the figure was far higher in Australia, although numbers in Australia are declining.

Source: OECD Health data (2022b). Note that there are no Australian data before 2013.
Looking at dentists (Figure 4.7), the only comparable international data available begin in 2011. Across the period, New Zealand’s number of dentists per 1000 population remained static at a little over 0.6 each year. This has been higher than the rates for Australia and the United Kingdom, but Canada’s rate has outstripped New Zealand’s since 2015.

**Figure 4.7 Number of dentists per 1000 population in selected countries, 2011–2018**

New Zealand has at least 43 other allied health professionals delivering services across the country. Those registered under the Health Practitioners Competence Assurance Act 2003 include:

- Chiropractic
- Dental therapy/oral health therapy
- Dietetics
- Medical laboratory science/Anaesthetic technology
- Occupational therapy
- Optometry
- Osteopathy
- Paramedicine
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology
- Psychotherapy.
Other professions include acupuncture, audiology, social workers, exercise professionals, hospital play specialists, and laboratory workers. Allied Health Aotearoa New Zealand is a national body with 32 allied health associations, representing around 30,000 allied health professionals (Allied Health Aotearoa New Zealand, 2022). Ngā Pou Mana is a Tangata Whenua Allied Health group representing many Māori allied health workers, including counsellors, cultural advisors, play specialists, Whānau Ora navigators, and a range of other health workers (Ngā Pou Mana, 2022).

Limited New Zealand and international comparative data are available on allied health workers. Looking at the number of pharmacists per 1000 population (Figure 4.8), New Zealand has notably fewer pharmacists than three comparable countries, Canada, Australia and the United Kingdom. In 2012, New Zealand had 0.65 pharmacists per 1000 population, rising to 0.72 by 2020. However, across the same period, the other three countries had markedly higher relative numbers.

**Figure 4.8 Number of pharmacists per 1000 population in selected countries, 2012–2020**

![Figure 4.8 Number of pharmacists per 1000 population in selected countries, 2012–2020](image)

*Source: OECD Health data (2022b)*

The number of physiotherapists per 1000 population in New Zealand has been growing steadily since 2007, rising from 0.91 per 1000 population to 1.14 in 2020 (Figure 4.9). There have been similar rises in other countries over time, although there are relatively more physiotherapists in New Zealand.
than in comparable countries, with Australia on 1.09, Canada on 0.67 and the United Kingdom on 0.47 per 1000 population in 2020.

**Figure 4.9 Number of physiotherapists per 1000 population in selected countries, 2007–2020**

![Graph showing number of physiotherapists per 1000 population from 2007 to 2020 for selected countries.](source: OECD Health data (2022b))

### 4.2.2 Professional mobility of health workers

Predicting the future requirements for a health-care workforce is not easy. Both local and international labour market factors influence supply while demographic changes, changes in health, and government funding all affect demand. Recent work in New Zealand (Ministry of Health, 2021i) has also emphasized the need for:

- making better use of the existing workforce by developing new roles and extending existing roles;
- focusing on prevention, rehabilitation and self-care as resources shift from hospital to community;
- harnessing the potential of IT, including telemedicine.

The health-care workforce also involves long time lags in training health-care professionals, although it has been expected to respond to rapid policy-driven changes. Typically, in New Zealand there are shortages of medical practitioners, including some specialists such as psychiatrists and GPs; midwives, mental health and aged care workers, including psychologists; radiologists (New Zealand Immigration, 2019) and there are long-standing
problems in attraction and retention of professionals in rural areas. Māori and Pacific workforces should be a particular focus of workforce development (Ministry of Health, 2021i).

New Zealand has a relatively high proportion of doctors and nurses trained overseas. In 2020, 42.4% of New Zealand’s doctors were trained overseas. The same figure for Australia was 32.3%, United Kingdom 30.8% and Canada 21.1%. In the same year, 28.6% of New Zealand’s nurses were trained overseas, as compared to 18.1% for Australia, 16.4% United Kingdom and 8.6% Canada (OECD, 2022b).

Health professionals work in an international market. Medical doctor graduate retention problems were significant in the past, with graduates frequently leaving New Zealand in search of better pay and conditions overseas. This problem has been mitigated in recent years, with initiatives such as the MoH’s Voluntary Bonding Scheme playing a part. The scheme was introduced in 2009 and financially assists medical students to encourage them to work in areas (locations and specialties) that are hard to staff. (For details of the bonding scheme, see Ministry of Health, 2021j.)

On average, between 2001 and 2006, 98% of graduates were retained two years after graduation, falling to 82% after five years. In the period 2007–2012, again, 98% of graduates were retained two years after graduation, whereas 87% remained after five years. In the period 2013–2018, 100% of graduates were retained after two years and, of those who graduated in 2013–2016, 93% were still in the country after five years.

Most New Zealand-trained doctors who leave the country go to Australia (2187 in 2019), which is not surprising, given Australia is New Zealand’s nearest (and largest) neighbour. Two other nations where relatively significant numbers of New Zealand-trained doctors practised in 2019 were the United Kingdom (184) and Canada (104) (Medical Council of New Zealand, 2022a; Medical Council of New Zealand, 2021).

As noted above, just over 40% of doctors registered in New Zealand were trained overseas. Such graduates play an important role in the medical workforce, filling gaps New Zealand cannot fill with locally trained doctors. Some graduates come to New Zealand to gain experience they cannot obtain in their home country. Others move to New Zealand permanently. Most such graduates do not remain in New Zealand for long periods, however. Just over 60% leave in the first two years after they register. Overseas-trained doctors continue to leave in subsequent years until there are about 20% remaining long term (Medical Council of New Zealand, 2022a).
In 2019 (the most recent data available), the three largest ethnic groups with which overseas-trained nurses identified were Filipino (33%), Other European (31%) and Indian (21%). The most common countries of the overseas-trained workforce were similar to the ethnic breakdown, with 33% educated in the Philippines, 26% in the United Kingdom, and 18% in India and Sri Lanka. The overseas-trained nurse workforce is prominent in the rest home/residential care setting, with 50% of the workforce in that setting comprising internationally trained nurses; the next largest percentage was nursing agency employment (37%) [Nursing Council of New Zealand, 2020].

Gender representation in the health workforce varies significantly, depending on the profession. Whereas females comprise 47% of doctors, they comprise 91% of nurses, for instance. The proportion of female doctors is on a steady increase, however. The proportion of females was 33% in 2000 and a projection of the current trend indicates that women will outnumber men by 2025 [Medical Council of New Zealand, 2022a; Nursing Council of New Zealand, 2020].

Māori and Pacific people are markedly underrepresented among health professionals. Māori comprise 17% of the New Zealand population, but only 4% of doctors and 8% of nurses. Likewise, Pacific peoples comprise 8% of the New Zealand population, but only 2% of doctors and 4% of nurses [Medical Council of New Zealand, 2022a; Nursing Council of New Zealand, 2020]. Greater Māori and Pacific participation in the health sector requires improvements in Māori education as well as more resources for professional training and development.

Efforts to address this include the Hauora Māori health training scholarships [Ministry of Health, 2022k]. The Auckland Medical School offers a one-year foundation programme Certificate in Health Sciences aimed at preparing Māori and Pacific students for health sciences courses, and a Māori and Pacific Admission Scheme for medicine, health sciences, pharmacy and nursing courses [University of Auckland, 2022a]. Otago University has a number of initiatives to support Māori and Pacific students’ academic pathways to and through professional health programmes. These include access to a one-year foundation programme aimed at preparation for health science study, and a range of tailored academic support programmes aimed at increasing the number of Māori and Pacific students within the intakes for all its health professional courses [University of Otago, 2022a; University of Otago, 2022b].
4.2.3 Training of health workers

The Ministry of Education part-funds undergraduate education and the training of health professionals, and students also pay tuition fees.

The MoH Health Workforce Directorate, prior to 1 July 2022, supported nurses, midwives, pharmacists and doctors in their first year of practice; subsidizes the costs of vocational (specialist) training for doctors, including GP trainees; supports postgraduate education for a range of practitioners (e.g. nurses, midwives, allied health and scientific workers) and supports a non-regulated Māori workforce in obtaining formal competencies and moving into other roles (Health and Disability System Review, 2019).

The Health Workforce Advisory Board, responsible to the Minister of Health, advised the government on a national health workforce plan, including enabling greater participation by Māori and Pacific peoples (Ministry of Health, 2022l).

Sixteen regulatory bodies (e.g. Medical Council, Nursing Council) define the scopes of practice, set out the qualifications necessary for practise, register practitioners and issue annual practitioner certificates, under the Health Practitioners Competence Assurance Act 2003. These bodies also investigate competence and conduct. There are 15 medical colleges that train and offer ongoing professional development; many are Australasian Colleges.

4.2.3.1 Doctors

Primary health-care practitioners and hospital-based doctors receive the same initial training: six years of medical school (including one year as a trainee intern) and usually two years as a house officer.

University Medical Schools in Auckland (University of Auckland), Dunedin, Christchurch and Wellington (all part of the University of Otago) train medical practitioners in six-year undergraduate courses. There are no graduate entry medical programmes in New Zealand, although both the Auckland and Otago intakes include some graduates.

There are specifically targeted subcategories for doctor training. These are Māori, Pacific, socioeconomic, refugee and rural students (see University of Auckland, 2022b; University of Otago, 2022c).

Overseas-trained doctors must apply to the Medical Council of New Zealand for registration and have their qualifications and experience assessed and verified. The Medical Council of New Zealand regards the primary medical qualifications listed in the World Directory of Medical Schools as
an acceptable standard of qualification to be considered for registration to practise in New Zealand. However, they may also be required to pass an English language assessment and a New Zealand registration examination (Medical Council of New Zealand, 2022b).

Doctors are initially granted provisional registration with a general scope of practice for up to two years. They may then be registered in a general scope or study to become a specialist or GP, with the relevant vocational scope of practice. The main vocational training areas are listed in Table 4.3 (those with more than 20 trainees). Registrars may spend three to five years in such training. Medical speciality training and standards are set through the respective Colleges, some jointly with Australia (e.g. Royal Australasian College of Physicians; Royal Australasian College of Surgery).

Table 4.3  Main vocational training areas, 2021

<table>
<thead>
<tr>
<th>Anaesthesia</th>
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<tr>
<td>Diagnostic radiology</td>
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<td>Emergency medicine</td>
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<td>General practice</td>
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<td>Intensive care medicine</td>
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<td>Internal medicine</td>
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<td>Obstetrics and gynaecology</td>
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<td>Ophthalmology</td>
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<td>Orthopaedic surgery</td>
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<td>Otolaryngology head and neck surgery</td>
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<td>Paediatrics</td>
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<td>Pathology</td>
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<td>Plastic and reconstructive surgery</td>
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<td>Psychiatry</td>
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<td>Public health medicine</td>
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<td>Radiation oncology</td>
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<td>Rural hospital medicine</td>
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<td>Urgent care</td>
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<tr>
<td>Urology</td>
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</table>

*Source:* The New Zealand medical workforce in 2021 (Medical Council of New Zealand, 2022a)

#### 4.3.2.2 Nurses

There are numerous institutions that train nurses in New Zealand, including universities and a now single, national technical institute: New Zealand
Institute of Skills and Technology (Te Pūkenga). For a complete list of nursing training courses (see Nursing Education in the Tertiary Sector 2022).

Registered nurses are trained in three-year tertiary-level courses that are offered in both universities and Te Pūkenga. Training consists of both theoretical and practical placements, with clinical experience being introduced from the first year. Graduates are eligible for registration as registered nurses who may practise in a wide variety of clinical contexts. After a minimum of four years’ experience in a specific area of practice and completion of a clinically focused master’s degree programme, nurses may be eligible for registration as a nurse practitioner and work at an advanced level within a specific area of practice. New Zealand also has enrolled nurses who undergo an 18-month training programme and must practise under the direction and delegation of a registered nurse or nurse practitioner (Nursing Council of New Zealand, 2022a).

New Zealand has reciprocal nursing registration with Australia only. Other overseas-trained nurses are assessed in accordance with the requirements of the Health Practitioners Competence Assurance Act 2003 and may have to meet English language requirements and demonstrate their competency to practise through their educational equivalence and/or a Nursing Council-approved competence assessment programme or individualized assessment programme (Nursing Council of New Zealand, 2022b).

The number of nurses in New Zealand per 1000 in the population has trended upwards since 2005. At 10.6 nurses per 1000 population, New Zealand is a relatively high performer internationally (see Figure 4.5).

### 4.3.2.3 Midwives

Midwifery has its own degree courses. There were 3085 midwives with an annual practising certificate in 2022, of whom 99.6% were female, with an average age of 47 years. Regarding ethnicity, 82.3% identified as having New Zealand European as their primary ethnicity, 7.7% Māori, 4.9% Asian and 1.5% Pacific Island (Midwifery Council of New Zealand, 2022).

Scopes of practice for midwives and nurse practitioners have expanded over time. Limited prescribing rights were given to registered midwives under the Nurses Amendment Act 1990 (see Section 5.4.3). The Medicines Amendment Act 1999 extended these rights further to nurses and to other health professions, including the use of standing orders. Standing orders are written instructions issued by an authorized prescriber (generally a doctor) allowing another health practitioner (here, a nurse) to supply or administer a specified medicine in circumstances defined by the order. For example, at a school
health clinic staffed by nurses, some medication may be able to be supplied to students under a standing order from a local GP, avoiding the need for students to visit a GP to obtain a prescription.

4.3.2.4 Dentists
Dentistry training is available only through the University of Otago. Students complete a first year Health Sciences programme, followed by a four-year Bachelor of Dental Surgery. In 2021, there were 2644 practising dentists in New Zealand (OECD, 2022b). In 2019 (the most recent figures available) 57% of dentists were male, and 45.6% were of European/New Zealand ethnicity, with 3.6% Maori. Just over two thirds (67.3%) qualified in New Zealand. Just under two thirds (61.7%) were self-employed in private practice, while 9.6% were employed in private practice and 5.6% were employed by DHBs (Dental Council of New Zealand, 2019).

4.3.2.5 Pharmacists
Pharmacy training is available through the University of Otago and University of Auckland. Students complete a first year Science or Health Sciences programme, followed by a three-year Bachelor of Pharmacy. Students must also complete 52 weeks of a trainee internship at an approved institution. In 2021, there were 4062 practising pharmacists registered with the Pharmacy Council, with 1074 non-practising pharmacists, and 256 intern pharmacists. Sixty-seven per cent are female. Forty-four per cent are of New Zealand European ethnicity, 28% are of Asian ethnicity, 2% are Māori and 1% are of Pacific ethnicity. Most pharmacists work in community pharmacies (3108 or 78%), with a number working in hospital pharmacies (545, 14%) (Pharmacy Council of New Zealand, 2021).

4.3.2.6 Physiotherapists
Physiotherapists also complete a four-year degree qualification, either at University (University of Otago, Auckland University of Technology) or at the national skills institute Te Pūkenga, at its Waikato campus. Courses include clinical practice placements. There were 7556 registered physiotherapists in 2022, 76% of whom are female. Seventy-one per cent are of New Zealand European ethnicity, 5% are Māori, 6% are Asian and 1% Pacific (Physiotherapy Board of New Zealand, 2022).

4.2.3.7 Other allied health workers
Each recognized health occupation has its own Board or Council that licenses and regulates its members under the Health Practitioners Competence Assurance Act (see Section 2.8.3), including requirements for continuing professional development. Registration Boards or Councils also set
standards of competence that educational providers use for curriculum development. They monitor educational providers and educational standards of students by examination (in some instances set by the registration board) or in formal approval/accreditation processes. Allied health workers complete their training at either universities [e.g. social workers, psychologists, chiropractors] or the national skills institute [e.g. social workers, physiotherapists] and sometimes private training organizations [e.g. acupuncture]. Courses vary in length.

4.2.4 Doctors’ career paths

Doctors and other health workers work in a variety of organizations [e.g. DHBs, GPCs, privately owned hospitals, and the MoH] and roles [e.g. practising clinicians, managers, policy roles] and their career pathways are determined by the policies and processes of those organizations.

Doctors working in house officer rotations are virtually all recent graduates. A Medical Council Workforce Survey for 2019 found that the average age of such house officers is 28 years, the youngest average age for a work type in the Council’s survey. The average age is highest for doctors in occupational medicine [58], followed by medical administration [54], and primary care other than GP [55]. The average age for all doctors is 45 [Medical Council of New Zealand, 2022a].

4.2.5 Other health workers’ career paths

As noted above, other health workers and doctors work in a variety of organizations [e.g. DHBs, GPCs, privately owned hospitals, and the MoH] and roles [e.g. practising clinicians, managers, policy roles] and their career pathways are determined by the policies and processes of those organizations.

4.2.6 Dual practice

New Zealand health workers are able to work in either the public or private sectors. Dual practice is permitted, with the practice governed by each employer and through an employment contract staff have with each employer.
Chapter summary

Public (or population) health services in New Zealand, such as national screening and immunization programmes, are overseen by the Ministry of Health (MoH), which, prior to 1 July 2022, also had responsibility for directly funding and purchasing some national initiatives (e.g. well-child services). Prior to 1 July 2022, the MoH also directly funded 12 District Health Board (DHB)-owned regional public health units (RPHUs), covering environmental and communicable disease control, health promotion and preventive services. DHBs in turn funded and supported many public health programmes, while a wide range of health providers also deliver such services to their local populations. Occupational workplace health and safety is overseen by a separate government agency, WorkSafe.

New Zealanders have a range of ways of keeping themselves well and may make use of a wide variety of non-funded services regularly (e.g. nutrition advice, physical activities, regularly visiting an alternative practitioner). People who feel unwell will first rest and may access advice from a national healthline and obtain over-the-counter medicines from pharmacists. They may also call for an ambulance or visit a publicly funded and provided emergency department (which are open 24 hours a day) or a privately owned after-hours clinic.

For further advice and treatment, people will visit a primary health care (PHC) provider, who might then organize further diagnostic tests, prescribe medicine or refer them to another PHC provider (such as a physiotherapist) or to a hospital specialist. Since 2001, PHC has been coordinated through PHOs, which received capitation funding for their enrolled populations, and which contracted GPCs and other providers to deliver PHC services. There are user charges for using general practice GPC services. The role of nurses – including advanced nurse practitioners – is increasing over time. New Zealanders have relatively good access to PHC, but rates of enrolment with GPCs have been falling and there are quite high levels of unmet need, especially for Māori and Pacific peoples, those in more deprived areas, and for disabled people.
Most specialists are employed by publicly owned hospitals, but many also maintain their own private practices. Hospital outpatient and inpatient services are provided mainly by publicly owned hospitals. Maternity services are provided through a lead maternity carer, most of whom are midwives, working in publicly funded health providers or in independent practice. There are no charges for inpatient or outpatient treatment in publicly owned hospitals, or for maternity care. Patients are prioritized for access to publicly funded elective/planned services. People can also access services delivered in privately owned hospitals if they pay for care themselves or through private health insurance.

There are two main providers of ambulance services, staffed with paramedics and volunteers. One service is free and the other has user charges for some services. There is also a nationwide air ambulance service. Such services are funded by the Accident Compensation Corporation (ACC) in the event of an emergency.

Pharmacists deliver services largely from independently owned community pharmacies, as well as from hospital pharmacies, with pharmacy services expanding over time. PHARMAC is the national government organization that decides, using decision-criteria, including cost-effectiveness, which medicines, vaccines and devices are to receive public funding, given its capped budget.

Accident-related rehabilitation services are funded by ACC; other services are funded by publicly funded health providers and delivered by publicly or privately owned providers. Long-term care can include disability support services, aged care (including home-based services and residential rest home services), and care for long-term conditions. Funding arrangements differ across these services, and services are delivered by a range of providers. There are some services to support family carers, and recurring legal cases over payment for those family members supporting people with disabilities.

Palliative care is funded in part by government, and delivered by privately owned, not-for-profit hospices, which rely on donations as well.

Funding from the government for mental health services has historically focused in particular on the estimated 3% of the population with severe mental distress. Options for government-funded primary mental health care (other than medicines) have been limited but are now expanding.

Basic dental care is free for children under 18 years, but there is limited publicly funded dental treatment for adults, other than for emergencies.
Many forms of complementary and alternative care are available in New Zealand, delivered by a range of privately owned providers. Some are funded by ACC for those with accident-related needs.

There are a range of plans in place throughout the health sector to be used when disaster strikes. A review of a selection of major disasters and emergencies in New Zealand over the past 10 years suggests that the health sector has generally performed well during such events, including during COVID-19.

5.1 Public health

New Zealand’s first Public Health Act was passed in 1872 in response to concerns about outbreaks of infectious diseases. It allowed for central boards of health in each province with additional local boards (Dow, 1995). This resulted in tensions between competing authorities and attempts to shift responsibility, until the 1900 Public Health Act replaced local boards with one central agency and a Chief Officer of Health, plus six Health Districts with District Health Officers (Dow, 1995). In 1909, the Department of Public Health amalgamated with the Department of Hospitals and Charitable Aid (Dow, 1995). Various incremental changes continued over the years, including restructuring of the public health division within the Department of Health (from 1920) and changes to health districts (of which there were seven in 1920, 13 in 1948, 17 in the 1960s and 18 by 1974) (Dow, 1995).

With the establishment of area health boards (AHBs) under a 1983 Act, public health services became part of their core responsibility “to promote, protect, and conserve the public health, and to provide health services” (section 9a). In subsequent reforms (see Chapter 6), public health had its own purchasing authority (the Public Health Commission) between 1993 and 1995, with services provided by Crown health enterprises (CHEs). The public health purchasing role was then allocated to the regional health authorities (RHAs) followed by the Health Funding Authority (HFA) and delivered via hospital and health services (HHS) (the later name for CHEs).

Public health is now overseen by the Ministry of Health (MoH), with a Director of Public Health providing statutory advice and supporting public health services. The MoH undertakes policy work and funds a range of national public health services directly. The MoH has also funded health promotion strategies, in particular, in relation to reducing harm from alcohol; the Institute of Environmental Science and Research (ESR) for scientific services; and the University of Auckland to deliver immunization advisory services (Health and Disability System Review, 2020). The MoH similarly oversees
a number of national screening programmes (breast, bowel, cervical, metabolic, and newborn hearing), as well as a Community Action on Youth Alcohol and Drugs programme, delivered by a range of providers.

Until the reforms of mid-2022, the MoH directly funded 12 DHB-owned regional public health units (RPHUs), which each delivered services for their region (some were aligned with a single district health board [DHB], while others worked with two or three DHBs). These RPHUs provided basic health protection services, such as water and food safety, and health promotion services such as antismoking programmes. Their employees included public health physicians and other health-care professionals, as well as officers who monitored and enforced public health legislation, such as the Tuberculosis Act 1948, the Health Act 1956, the Food Act 1981 and the Smokefree Environments Act 1990.

Again, until the reforms of mid-2022, some primary health organizations (PHOs) were also contracted by DHBs to deliver public health services, such as ProCare running stop smoking services across two Auckland DHBs (Health and Disability System Review, 2020). General practitioners (GPs) and other primary health care (PHC) providers also provided prevention services for their patients, such as immunizations, as well as individual and group health education and promotion.

Nongovernment organizations (NGOs) are active in prevention and promotion as well as some patient support and advocacy. They offer health-related services with funding from their own fundraising and from government contracts. For example, the MoH funds the National Heart Foundation for heart health promotion services; the Burnett Foundation for prevention and support programmes relating to HIV and AIDS; the Mental Health Foundation for mental health promotion, and Hapai Te Hauora Tapui Ltd for a national sudden unexpected death in infancy (Health and Disability System Review, 2019). Publicly owned health providers have also supported NGOs, such as West Fono Health Trust, which delivers physical activity services to Pacific communities in West Auckland and Pirirakau Hauora Charitable Trust, which delivers sexual and reproductive health services and mental health services in Te Puna and Western Bay of Plenty (Health and Disability System Review, 2020).

New public health arrangements were established in July 2022. These are detailed in Chapter 6.
5.1.1 Environmental and communicable disease control

Environmental and communicable disease control services include monitoring public health risks, advice on public health protection and regulatory services, investigating public health complaints, and taking action where necessary to protect public health. Public health protection and regulatory services run by public health units cover the following areas (although in some cases another organization, such as local government, is the lead agency):

- Contaminated land
- Drinking water quality
- Sewage treatment and disposal
- Waste management
- Hazardous substances
- Resource management
- Environmental noise management
- Air quality
- Burials and cremation
- Food safety and quality
- Biosecurity and quarantine
- Communicable disease control.

The Notifiable Disease Surveillance system in New Zealand currently covers about 60 conditions for which reporting by medical practitioners is mandatory (Ministry of Health, 2021k). Notification data are recorded on a computerized database installed in each public health service and are used to guide local control measures. The data are collated, stored and analysed at the national level by the Institute of Environmental Science and Research (Institute of Environmental Science and Research, 2022). Monthly, quarterly and annual surveillance reports are published that contain data and commentary on notifiable disease trends and events. The MoH monitors the national rates of communicable disease and immunization coverage, develops policy, and promulgates regulations in fulfilment of national and international requirements. The MoH also provides oversight of statutory public health officers employed by DHB PHUs (Medical Officers of Health and Health Protection Officers).

New Zealand has had an Influenza Pandemic Action Plan since 2002, which was subsequently revised in light of the international concern about the evolving threat from H5N1 influenza and the influenza A (H1N1) 2009 pandemic. A number of actions in the Plan are authorized under relevant statutes, namely the Health Act 1956, the Civil Defence and Emergency

The worldwide pandemic COVID-19 became a major issue in 2020–2022, requiring a raft of new arrangements to be developed, from border controls, through to managed isolation and quarantine, through to improved hygiene measures, and a vaccination programme (see Section 5.1.15).

### 5.1.2 Health promotion and education

Services are provided in the following areas:

- Social environments, such as healthy school and healthy community programmes
- Well-child services
- Immunization
- Injury prevention, such as the promotion of child restraints in cars and community-based injury prevention programmes
- Mental wellbeing measures, such as programmes to reduce the stigma associated with mental illness
- Nutrition and physical activity, such as programmes to promote healthy diet and physical exercise
- Sexual health, such as “safer sex” and family planning programmes
- Alcohol and drugs, such as services to reduce and/or prevent drug-related harm
- Tobacco, such as tobacco control programmes, including monitoring and compliance with smoke-free legislation and public smoking education programmes.

These services are funded and provided by a variety of organizations, including the MoH, publicly owned health providers, other government departments and agencies (such as Sport NZ), and NGOs.

### 5.1.3 Preventive services

Preventive services are targeted at a range of conditions and population groups and are linked to environmental and communicable disease control and health promotion services. These programmes often involve a range of other organizations and providers. Some key programmes are outlined below.

#### 5.1.3.1 Well-Child/Tamariki Ora services

All children from birth to five years are covered by this programme. It is aimed at protecting child health and reducing risks to children’s health,
development and wellbeing, as well as early identification of any issues and referral to specialist services.

It includes a universal health assessment, screening, education and support, including postnatal visits (to six weeks of age) from lead maternity carers (LMCs), newborn and early childhood screening, a six-week check at GPCs at the time of first immunization, infant and child contacts and a B4 school check. Around 728,500 contacts to 185,000 children occur each year, with around 56,000 children receiving B4 school checks (Health and Disability System Review, 2020).

The MoH funds a Well-Child programme, with significant funding allocated to Plunket, a national well-child provider. The MoH also contracts with publicly owned health providers, who in turn contract with a wide range of community providers, most of which are Māori and Pacific providers. Around 80% of non-Māori, non-Pacific children receive all their funded contacts, but rates are lower for Māori (around 65%), Pacific (just over 60%), and children from the highest deprivation quintile (near to 70%) (Health and Disability System Review, 2020).

5.1.3.2 Immunization

Immunization has contributed significantly to the control of many infectious diseases in New Zealand, although some vaccine-preventable diseases continue to be public health problems, such as pertussis and measles (Immunization Advisory Centre, undated).

The New Zealand National Immunisation Schedule sets out the immunizations available free to New Zealanders, including for pregnant women (influenza and tetanus/diphtheria/pertussis [whooping cough]); children at various ages (rotavirus, diphtheria/tetanus/pertussis/polio/hepatitis B/Haemophilus influenzae type b, pneumococcal, measles/mumps/rubella, Haemophilus influenzae type b, varicella [chickenpox]), young people 11–12 years (tetanus/diphtheria/pertussis, human papillomavirus), adults 45 years (tetanus/diphtheria/pertussis) and older adults 65 years (tetanus/diphtheria/pertussis, zoster [shingles] and influenza). Other vaccines are available free for high-needs groups due to other conditions (e.g. hepatitis A, hepatitis B, Haemophilus influenzae type b, human papillomavirus, influenza, meningococcal, pertussis [Tdap], pneumococcal, tuberculosis and varicella) (Ministry of Health, 2021).

The New Zealand Health Strategy included 13 priority population health objectives, of which one was “ensuring access to appropriate child health services including well child and family health care and immunization” (King,
In May 2009, the Minister of Health announced a simplified set of six health targets for DHBs to focus and report on, including “increased immunization” (Ryall, 2009a).

The new goal was to fully immunize 95% of eight-month-old children by December 2014 and maintain this to June 2017. To achieve this goal, the health target by July 2013 was for 85% of eight-month-olds to have had their primary course of immunization at six weeks, three months and five months on time, increasing to 90% by July 2014 and 95% by December 2014 (Ministry of Health, 2020d). There were also targets for PHOs to meet up until 2016/2017, with PHOs delivering 93.5% of eligible children immunized that year, with 16 of 36 PHOs at 95% and a further four on 94% (Ministry of Health, 2021m).

A new performance framework of health system indicators will apply in the reformed health system from July 2022, with childhood immunizations at 24 months one of the indicators (Ministry of Health, 2021n).

Children born from 2005 are placed on a National Immunisation Register (NIR), which is a computerized information system that holds immunization details of New Zealand children. The NIR has two main aims: to help health professionals quickly and easily find out which vaccines a child has been given and to provide a more accurate record of immunization coverage rates (Ministry of Health, 2021o). The country has been investing in a new national immunization solution system to replace the NIR to better monitor immunization coverage, including for COVID-19 (Ministry of Health, 2021p); it was launched on 1 April 2022.

5.1.3.3 Other preventive programmes

New Zealand has a range of active preventive programmes at national, regional and local levels; some key programmes are described below.

Family planning aims to assist people to make informed choices about their reproductive and sexual health. Family planning advice is offered from various sites: GPs, private specialists, family planning clinics, student health clinics, sexual health clinics, and marae-based health services (Māori community centres) (Ministry of Health, 2021q).

The National Breast Screening Programme (known as Breastscreen Aotearoa New Zealand) was established in December 1998. Through early detection, it aims to reduce breast cancer mortality by offering free mammography services to women aged 45–69 years every two years. Women who have had breast cancer can also have free mammograms starting five years after their
breast cancer was diagnosed (Time to screen, 2022a). Breast cancer is New Zealand’s third most common cancer and kills 600 people a year (Ministry of Health, 2021r).

The National Cervical Screening Programme was established in 1990. It is coordinated nationally but managed and delivered locally. Women aged 25–70 years are recommended to have a screen every three years. Publicly funded, the National Screening Unit contracts 11 independent service providers to provide screening support services for women who are less likely to have been screened, such as Māori. Across the country, there are about 7300 smear takers (mostly GPs and nurses) and seven laboratories providing testing services to the programme. Publicly owned health providers are contracted by the National Screening Unit to provide colposcopy services. Women can also use private colposcopy services. Since the programme began in 1990 the incidence of cervical cancer has decreased by about 50%, and in 2016, the cervical cancer incidence was 6.3 per 100 000 women and cervical cancer mortality was 1.1 per 100 000 women (age standardized to the World Health Organization population, all ages) (National Screening Unit, 2021). A human papillomavirus vaccine to prevent cervical cancer has been available in New Zealand since September 2008 and is now available for those aged 9–26 years. From July 2023, the primary test for cervical screening will change to a five-yearly human papillomavirus test, with the option of self-testing (Time to screen, 2022b).

The National Bowel Cancer Screening Programme is currently being rolled out around New Zealand. It offers self-test screening for all those aged 60–74 years of age. The roll-out followed a six-year pilot that began in 2012 and commenced in July 2017 (Time to screen, 2022c).

Anti-smoking programmes are actively pursued in New Zealand. In 1990, the government passed the Smoke-free Environments Act. The Act banned smoking in office workplaces and certain other enclosed public spaces apart from clearly defined smoking areas; restricted tobacco advertising and sponsorship; mandated labelling of products with health messages; and established the Health Sponsorship Council. Graphic pictorial warnings on all tobacco packages sold were required from February 2008. The warnings include pictures of gangrenous toes, rotting teeth and diseased lungs. Also, information on quitting smoking had to appear on cigarette packages. Legislation passed in 1997 raised the age at which people may legally be sold tobacco products from 16 to 18 years and banned the sale of single cigarettes and small packs of tobacco (Stats NZ, 1998).
A Smoke-free Environments Amendment Act was passed in 2003. Since the Act became law, the buildings and grounds of schools and early childhood centres have become smoke-free areas. Indoor areas of licensed premises (bars, restaurants, cafes, sports clubs and casinos) are smoke-free. Also, other workplaces, including offices, factories, warehouses and work dining areas are smoke-free. The display of tobacco products in retail outlets has been restricted, and “smoking kills” signs have to be erected near tobacco displays. Further, herbal smoking products are included in smoking bans and their sale or supply to under 18-year-olds is prohibited.

In the 2019/2020 New Zealand Health Survey (Ministry of Health, 2022b), 11.9% of New Zealanders were daily smokers, and 13.7% smoked at least once a month. However, Māori (28.6% daily smokers and 31.2% monthly smokers), Pacific peoples (18.4% and 22.5%), those living in the most deprived areas (24.2% and 26.6%) and the disabled (17.6% and 19.5%) continue to have higher rates of smoking and consequent ill-health (see Section 7.4.1). As a result, the government recently revamped its approach and has established a non-smoking campaign called Smokefree Aotearoa. It has set a goal that by 2025, fewer than 5% of New Zealanders will be smokers. This will be achieved by:

- protecting children from exposure to tobacco marketing and promotion;
- reducing the supply of, and demand for, tobacco;
- providing the best possible support for quitting (Smokefree, 2022).

One of the key actions will be to ban the sale of cigarettes to all those aged 14 years and under; the age will rise each year so that this cohort of people will never be able to purchase tobacco (Verrall, 2021).

Alcohol programmes are also a public health priority. The 2019/2020 New Zealand Health Survey found that 21.3% of adults were hazardous drinkers. The highest prevalence of hazardous drinking was among those aged 18–24 years, at 32.6%. Men (29.0%) were more than twice as likely to be hazardous drinkers than women (13.8%). Of Māori adults, 36.4% were hazardous drinkers, while 24.5% of Pacific adults were hazardous drinkers (Ministry of Health, 2022b).

Heavy drinking over a long period has been linked to a number of health problems, particularly liver and heart damage, hypertension and some cancers. The National Alcohol Strategy released in 2001 outlines initiatives in three areas: supply control, demand reduction and problem limitation. A wide range of government and nongovernmental providers offer alcohol-
related health promotion and treatment services. The Health Promotion Agency (established in 2012) included a focus on alcohol, continuing the work of the former Alcohol Advisory Council of New Zealand (established in 1976). The Health Promotion Agency had the specific function of giving advice and making recommendations on the sale, supply, consumption, misuse, and harm of alcohol. The agency was folded into Health New Zealand (HNZ) as part of the 2022 reforms of the health sector, and now acts as a shared service between HNZ and the Māori Health Authority (MHA) [see Chapter 6].

In 2009, the Law Commission produced an issues paper, *Alcohol in our lives*, which reviewed the regulatory framework relating to the sale and supply of liquor (Law Commission, 2009). Submissions were invited and the Law Commission produced its final report with 153 recommendations for the government, including restrictions on the places and times alcohol can be sold and increasing the purchase age from 18 to 20 years (Law Commission, 2010).

Subsequently, the government introduced new legislation, which drew wide public interest and submissions. The Sale and Supply of Alcohol Act was passed in December 2012, retaining the existing minimum purchase age of 18 years. Alcohol may be supplied “in a responsible manner” to people under 18 years by a parent or with the express consent of the parent (section 241 [3]). Maximum trading hours (which apply from December 2013) are from 8 a.m. until 4 a.m. the next day for on-licence premises and 7 a.m. to 11 p.m. for off-licences. Territorial authorities (TAs) may choose to develop local alcohol policies (LAPs), which may restrict the number or location of licensed premises or their trading hours. LAPs are slowly being developed around the country as TAs learn from each other about the process and what works (Ministry of Justice, 2022).

5.1.4 Occupational health services

New Zealand workplaces are bound by the Health and Safety at Work Act 2015, which aims to secure the health and safety of workers and workplaces and sets out responsibilities for achieving this. Work-related ill-health and injuries have a significant impact on New Zealand’s health system and productivity. It is estimated that there are 750–900 work-related health deaths a year and 5000–6000 hospitalizations each year due to work-related ill-health (WorkSafe, 2022a). In 2020, there were 66 work-related deaths in New Zealand, and in 2019 there were 32 766 work-related injuries that resulted in more than a week away from work (WorkSafe, 2022b; WorkSafe, 2022c).
The majority of work-related injuries occur in males. Looking at claims made to the Accident Compensation Corporation (ACC) in 2018, males had the highest incidence rate of 128 work-related injury claims per 1000 full-time equivalents, compared with 69 claims per 1000 full-time equivalents for females. Virtually all claims for fatal work-related deaths that year (96%) were for males (Stats NZ, 2022d).

In 2012, the government commissioned a review to assess whether the workplace health and safety system in New Zealand was fit for purpose, and to recommend practical strategies for reducing the rate of workplace fatalities and serious injuries (Independent Taskforce on Workplace Safety and Health, 2013). The Taskforce recommended that the government establish a new workplace health and safety agency with a clear identity and brand, and statutorily defined functions. Around the same time, the Royal Commission on the Pike River Tragedy (a mining disaster in which an underground explosion at a New Zealand coal mine resulted in the deaths of 29 miners) also recommended that such an agency be established (Royal Commission on the Pike River Tragedy, 2012). The result was the government establishing WorkSafe, a stand-alone workplace health and safety regulatory agency in 2013.

More recently, the government established a high-level strategy on workplace safety (New Zealand Government, 2018), noting that the country’s level of work-related harm is high by international standards. Indeed, based on the most recently available statistics, New Zealand has 2.3 occupational deaths per 100 000 workers, well ahead of Australia on 1.6 and the United Kingdom on 0.8. Likewise, New Zealand has 1200 non-fatal occupational injuries per 100 000 workers, again well ahead of Australia on 899 and the United Kingdom on 760 (International Labour Organization, 2022).

The strategy also observed that some population groups are at greater risk of harm (such as Māori, Pacific peoples, migrants, older workers and youth) and some businesses and sectors face challenges in managing their health and safety risks well, including small businesses and higher-risk sectors (such as forestry). A further publication, giving detailed statistics on New Zealand’s workplace safety record, noted, for instance, that the burden on workers, their families and the wider economy from work-related ill-health far outweighs the burden from work-related acute injuries. These health issues include cancer, respiratory illness and mental illness (New Zealand Government, 2019).
5.2 Patient pathways

New Zealanders have a range of ways of keeping themselves well. They may make use of a wide variety of non-funded services regularly, including focusing on nutrition and physical activity, using a range of supplements (such as vitamins), and/or regularly visiting a massage therapist, *Rongoā Māori* practitioner, a Pacific healer, a Chinese medicine practitioner, or other alternative practitioners such as chiropractors, acupuncturists, or naturopaths (see Section 5.13).

New Zealanders who are unwell may also rest or use over-the-counter medicines they pay for themselves (e.g. paracetamol, cough and cold medicines), available through pharmacies and other retail outlets, to manage their condition. They may contact one of two general healthlines, Healthline and PlunketLine, for advice (PlunketLine focuses on child health). Following the outbreak of COVID-19 in 2020, a COVID-19 healthline has also been set up, along with a COVID-19 vaccination healthline. A number of other health advice lines are also provided via NGOs, for example, in mental health (e.g. Lifeline, Samaritans, Youthline), relating to poisons/poisoning (National Poisons Centre), while a range of online support tools are also available (e.g. SPARX.org.nz).

If people have a condition that they think requires assessment or treatment, in terms of publicly funded providers, they will generally contact their usual PHC practitioner (e.g. GP/GPC, nurse practitioner, Māori health provider, or Pacific health provider). Most New Zealanders have a usual GP or medical centre that they go to if they are feeling unwell. The PHC practitioner will assess the person’s condition and discuss their options, including whether to undertake further diagnostic tests, prescribe medication, or refer them to a hospital specialist. The PHC practitioner may charge a user charge (see Section 3.4.1). For some injuries, a physiotherapist can also be a first port of call, covered by ACC, and there is a wider range of practitioners that GPs can refer to, including, for example, acupuncturists, chiropractors and osteopaths.

In emergencies, or after hours, people may visit an accident and emergency clinic, with such services available free to service users through publicly owned hospitals, although charges are incurred at privately owned after-hours clinics.

If the patient is referred to and accepted by a publicly funded and employed specialist (working in a publicly owned hospital), they will first determine whether a case is urgent (i.e. the patient must be admitted immediately) or semi-urgent (for admission within seven days). Beyond this time frame, the
patient becomes an “elective” or “planned” services patient, and a specialist must first decide whether specialist assessment is required and notify the patient and PHC provider of this decision within 10 days. People accepted for referral must currently be seen within four months [New Zealand Government, 2022a]. The PHC practitioner will care for the patient while they are waiting for their specialist appointment. The specialist appointment will be fully funded by the government, whereas ongoing PHC practitioner appointments may incur user charges.

A publicly funded specialist will determine the patient’s options based on currently funded treatments. If publicly funded services are not available for a patient, they will continue to receive care from their PHC practitioner. If publicly funded services are available (e.g. elective/planned surgery), the patient should receive treatment within four months. An elective/planned services booking system governs this process (see Section 5.4.5). DHB performance on achieving the targets for referral and treatment is monitored by the MoH and results are available on its website [Elective Services Patient Flow Indicators].

If a patient does not want to wait for a specialist appointment, they may choose to see a specialist in private practice, which they would pay for themselves or through private health insurance. A private specialist appointment, and subsequent treatment in a private hospital if required, will usually be obtainable more quickly than in the publicly funded system. Sometimes, people may be referred back to a publicly owned hospital for their treatment, especially where they cannot afford treatment in a privately owned hospital or where specialist services are provided only in the publicly owned system. Thus, by paying for specialist assessment appointments privately, people can avoid longer waits but still receive care through the public system.

After specialist treatment, the patient will receive follow-up treatment from their specialist or their PHC practitioner, and perhaps by other community health services or allied professionals. Long-term follow-up care will be provided by a PHC practitioner.

5.3 Primary/ambulatory care

Traditionally, GPs have provided most primary medical care from their own privately owned practices. In 2020, there were approximately 4917 GPs working in New Zealand (0.97 GPs per 1000 population) [OECD, 2022b]. That same year, 69% of GPs worked in privately owned practices owned by the GPs themselves, 10% in fully or partially corporate-owned practices, 7% in community-owned ones or owned by a trust or charity, and the rest in a
variety of other ownership models (Allen and Clarke, 2020). Most sole private practices have involved one-to-two doctors working alongside a practice nurse and possibly a receptionist, while larger practices can have managers and other health professionals such as nurse practitioners, physiotherapists, pharmacists, social workers and community workers working as part of a PHC team.

People visit GPs frequently. According to the 2019/2020 New Zealand Health Survey, 74.5% of children and 78.9% of adults had visited or spoken with a GP at least once in the preceding year (Ministry of Health, 2022b).

**Figure 5.1  Doctor consultations per capita in selected countries, 2017**

![Doctor consultations per capita in selected countries, 2017](image)

*Source: OECD Health data (2022b)*

Figure 5.1 shows that doctor visits per person in New Zealand are low compared with comparable countries, for the most recent year for which data are available. New Zealand’s per capita rate of 3.8 visits per year is around half that of the nation’s nearest major neighbour, Australia.

Nurses play an increasing role in delivering PHC in New Zealand. In the 2019/2020 New Zealand Health Survey, 26.7% of children saw a practice nurse, as did 29.9% of adults (Ministry of Health, 2022b). The role of nurse practitioner – an advanced nursing role – was introduced in New Zealand in the year 2000. Such nurses can diagnose and treat patients, including ordering diagnostic tests and making referrals. In 2019, the MoH reported that over 370 nurse practitioners were working in New Zealand (Ministry of Health, 2019c), many of whom work in PHC settings (Adams et al., 2020).

GPCs perform a gate-keeping role since an individual cannot access publicly financed medicines, diagnostics such as blood tests and X-rays, and secondary and tertiary services unless they are referred by their
GPC (except for accident and emergency services). This is also common practice in the private health sector – many specialists will only see patients referred by a GPC.

Other publicly funded PHC services include:

- health services for Māori and Pacific peoples (providing prevention, treatment and wider social services) (see Section 2.3);
- diagnostic services, which provide laboratory tests and diagnostic imaging in private community-based facilities on referral from a PHC practitioner;
- pharmaceutical services, which include a comprehensive range of subsidized medications and an increasing range of other services available through community pharmacists.
- Therapeutic and support services, which include physiotherapy, speech therapy, dietary advice, meals on wheels and home-help services, some of which require a referral from a GP.

The release of the Primary Health Care Strategy (PHCS) in 2001 aimed to improve access to PHC services, and to widen the range of health-care professionals providing care in GPCs. It also announced the creation of PHOs. These not-for-profit bodies manage capitation funds for enrolled patients with funds that were allocated by the local DHBs. Patients are free to choose or change their GP/GPC and can enrol with any GPC they choose, limited only by the provider’s ability to take on new patients. GP/GPCs then decide which PHO to join (see Chapter 6 for further information about the PHCS and PHOs).

5.3.1 Distribution and access

There is considerable variation in the distribution of GPs, with rural areas generally underserved. Three quarters of doctors (74.8%) are in the main urban areas compared with 61.2% of the population. By contrast, only 11.6% of doctors are in rural areas, whereas 25% of people live in rural areas (Medical Council of New Zealand, 2022a).

There are high rates of unmet need for some PHC services in New Zealand; these have been persistent over time, increasing during the 2010s before reducing somewhat in 2018/2019 as a result of new government funding to reduce the costs for those with community services cards. Similarly, there are inequities in the use of PHC services as a result. Section 7.3.2 for further discussion on both unmet need and use of PHC services.
5.3.2 Rural health services

Rural areas in New Zealand have small, dispersed populations, a smaller number and range of health-care providers, and greater distances for people to travel for treatment and assistance. Rural communities also have specific needs that must be taken into account as follows: poor health status among Māori and lower socioeconomic groups; people with disabilities who require assistance; more children and older adults; and a higher injury rate.

Rural communities have difficulty attracting and retaining physicians and other health professionals, despite some incentive payments and premiums on contracts. Funding was introduced in 2002 for “reasonable rosters” (to reduce on-call time for rural doctors and nurses) and workforce retention funding (to assist with recruiting and retaining health professionals in rural areas); the level of these grants is based on the rural ranking scale of the practice. The MoH’s rural ranking score takes into account travelling time from a doctor’s surgery to a major hospital; on-call duty; being on call for major trauma; travelling time from a doctor’s surgery to the nearest GP colleague; travel time to the most distant practice boundary; and whether or not peripheral clinics are held regularly (Ministry of Health, 2004). Rural practices are defined as those scoring 35 or more on the scale. The rural workforce retention funding rates (in addition to standard capitation funding) are shown in Table 5.1.

Table 5.1 Rural workforce retention capitation rates, 2022

<table>
<thead>
<tr>
<th>Rural ranking score (points)</th>
<th>Rate per capita (NZ$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>35–40</td>
<td>8.10</td>
</tr>
<tr>
<td>45–50</td>
<td>12.17</td>
</tr>
<tr>
<td>55–65</td>
<td>16.22</td>
</tr>
<tr>
<td>70+</td>
<td>20.26</td>
</tr>
</tbody>
</table>

Source: Capitation rates from 1 July 2022 (Ministry of Health, 2022m)

A voluntary bonding scheme was set up in 2009 that provides recent medical, dental, nursing and midwifery graduates the opportunity to work in hard-to-staff areas in exchange for incentive payments. Initially 350 positions (100 medical graduates and 250 nursing or midwifery graduates) were made available, but this was extended to 893 positions (115 medical graduates, 95 midwives and 683 nurses) due to the high response of applicants (Ryall, 2009b). Medical physicists and radiation therapists were added for the 2012 to 2015 intakes, and again from 2021. Sonographers were included from 2015 and dentists from 2016. The scheme is designed to encourage newly
qualified health professionals to work in the communities and specialties that need them most, retain essential health professionals in New Zealand, and increase representation of Māori and Pacific peoples within the health workforce.

The scheme provides repayments of student loans (or cash payments if the holder does not have a student loan) for up to five years while the person works in a hard-to-staff area or discipline. The annual after-tax credits (paid in a lump sum after three years and annually thereafter) are as follows:

- Doctors: $30 000 (third year), $10 000 (fourth year), $10 000 (fifth year).
- Midwives: $10 500 (third year), $3500 (fourth year), $3500 (fifth year).
- Nurses: $8499 (third year), $2833 (fourth year), $2833 (fifth year) [Ministry of Health, 2021j].

The MoH also funds a locum scheme where a GPC with a rural ranking score of greater than 35 can apply for a 2-week break; NZLocums supports the scheme as well as rural recruitment of GPs.

Some mobile services also support those living in more rural locations, e.g. breast cancer screening, oral health, surgical bus (mobile surgeries in vehicles, which travel around rural areas performing procedures for the local populace), and psychiatric and community psychiatric nurses [Ministry of Health, 2021s].

A National Travel Assistance Scheme, administered by the DHBs, covers travel, accommodation and support person costs, targeted at those travelling long distances; with frequent visits; and who are community services card (CSC) holders [Ministry of Health, 2021t].

### 5.3.3 School health clinics

New Zealand schools do not have a standardized on-site health service [Buckley et al., 2012], although the work of public health nurses (funded by DHBs, PHOs or RPHUs) can include health assessment, health promotion and immunization programmes in schools. From 2008 on, the government has funded school nurses or school-based health services in the secondary schools attended by young people of highest need: decile 1 and 2 secondary schools, teen parent units and alternative education facilities. From 2013, this was extended to decile 3 schools. There are also government-funded School Based Health Services, which focus on the lower decile schools and received increased funding recently.
A 2014 survey of secondary schools found that 12% of schools had no health services beyond the minimum requirement of first aid provision; this was more common among private schools than integrated or State-funded schools. The other 88% of schools reported some level of health service. The most common model of health service provision, in 56% of all schools, was by visiting health professionals. Other schools had on-site health professionals: 20% had a health professional (a school nurse) and 12% had a collaborative health team of health and other professionals on site for most of the week. The most common health professionals working in schools were registered nurses (59% of the health professionals). There were also a small number of doctors (5%). Most of the rest were guidance counsellors, who gave the students access to other health services (Adolescent Health Research Group, 2014).

5.3.4 After-hours care

After-hours care is defined as “primary health care that is designed to meet the needs of patients which cannot be safely deferred until regular or local general practice services are next available” (After Hours Primary Health Care Working Party, 2005). Adults must pay for such services, while services have been free for children since 2011, and now applies to children aged under 14 years.

Fewer people in New Zealand (33%) previously reported difficulty in getting care at night, on weekends and holidays without going to an emergency department compared to other developed countries (e.g. the United Kingdom, 43%; Australia, 54%; Canada, 59%) (After Hours Primary Health Care Working Party, 2005).

Until mid-2022, DHBs were responsible for ensuring that children aged under 14 years have access to zero user charge after-hours care, and that there is a reasonable travel time (maximum of 1 hour) to after-hours general practice and pharmacy services for 95% of its enrolled population. PHOs were responsible for providing after-hours medical care and must demonstrate to their respective DHB that they have arrangements in place for all service users for all hours of each day [i.e. “24/7” service] (After Hours Primary Health Care Working Party, 2005).

There is, however, an unmet need for after-hours care among both children and adults; this is discussed further in Section 7.3.2.
5.4 Inpatient care

Specialist physicians and surgeons provide care in community-based publicly or privately owned clinics or in hospital outpatient departments. Most specialists are employed by publicly owned hospitals, but many also maintain their own private practices. Hospital outpatient and inpatient services are provided mainly by public hospitals.

The boundary between secondary and tertiary care is no longer clear since, with advances in technology including non-invasive surgery, procedures initiated in tertiary care hospitals are rapidly adopted in regional and district hospitals. Tertiary care services usually refer to high-technology services of high cost and low volume. A second distinction, particularly for surgery waiting lists, is between acute services for urgent conditions that need immediate treatment, and elective/planned services for nonurgent conditions. A third distinction is between acute care and long-term care hospitals. Hospitals now mainly treat people for conditions that require short-term and intensive treatment, with long-stay treatment and care being shifted to private nursing homes.

Publicly owned hospitals provide most publicly financed secondary and tertiary hospital services, including all acute and most elective/planned services. Privately owned hospitals offer services to patients who choose to use, and pay for, them, but they may also provide some publicly funded elective/planned services. Hospital procedures are overwhelmingly conducted in the publicly owned hospital system, representing 88% of all procedures. In 2017/2018, there were 1,539,865 procedures at publicly owned hospitals and more than 212,587 privately funded procedures in privately owned hospitals (Ministry of Health, 2021u).

Privately owned surgical hospitals are represented by the New Zealand Private Surgical Hospitals Association. The Association’s members provide procedures for approximately 171,359 patients every year (New Zealand Private Surgical Hospitals Association, 2021).

5.4.1 Access issues

There are currently no charges for inpatient or outpatient treatment in publicly financed and owned hospitals. This has been the case since 1938, with the exception of charges for inpatient and outpatient services that applied briefly during the early 1990s. See Chapter 6 for more detail.

New Zealand has a reasonably good geographical distribution of hospitals. Level 1 services with advanced trauma care and intensive care units are available in the main population centres to 58.9% of New Zealanders within
60 minutes, while adding Level 2 resuscitation services available in provincial centres brings the total to 84.6%. However, for Māori, the figures are 45.6% and 78.7%, respectively. People of Asian ethnicity had the best access, with 0.78% more than 90 minutes from hospital care, while Māori had the worst access, with 4% living more than 90 minutes from services (Lilley et al., 2019).

Considerable policy attention has focused upon waiting lists for hospital services and equitable access to elective/planned surgery. Following many years of problems with lengthening waiting lists and times, New Zealand introduced a priority booking system during the 1990s and 2000s. The aim was to provide certainty and equity in relation to access to elective/planned surgery. The system required DHB specialists to decide if they will assess a patient within 10 days; to assess them within four months; and treat those accepted within a further four months.

Clinical Priority Assessment Criteria (CPAC)/prioritization tools are used to determine if people have the highest needs for treatment, and each DHB had a cut-off point it used to determine if it can treat people within four months and hence to determine if it will accept them for surgery (Cumming, 2013). Those not reaching the clinical score threshold are referred back to their GP for ongoing care (see Section 5.4.4).

The system does provide a degree of certainty for New Zealanders as to whether they can obtain publicly financed elective/planned services, but equity issues remain a concern. This is because different CPAC/prioritization tools were used by different hospitals and DHBs for the same condition, and because DHBs created their own treatment thresholds based on their ability to treat people within the government’s set time frames. These thresholds may change. Information was provided on DHB performance in relation to a set of indicators on elective/planned services (Ministry of Health, 2021v), but information on the thresholds and changes to them are not available.

People with private health insurance or who are able to pay may receive an appointment privately with a specialist quicker than others, and thereby reduce the time to having an assessment; they may then be treated within the publicly financed system or receive their surgery in a private facility (which would usually be quicker than waiting for publicly financed surgery).

5.4.2 Hospital management

Since the merging of the Department of Public Health and the Department of Hospitals and Charitable Aid in 1909, publicly owned hospitals in New Zealand have experienced several changes in management. By the 1950s,
most publicly owned hospitals were fully government funded. Prior to the 1980s, a triumvirate management approach existed where a chief executive, a chief medical officer, and a chief nurse were responsible for the hospital’s business management, medical services and nursing services, respectively. The triumvirate management approach ended in 1988 as AHBs began to take over between 1985 and 1989 (Ashton, 1993; Malcolm, 1991).

AHBs were charged with appointing their own chief executives who were responsible for the day-to-day running of the health services and accountable to the board. AHBs only endured for a short time before being transformed into Crown Health Enterprises (CHEs) after 1993. Five years later (1998), in a largely cosmetic change, these enterprises were converted into non-profit statutory companies called Hospital and Health Services (HHSs). From 2000, hospitals were moved under the management and ownership of DHBs.

In the early 1990s, under CHEs, managers with business credentials, with experience outside of the health sector, were recruited to run New Zealand hospitals, but efficiencies did not reach the levels expected (see Chapter 6). By the mid-1990s, those more experienced in health and clinicians were being brought back into management roles, although there is no requirement for hospital chief executives to have medical backgrounds. However, most hospitals would have a Chief Medical Officer (a practising physician) as part of a hospitals executive team (Cumming, Bryson & Inder, 2008).

In 1998, New Zealand joined the Royal Australasian College of Medical Administrators, which offers a three-year postgraduate specialization programme in medical administration (Alexander, 2000; Royal Australasian College of Medical Administrators, undated). New Zealanders may also become certified health executives through the Australasian College of Health Service Management. Further, some New Zealand universities offer Masters’ programmes in public health management and health services management.

Hospitals were expected to operate according to commercial principles in the 1990s, funding not only services, but also repairs, maintenance and capital development from their own funds. During the 1990s reforms (see Chapter 6), CHEs were expected to make a surplus to return to the health sector; this requirement was abolished in 1998. Since 2001, the management of public hospitals was overseen by DHBs. DHBs were expected to operate within their budgets, but deficits have become a major feature of recent years.

Individual DHB Chief Executive Officer roles ceased to exist following the reform of the health system from 1 July 2022. At the time of writing, Interim
Regional Director roles had been established to oversee publicly owned services and service delivery.

5.4.3 Maternity services

Prior to 1990, all births had to be supervised by a doctor. The majority of labour and birth care occurred in maternity hospitals with midwives working rostered shifts. GPs attended part of labour and birth, and obstetricians would provide specialist care when required. A woman might therefore receive care from several maternity providers during the course of her pregnancy. This style of service was seen as impersonal, and women and the midwifery profession lobbied for reform.

In 1990, the Nurses Act was amended to allow midwives to operate as fully independent providers of pregnancy and childbirth services, including prescribing medications without the supervision of a medical practitioner. This allowed midwives to provide maternity care in the community from pregnancy to six weeks post-birth, in addition to general practitioner and obstetrician care (Health Funding Authority, 2000).

In 1996, a new notice was issued under section 51 of the Health and Disability Services Act 1993, which introduced the concept of a lead maternity carer (LMC) who would have overall clinical responsibility for a woman’s maternity care (Health Funding Authority, 2000). An LMC can be a general practitioner, a midwife or an obstetrician (Ministry of Health, 2022n). There was significant controversy after the changes to the Nurses Act and the introduction of the LMC model, particularly from doctors concerned about their reduced role in pregnancy care.

LMCs care for women throughout their pregnancies, attend labour in hospitals, and provide care for six weeks after birth. Publicly owned hospitals also employ midwives, who can work as LMCs. These midwives also care for women who need more intensive secondary care.

A National Maternity Monitoring Group, established in 2012, oversees and reviews national maternity standards (Ministry of Health, 2011a), does analysis and reporting, and provides advice to the MoH and publicly owned health providers on priorities for improving maternity services. It includes clinical expertise as well as two consumer representatives (Ministry of Health, 2022o). In 2018, a Maternity Action Plan was developed, and includes a range of actions to improve the quality of services, improve equity and retention of midwives (Ministry of Health, 2022p).
According to a relatively recent survey (2015), 98% of pregnant women were enrolled with an LMC, with slightly lower rates for Māori and Pacific women (95% each). In turn, 81% of LMCs were midwives, with the rest being private obstetricians (8%), shared care between a midwife and a GP (5%) and GP-only care (less than 1%) (Growing Up in New Zealand, 2022). A later study (2018) only considered women registered in the first trimester of their pregnancy. This reported that, whereas in 2009 only 58% of women in the first trimester of their pregnancy were registered with an LMC, by 2018 this figure had risen to 73% (Health Quality and Safety Commission, 2022a). These later data also reported results by DHB and ethnicity (National Maternity Monitoring Group, 2018).

There are, however, major concerns over access to midwifery services across New Zealand. There are major shortages of midwives, midwives leaving the profession, heavy caseloads, difficulties for women accessing LMCs, concerns over cultural competency, concerns over equity (with Māori women having almost double the rate of maternal mortality of European women), issues with a lack of maternal mental health services, and very few Māori, Pacific and Asian midwives (National Maternity Monitoring Group, 2018; Technical Advisory Services, 2018; Dawson et al., 2019).

5.4.4 Elective surgery

Access to elective services (now called “planned care”) is based on assessment of the patient’s need and ability to benefit (Cumming, 2013). In New Zealand, the elective services booking system refers to the entire medical pathway from an initial consultation with a GP (Derret, 2005) to a patient’s confirmed surgical date. The system was developed from the 1990s onwards because of major concerns over the management of waiting lists and long waiting times for surgery. Thus, in 1991, it was estimated that about 62,000 people were on a waiting list for elective/planned surgery, of whom 45% would wait less than six months while 15% would wait more than two years (Upton, 1991). Major reforms to the system were introduced in the mid-1990s onwards, with the current approach as follows (Cumming, 2013; Ministry of Health, 2013a).

When a GP sends a letter of referral to an outpatient centre, the referral letters are triaged by clinicians to prioritize patients so that the most urgent referrals are seen before less urgent ones. Specialists must let people know within 10 days if they are able to more fully assess people’s needs for surgery. First specialist assessments must be completed within a set time frame, currently four months.
CPAC/prioritization tools are then used to score people’s needs. Those meeting a particular threshold are to be booked and treated within four months. The thresholds are not fixed clinical thresholds, but they differ across regions depending on capacity. Those who cannot be treated within four months are returned to their GP for ongoing care. Those close to the threshold can be reassessed in six months, and reassessment is also possible where a person’s condition deteriorates.

Publicly owned hospitals do have incentives to deliver on the elective/planned services programme: they must ensure delivery of a certain number of first specialist assessments and operations, and they can have funding withheld if they are not meeting elective/planned services targets. Performance is monitored through a detailed set of patient flow indicators (Ministry of Health, 2021v).

5.4.5 Day care
See Section 7.5.2.

5.4.6 Quality of care
See Sections 2.3.2, 2.9.5, 7.3.1.1, 7.4.3.

5.5 Emergency care
Full emergency services are based in publicly owned hospitals. Some privately owned medical centres provide urgent PHC in cities.

It is free for patients to attend emergency services in publicly owned hospitals; and at times, there can be significant pressure on those services. People are encouraged to ring Healthline for advice and/or visit their GPC in the first instance for non-life-threatening issues, but with GPCs there are user charges and affordability issues do encourage people to use emergency services instead.

Ambulance services (both road and air) are independent service providers, which contract with the ACC, the MoH, and publicly owned hospitals to provide emergency trauma and medical services. They also provide medical transport services to hospitals, and particularly with regard to the air ambulance, rely quite heavily on sponsorship for funding.

There are two main providers of ambulance services in New Zealand (both NGOs) staffed by trained paramedics: St John and Wellington Free Ambulance. St John provides ambulance services 24 hours a day, seven
days a week and covers nearly 90% of the country’s population. St John utilizes conventional ambulances, helicopters and motorcycles to improve response times and access isolated people. St John has four funding streams: contracts with public hospitals, ACC and the MoH (80% of funding); patient part charges for medical emergencies; patient full charges for non-emergency transportation; and community donations and fundraising. The patient part-charge for emergency travel is $98. St John’s workforce relies heavily on volunteers, with 8482 volunteers and 1500 paid staff. St John works independently of government and business and operates as a charitable organization (St John, 2022).

Wellington Free Ambulance is an incorporated society run by its own board of management and is the only free (to the patient) metropolitan ambulance service in New Zealand. It serves people in the lower North Island (covering a population of about 500,000). Wellington Free Ambulance is part funded by government agencies, including the MoH and ACC, with the shortfall funded from sponsorship, grants, donations, fundraising events and public appeals (Wellington Free Ambulance, 2022).

The Life Flight Trust operates a nationwide air ambulance service, transporting critically ill patients who require specialist hospital services [Life Flight Trust, 2022].

A National Ambulance Sector Office provides leadership on behalf of the ACC and MoH in relation to ambulance services. It also commissions such services. It became part of Health New Zealand (HNZ) following the health reforms that came into effect on 1 July 2022 (National Ambulance Sector Office, 2022).

### 5.6 Pharmaceutical care

Two types of pharmacies operate in New Zealand, community pharmacies and hospital pharmacies. Community pharmacies are located in towns and cities throughout the country and dispense prescriptions, sell pharmacy-related products and provide counselling on the maintenance of good health.

The licensing of pharmacies is governed by the Medicines Act 1981. All pharmacies are required to operate under the supervision and control of a registered pharmacist. A company or person may operate or hold a majority interest only in a maximum of five pharmacies. Pharmacies can operate within health centres, in conjunction with other businesses and within other businesses (e.g. operate within a specified area of a supermarket). GPs cannot own pharmacies and there are restrictions on authorized prescribers.
of pharmaceutical medicines having an interest in a pharmacy unless the licensing authority “is satisfied that there are sufficient safeguards to prevent the issue of prescriptions, the manner in which prescriptions are issued, or the other provision of health care by the authorized prescriber being influenced by the commercial or financial prescriber or any other person holding an interest in the pharmacy” (Medicines Act 1981 section 42C(3)).

In 2020/2021, there were over 1100 pharmacies (excluding hospital pharmacies) in New Zealand, and approximately 3652 practising pharmacists with an average of 0.72 pharmacists per 1000 population (Pharmacy Council, 2022; OECD, 2022b).

As part of the PHCS released in 2001 and a more recent Pharmacy Action Plan (2016–2020), the role of pharmacists and pharmacies in New Zealand is changing, from emphasizing the dispensing of medicines to providing more support for people to manage their own wellbeing, providing minor ailment services, supporting better medicines management (including polypharmacy), and making use of new technology to better support prescribing and dispensing (e.g. through e-prescribing) (Ministry of Health, 2016b).

Two government organizations control the use of pharmaceuticals in New Zealand: the New Zealand Medicines and Medical Devices Safety Authority (Medsafe), and the Pharmaceutical Management Agency (PHARMAC). Most pharmaceutical products are imported into New Zealand, with a small amount of local production.

Medsafe administers the Medicines Act 1981 and Regulations 1984, and parts of the Misuse of Drugs Act 1975 and Regulations 1977, to manage the risk of avoidable harm associated with the use of medicines. Medsafe is also responsible for ensuring that the therapeutic products available in New Zealand can be expected to have greater benefits than risks if used appropriately. Pre-marketing approval must be obtained for new and changed medicines. Data that satisfactorily establish the quality, safety and efficacy of the product, for the purposes for which it is to be used, must be submitted for evaluation before consent can be granted. Post-marketing surveillance monitors the safety of medicines and medical devices in use. Products shown to be unsafe are removed from use, and prescribers are advised about new safety information for products. Medsafe thus is the gatekeeper of the New Zealand market, charged with ensuring that medicines are safe and effective, and PHARMAC decides on subsidy levels after Medsafe has approved drugs for use.
PHARMAC was set up in 1993 as a Crown Agency to manage the country’s positive list called Pharmaceutical Schedule, and then became a limited liability not-for-profit company under the Health Funding Authority. Following the New Zealand Public Health and Disability Act 2000, PHARMAC became a separate Crown Agency with its functions and responsibilities largely unchanged.

The PHARMAC Board makes decisions on listing, subsidy levels, and prescribing guidelines and conditions, with input from independent medical experts on the Pharmacology and Therapeutics Advisory Committee and its specialist sub-committees. Pharmaceutical suppliers may apply to have a medicine listed on the Pharmaceutical Schedule for subsidy, following Medsafe registration of the product. PHARMAC publishes updates of the Pharmaceutical Schedule, which involves continual assessment of drug performance and cost, usually by reviewing trends within defined groups of drugs (therapeutic group reviews).

A wide range of subsidized medicines, approved appliances and related products are listed on the Pharmaceutical Schedule, and can be prescribed by medical practitioners, midwives, some nurses, and dentists. Consumers make a small co-payment while concession mechanisms are intended to ensure that people can afford drugs (see Section 3.3.1).

PHARMAC funds nearly 1000 different medicines (in over 2000 different preparations). The Pharmaceutical Schedule, updated monthly and reprinted three times a year, also sets out prescription guidelines, and records the price of each drug and the subsidy. PHARMAC decides which drugs should be listed on the Pharmaceutical Schedule based on evidence of effectiveness, and also decides the price that government is prepared to pay the supplier. As a monopsony purchaser with considerable bargaining power, PHARMAC has applied supply-side controls. It uses a range of strategies to control pharmaceutical expenditure, including reference pricing with suppliers. PHARMAC manages pharmaceutical expenditure through negotiations and contracts with pharmaceutical suppliers.

As a result, total pharmaceutical expenditure as a percentage of the total expenditure on health had fallen from a high of 15.8% in 1994 to 9.3% in 2009 (OECD, 2011). This compared with the United Kingdom’s pharmaceutical expenditure of 11.6% of total health expenditure (2008), the United States’ 12.0% (2009), Australia’s 14.6% (2008) and Germany’s 14.9% (2009) (OECD, 2011). In its first decade (to 2003), PHARMAC estimated cumulative savings from its work at over $2 billion; and estimates an additional $6 billion in savings between 2007 and 2017 (PHARMAC, 2018).
Reference pricing is based on the classification of pharmaceuticals into therapeutic groups and subgroups. A “therapeutic group” is defined as a set of pharmaceuticals that are used to treat the same or similar conditions, and a “therapeutic subgroup” is defined as a set of pharmaceuticals that produce the same or similar therapeutic effect in treating the same or similar conditions. The application of reference pricing means that all pharmaceuticals in a given subgroup are subsidized at the level of the lowest priced pharmaceutical. PHARMAC can consult on the method for calculating the reference price and is not bound to apply reference pricing in every situation where pharmaceuticals have been classified into a therapeutic subgroup.

Consumer co-payments for pharmaceuticals were also intended to manage consumer demand and contain expenditure (Stats NZ, 1998). An initiative of the PHCS increased the subsidy for pharmaceutical prescriptions, reducing the price that the public pays for prescriptions. People who are eligible for publicly funded health and disability services, and whose medication is funded by PHARMAC, will pay a maximum of $5 per item prescribed for their prescription (for a maximum of 20 prescriptions per year per family). The cost results in some unmet need for prescriptions; further discussed in Chapter 7.3.2.

In 2021, the government commissioned an independent review of PHARMAC. The review was charged with assessing how well PHARMAC performs against its current objectives, whether PHARMAC’s current objectives maximize its potential to improve health outcomes for all New Zealanders, and whether PHARMAC’s objectives should be changed (Pharmac Review, 2021a). The review’s interim report was published in December 2021. The interim report did not make recommendations. Instead, it signalled the areas of main concern and where the panel would do more work. The review noted that PHARMAC is a relatively small agency staffed by highly skilled people with a reputation for achieving cost reductions and maximizing the value of the annual pharmaceutical budget. The review also found that PHARMAC operates in an environment where it is a very small player on the world stage, and where there are rising numbers of sophisticated new drugs hitting the market.

However, the review found that PHARMAC is underperforming in its efforts to remove inequitable health outcomes. Indeed, its prioritization approach appears to disadvantage Māori, Pacific people, disabled people and those with rare disorders, and that Te Tiriti o Waitangi principles are largely unseen in PHARMAC’s decision-making processes. The review also found that PHARMAC may have an excessive focus on containing costs and that
its decision-making is opaque and perceived as being slow. PHARMAC’s engagement with consumers and patient advocacy groups needs to be more meaningful and that there are convoluted procurement processes discourage pharmaceutical companies. Finally, the review found that there is a perception that New Zealand is falling behind other developed countries when it comes to pharmaceutical management (Pharmac Review, 2021b).

The final report also noted that:

- PHARMAC must make explicit the expectation that in seeking the best health and equity outcomes, PHARMAC must work collaboratively with the MoH and the newly created HNZ and MHA.
- PHARMAC’s Consumer Advisory Committee should be appointed by the Minister. This would provide a strong signal that PHARMAC regards consumer input as independent of PHARMAC’s preferences of the day.
- PHARMAC must ensure its contractual obligations do not preclude the sharing of commercially sensitive information with the government’s key monitoring agencies.
- PHARMAC be required to improve the transparency and accessibility of its systems, processes, resources, and communications to allow disabled people to participate and contribute on an equal basis (PHARMAC Review, 2022).

The government has agreed with the review’s findings and had directed PHARMAC to ensure they are implemented (New Zealand Government, 2022b).

New Zealand complies with the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement. When the Agreement started in New Zealand, the patent length for pharmaceuticals increased from 16 years to 20 years and patent extensions were no longer allowed (Lynch, 2003). The pharmaceutical industry has pushed to have a supplementary protection certificate system developed in New Zealand so that New Zealand trading laws are in line with some of its trading partners. Such systems currently operate in Japan, the United States, Australia and the European Union (Lynch, 2003).

5.7 Rehabilitation/intermediate care

ACC is the cornerstone of rehabilitation management. ACC was established in 1974 under the Accident Compensation Act. The purpose of the Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable
scheme for managing personal injury. The main goals of the Act are to minimize both the overall incidence of injury in the community, and the impact of injury on the community, including economic, social and personal costs (Accident Compensation Act 2001, section 3).

ACC provides comprehensive no-fault personal injury cover (financial cover) for New Zealand residents and visitors to New Zealand. People can apply for help regardless of how their injury occurred, or whose fault the injury was (ACC, 2021a). In return for cover, the ability to sue for personal injury has been removed, except for exemplary damages. Exemplary damages are not awarded as compensation to an injured person, but instead aim to reform or deter the person who caused injury, and others, from following the same course of action that caused the injury (Accident Compensation Act 2001, section 319).

ACC pays for a wide variety of medical costs, including, but not limited to, GPC visits, specialist fees and prescription costs, visits to allied health professionals, acupuncturists, audiologists, and some hospital treatment and surgery. People can receive ACC-funded care only from providers who have pre-registered with ACC. Further, people can receive weekly compensation while they are out of work due to an injury, of 80% of their pre-incapacity income. Common causes of personal injury that ACC frequently covers include physical injuries (sprain, laceration, fracture), work-related gradual process diseases or infections, mental injury caused by a physical injury, and mental injury caused by sexual abuse or assault (ACC, 2021a). ACC does not cover stress, hurt feelings, injuries related mainly to ageing, non-traumatic hernias and non-occupational gradual process injuries (ACC, 2021b).

ACC has several sources of funding. It receives some funding from general taxation to cover injuries to non-earners. Workplace and motor vehicle injuries are funded through levies on people’s earnings, businesses’ payrolls, petrol, and vehicle licensing fees.

There are concerns over how well ACC works with Māori. To create better ACC experiences and outcomes for Māori, ACC has developed Whāia Te Tika, its Māori strategy. Among its innovations are the establishment of a Māori Customer Advisory Panel in October 2019, and involving whānau (families) in treatment, such as a pilot programme whereby clients and their families received high-quality support and rehabilitation services in their homes and communities (ACC, 2020a).

Although ACC legislation is widely recognized positively in New Zealand for making access to compensation fairer and for ensuring that those injured
get the care they need, it has also introduced inequities: those injured often get access to a wider range of services, more quickly, than those where similar conditions arise as a result of non-accidental causes (Goodyear-Smith & Ashton, 2019). There are also concerns that the ways in which ACC coverage emphasizes key incidents (e.g. “accidents” over birth injuries) and the ways in which decisions are made are creating inequities for women, while for Māori, claim rates are low and outcomes worse as a result; claim rates are also low for Pacific peoples (Bradley, 2021). In late September 2022, the Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Bill passed into law, expanding cover to include birth injuries from 1 October 2022. It is expected to benefit 28,000 birthing parents each year (Sepuloni, 2022).

Other rehabilitation services are funded by publicly funded health providers, for example, for those with stroke or brain injury, musculoskeletal and orthopaedic conditions. Services are delivered by publicly funded health providers themselves, both in hospital settings and in the community. Some services are delivered on contract to the publicly funded health providers by privately owned providers.

5.8 Long-term care

This section reviews three areas that are closely linked to the health system: disability support services, the care of dependent older people, and the care of people with long-term conditions. Strategies and programmes that target these three areas are often interlinked and are not mutually exclusive.

5.8.1 Disability support services

Disability support services aim to increase the independence of people with long-term disabilities and to promote their participation in the community. The disability sector in New Zealand has adopted a social model of disability and has an active disability rights movement. The social model of disability focuses on removing barriers to a person’s opportunities for independence and participation in community life.

The most recent figures on disability in New Zealand are from 2013 (Stats NZ, 2014). At that time, about a quarter of the total population (24%) were identified as having a disability. This compares to 20% in 2001; the increase being partly explained by an ageing population. People aged 65 years or over were much more likely to have a disability (59%) than adults under 65 years (21%) or children under 15 years (11%).
The most common cause of disability for adults was disease or illness (42%). Physical limitations were the most common type of impairment for adults. For children, learning difficulty was the most common form of impairment. The most common cause of disability for children was a condition that existed at birth (49%).

Just over half of all people with disabilities (53%) had more than one type of impairment. Māori and Pacific people had higher-than-average disability rates, after adjusting for differences in ethnic population age profiles.

Schools are required to be inclusive under the Education and Training Act 2020. For instance, learning support is available for children and young people with autism spectrum disorder, who are blind or partially sighted, are identified as deaf or hard of hearing, or have speech, language and communication needs (Ministry of Education, 2022).

The government is the predominant government funder of disability support services. In 2018/2019, the MoH funded NZ$ 1.4 billion for disability support services for 38 000 disabled people (aged under 65 years when they entered the system) and 82 500 requests for equipment and modifications (including homes and vehicles) from people of all ages, many of whom additionally accessed other disability support funded either by the government. The same year, DHBs funded more than NZ$ 1.4 billion of support services for people aged 65 years and over (of these, 75 000 received home and community-based support and 33 000 received aged residential care), and for people disabled by mental health conditions and associated social and attitudinal consequences (Health and Disability System Review, 2020).

Eligibility for these services is determined by a needs assessment service coordination process, which identifies support needs, coordinates services, and allocates resources within a fixed budget. Carer support allows unpaid primary carers of a person with a disability to receive short-term breaks from care. Respite services are available to disabled people to provide short-term out-of-home breaks in a community setting (Ministry of Health, 2022q).

From 1 July 2022, responsibility for disability support services shifted to a newly established Ministry of Disabled People (MoDP) (see Chapter 6).

### 5.8.2 Aged care

Many disability support services also apply to older dependent people. The care of older people will become a more important public policy issue in New Zealand, since the proportion of people aged over 65 years is projected to
increase from 16% of the population in 2020 to 21–26% in 2048 and 24–34% in 2073 (Stats NZ, 2020).

New Zealand’s Healthy Ageing Strategy was released in 2016 (Ministry of Health, 2021w). It set the strategic direction through to 2026 for the delivery of services to people into and throughout their later years. The Strategy’s vision is that older people live well, age well and have a respectful end of life in age-friendly communities. Some of the key achievements so far include the implementation of a nationwide programme of falls and fracture prevention and treatment initiatives led by the ACC and DHBs; improved remuneration, training and employment conditions for care and support workers in aged care; and Hamilton and New Plymouth being accepted into the World Health Organization’s Global Network for Age-Friendly Cities and Communities.

All residential rest home-care services are now delivered by privately owned providers, and there is a trend towards much larger facilities, often developed in conjunction with retirement villages. (Retirement villages are where independent older people live within a village setting; they have a “licence to occupy” – to live in a house or apartment, paid for privately and costing similar amounts as any housing.) The MoH lists 662 certified services on its website, with just over 40 000 beds (Ministry of Health, 2022r).

The MoH is responsible for certifying and monitoring residential rest home services. DHBs were responsible for ensuring the supply of residential care rooms; in doing so, they consult with providers of rest homes and dementia and geriatric hospital-level facilities. To be eligible for publicly funded residential rest home care, people must first have a needs assessment that determines they do require such care. There is then an asset test that will determine whether a person is eligible for funded care; if they have assets over certain limits, they must pay for care themselves until their level of assets falls beneath the limits. There is then also an income test, with people paying a contribution towards the cost of their care (Work and Income, 2022b).

### 5.8.3 Long-term conditions

Long-term conditions have significant social and financial costs for society and the health sector. The most common long-term conditions include heart disease, diabetes and respiratory diseases, all of which are leading causes of death in New Zealand (see Section 1.4).

Care for people with long-term conditions is initiated by a person’s PHC practitioner, who may treat the patient themselves or refer them to a
specialist in a hospital or private practice. People may also receive help from not-for-profit and volunteer support groups.

Much attention is currently being paid to improving care for people with long-term conditions, with a particular focus on strengthening PHC services. The PHCs, for example, had a key focus on improving services for people with chronic conditions, including “Care Plus”, which provided additional funding to PHOs (for 5% of the population overall) for people with high health needs because of a long-term condition, acute medical or mental health needs, or terminal illness (see Section 6.1.5).

The government has a number of initiatives under way to better support people with long-term conditions. One key example is Te Ranga Ora, which is a mid-North Island initiative aimed at co-designing and implementing new approaches to care. It is aimed at Māori, Pacific people and people from lower socioeconomic areas and their whānau, with two or more chronic conditions. A learning partnership is under way, which aims to understand how to better prevent and treat such conditions, and how commissioning can also be improved to promote equity and wellbeing (Ministry of Health, 2021x).

5.9 Services for family/informal carers

An informal carer is anyone who supports a person with ill-health, a disability, mental illness or addiction, or in their old age (Carers New Zealand, undated). About one in 10 New Zealanders are carers, or about 430,000 people. This number will likely rise as the population ages and people live longer. The majority of carers are women (63%). Carers span all ethnic backgrounds, with the majority being European and Māori (European 70%, Māori 15%, Pacific 6%, Asian 7% and Other 2%). Nearly two thirds of carers are also employed outside of their caring role (63% in full-time or part-time employment) (Ministry of Social Development, 2022a).

Most informal carers are unpaid, although a small proportion are eligible for the means-tested Domestic Purposes Benefit – Care of Sick or Infirm if they care full-time at home for someone other than their spouse or partner who would otherwise need hospital, rest home or residential disability care. However, a group of parents of adult disabled children took a case to the Human Rights Review Tribunal, challenging the MoH’s refusal to pay them for providing disability support services to their family members. The Tribunal (and later the Court of Appeal) found in their favour and the MoH subsequently developed a new policy, Funded Family Care, which came into effect on 1 October 2013 (Ministry of Health, 2016c).
However, payment for family members was restricted to a small group of family members (other than a spouse) who cared for a disabled person aged 18 years or over who was assessed as having high or very high needs (through existing needs assessment processes) (Ministry of Health, 2016c). The Funded Family Care system ended in August 2020 and has been replaced by a new two-part system. A disabled person’s family can apply for a position as a resident funder carer with the disabled person as their client, and/or the disabled person can use the new individualized funding package where they employ a carer (Ministry of Health, 2021y) (Ministry of Health, 2021z).

A national Carers’ Strategy was published in 2008, the first time in New Zealand that a ministerial strategy focused solely on informal carers. The Strategy was developed by the Ministry of Social Development in partnership with the New Zealand Carers’ Alliance and other government agencies. The third iteration of the plan, *Mahi Aroha*, covers the period 2019–2023 (Ministry of Social Development, 2022b). *Mahi Aroha* has four areas of focus:

- Ensuring that carers are recognized, valued and acknowledged for their work.
- Better support to carers to navigate the system of assistance available to them.
- Supporting carers, including providing financial support and wellbeing.
- Supporting carers who want to balance paid work, study and other opportunities alongside their caring.

Although *Mahi Aroha* is for all carers, it has an additional focus on four target population groups: carers who are Māori, Pacific, young (up to 25 years) and older (65 years and older).

Many NGOs provide support for people with disabilities or chronic conditions and their families and informal carers. Two important umbrella organizations advocate specifically for carers: Carers New Zealand, a national charitable trust that provides information and support to carers, and the New Zealand Carers’ Alliance, a network of charities and NGOs formed to support carers and to lobby government about policy to address carers’ needs (Carers New Zealand, undated).

### 5.10 Palliative care

The government funds many palliative care and related services. Much community-based specialist palliative care is provided by privately owned hospices, many of which are not-for-profit organizations. Government funding covers most costs, but many hospices also rely on donations for their services.
A New Zealand Palliative Care Strategy was released in 2001 (Ministry of Health, 2001). The Strategy noted a number of service issues that needed addressing, including variable access to services, variation in services and variability in funding. The Strategy aims to provide a systematic and informed approach to the provision and funding of palliative care services. The Strategy has two underlying objectives: to develop a set of essential services for dying people who could benefit from palliative care, and to develop a flexible service configuration that is coordinated between existing services and the aims of the Strategy. The first priority of the Strategy is to ensure that all people requiring palliative care have access to at least one palliative care service within their geographical region, and access to specialist palliative care services within their wider region (e.g. Wellington, Auckland and Hamilton). Palliative care for a patient is usually initiated by the patient’s GP or primary care nurse. Other key stakeholders include Hospice New Zealand (the national body for many hospices in New Zealand), other health professionals, research institutions and community groups.

Palliative care is provided in three locations: at a person’s home, in day-care facilities or in inpatient facilities. Specialized paediatric palliative care is provided at the Starship Children’s Hospital in Auckland. Though palliative care is government funded through DHBs, hospices are also supported by corporate sponsorship, public donations and volunteers.

An MoH review of palliative care, published in 2017 (Ministry of Health, 2017b), identified several priority areas for enhancing palliative care in New Zealand. A palliative care Action Plan (Ministry of Health, 2017c) followed, with work for the immediate future to focus on responding to the voices of people with palliative care needs and their families, whānau; ensuring strong strategic connections; improving quality across all settings; an increasing emphasis on primary palliative care; and growing capability of communities and informal carers.

5.11 Mental health and addiction services

Mental health and addiction services describe a range of services for the treatment of mental distress and drug and alcohol dependency, as well as support services for those with long-term mental distress.

As in many other countries, the field of mental health services has changed radically over the past few decades. New Zealand overhauled its mental health services in the 1990s. The main change was the closure of large mental hospitals and the movement of care into the community, facilitated by new drugs and pushed by the deinstitutionalization movement. The rights of
patients were protected under the Mental Health (Compulsory Assessment and Treatment) Act 1992, which aimed for a balance between personal rights and protection of the public.

Mental health services, both hospital and community based, are predominantly publicly funded and are offered by a mix of publicly and privately owned providers, many of which are delivered by not-for-profit NGOs. Most community-based residential and day and support services are provided by NGOs. Typically, a person with a psychiatric disability living in the community is treated by a public-sector community mental health team but receives day-to-day support from NGOs. These services typically focus on the 3% of the population with the most severe mental health needs.

Those with a less severe mental health issue (e.g. mild-to-moderate depression) access PHC services through their GPC. Medication is funded by the government. There have, however, been longstanding concerns over the lack of services available to those with mild-to-moderate mental distress.

New Zealand embarked upon a national mental health strategy with the publication of Looking Forward [Ministry of Health, 1994a], followed by an implementation plan Moving Forward [Ministry of Health, 1997]. The strategy focused on those who are seriously unwell (estimated to be 3% of the population), while the implementation plan outlined steps for achieving more and better services and set targets and delivery dates. Funding for social support services was transferred from Social Welfare to Health between 1993 and 1997 to improve the links between clinical services and social support.

The government’s interest in mental health and substance abuse was broadened in 2005 by the second mental health and addiction plan and the strategic document Te Tāhuhu – improving mental health 2005–2015 [Ministry of Health, 2005a], which built on the earlier Looking Forward and Moving Forward. The plan outlined government expectations from all state services (which comprise all departments and Crown entities) with regard to mental health and addiction services.

Building on previous plans, Rising to the Challenge: the Mental Health and Addictions Service Development Plan 2012–2017 was published in 2012. It set out actions over the five years to improve outcomes, support better system integration and performance, increase access to services, make more effective use of resources, and strengthen whole-of-government partnerships [Ministry of Health, 2012b].
Historically, there have been numerous programmes aimed at supporting improved mental health. “Let’s get real” was a framework that described the essential knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services. It aimed to improve the competence and capability of the mental health workforce (Ministry of Health, 2008b); it was refreshed in 2018 (Te Pou, 2022). “Like Minds, Like Mine” was a public education programme that started in 1997 with the aim of reducing the stigma and discrimination faced by people with mental illness or people who have previously experienced of mental illness. Surveys reviewing the success of the campaign show it produced positive benefits in reducing the stigma and increasing people’s awareness of mental illness (Wyllie, Cameron & Howearth, 2008; Like Minds Like Mine, 2022).

In early 2018, the government announced a government inquiry into mental health and addiction, as a result of widespread concerns over mental health services. The Inquiry team collated information from many sources, including undertaking a stocktake of services, and engaged in significant consultation around the country. In its November 2018 report, the Inquiry pointed to a raft of issues relating to mental health and mental health services in New Zealand. It noted particular concerns over inequities for Māori, Pacific and Rainbow communities in terms of access to services (including diagnoses) and outcomes; poorer physical health for those with higher levels of mental distress; persistently high suicide rates; and concerns over mental health in schools and for children in State care.

The Inquiry made a number of recommendations, some of which are listed below:

- Expand access and choice, in particular, for those not covered by the current focus on the 3% of people accessing specialist services. A wider range of therapies, especially “talk” therapies, along with alcohol and drug services, and better culturally aligned services were recommended.
- Transform PHC so that people can get skilled help in their local communities, to prevent and respond to mental health and addiction problems.
- Strengthen the NGO sector to support the significant role NGOs (including Kaupapa Māori services) should play with the shift to more community-based mental health and addiction services.
- Take a whole-of-government approach to wellbeing to tackle social determinants and support prevention activities that affect multiple outcomes, not only mental health and addiction.
• Facilitate mental health promotion and prevention with leadership and oversight from a new commission, including an investment and quality assurance strategy for mental health promotion and prevention.
• Place people at the centre to strengthen consumer voice and experience in mental health and addiction services.
• Take strong action on alcohol and other drugs, including through a stricter regulatory approach to the sale and supply of alcohol, and providing a wider range of services.
• Prevent suicide, including by urgently completing and implementing a national suicide prevention strategy, with a target of a 20% reduction in suicide rates by 2030.
• Reform the Mental Health Act. Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992, to reflect a human rights approach, promote supported decision-making and align with a recovery and wellbeing model, and minimize compulsory or coercive treatment.
• Establish a new Mental Health and Wellbeing Commission to act as a watchdog and provide leadership and oversight of mental health and wellbeing in New Zealand.
• Refer to the Health and Disability Sector Review for consideration, broader issues such as the future structures, roles and functions in the health and disability system, including the establishment of a Māori health organization.
• Establish a cross-party working group on mental health and wellbeing to reflect the shared commitment of different parties to improved mental health and wellbeing in New Zealand (Government Inquiry into Mental Health and Addiction, 2018).

The government welcomed the inquiry’s recommendations, accepting, accepting in principle, or agreeing to further consider, 38 of the inquiry’s 40 recommendations (Ministry of Health, 2020k). In the May 2019 Budget, the government announced a $1.9 billion mental health package, in part focussed on supporting the implementation of the government’s response to the inquiry. The following were included:

• $455 million over four years for new universal frontline mental health service established, expected to help 325 000 people with mild-to-moderate mental health and addiction needs by 2023/2024.
• $200 million extra for new and existing mental health and addiction facilities.
• Expanding the nurses in schools programme to decile 5 secondary schools – reaching an extra 5600 students.
• $128.3 million for Department of Corrections to spend on mental health and addiction services.
• $197 million to tackle homelessness through Housing First.
• Funding for the Te Ara Oranga programme in Northland to help up to 500 people a year who are addicted to methamphetamine (Ardern et al., 2019).

Aspects of these new initiatives are well under way. A report issued by the Implementation Unit at the Department of Prime Minister and Cabinet noted that very good progress was being made, with the package on track to deliver intended output by 2023/2024. It suggested that a cross-agency governance mechanism be put in place, given the range of agencies involved and the common delivery issues that were arising in each programme. It also noted the importance of a stronger workforce planning and management process and of the importance of ensuring standardized training (Implementation Unit, 2021).

The new Mental Health and Wellbeing Commission commenced in February 2021. In 2022, it noted that new investment was important, particularly for boosting PHC and community services, but that there is a need for more support for specialist services, where waiting times for services have not changed much, and with concerns over waiting times for young people. It also noted the need for choice for Māori, and for outcome measures to focus on the things that matter to service users (Mental Health and Wellbeing Commission, 2022).

In 2021, the government also released Kia Manawanui Aotearoa Long-term pathway to mental wellbeing, which outlined its plan for transforming the approach to mental wellbeing (see Section 6.1.6.1).


People with a mental disorder or an intellectual disability who are charged with or convicted of an imprisonable offence may have to accept involuntary treatment or care and rehabilitation. If an accused person has a mental disorder, the court may make a Special Patient Order requiring the person to accept treatment until they are no longer a danger to themselves or others.
If an accused person has an intellectual disability, the court may make a Compulsory Care Order lasting up to three years, which can be extended by the family court (Ministry of Health, 2003b).

Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, people can also be compelled to receive treatment without having committed a criminal offence if the mentally ill person is a danger to themselves or others, or their mental state is such that it seriously diminishes their capacity to care for themselves. A strict set of protocols is followed when compulsory care or treatment of an individual is initiated. The rights of patients with mental disorders are also covered by the Act (Ministry of Health, 2003b).

As part of implementing the government’s response to the inquiry into mental health and addiction, considerable work is underway to repeal and replace the Act with legislation that reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment (Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2022s).

5.12 Dental care

Children are entitled to free basic health care from birth to the end of year 8 schooling (age 12–13 years), originally from dental therapists, who usually operated from school grounds either in on-site or mobile clinics. Dental therapists were employed by public or private health providers. Dental therapists provided oral health assessment (dental examinations), restorations (fillings) for both primary and permanent teeth, pulp-capping in primary and permanent teeth, extraction of primary teeth, preventive dentistry, including the placement of fissure sealants and application of fluorides, and oral health education and promotion.

The Good Oral Health, For All, For Life document was developed in 2006 and serves as the strategic vision for oral health in New Zealand. The key principles underlying the strategy include improving the oral health status of disadvantaged groups – particularly Māori, Pacific peoples and people from lower socioeconomic groups; developing strong preventive programmes that complement examination and treatment services (e.g. oral health promotion in schools and water fluoridation); and ensuring that there is a robust and appropriately trained workforce that provides a high-quality service. The DHBs had the primary responsibility to ensure that high-quality oral health services are available to all people within their geographical boundary (Ministry of Health, 2006b).
As a result, a new Community Oral Health Service has been established for child dental services. An MoH reinvestment programme (allocated $116 million in capital funding and $31.3 million per annum for operating expenses) led to the replacement of school dental clinics with a mixture of 177 stand-alone community-based clinics and 143 mobile units in outreach locations, including schools with health promotion services.

A new model of care sees a greater use of dental assistants and support staff, stronger linkages with primary health care to increase preschool enrolments and referrals through a "Lift the Lip" initiative (through which Well Child/Tamariki Ora providers check if infants or toddlers have dental caries and refer them to services), and engagement with family/whānau to support good oral health practices at home. An evaluation found that the new service was showing some positive results (e.g. in terms of enrolments and access) (Ministry of Health, 2016d).

Free basic dental services are also available for adolescents up to their 18th birthday and are provided by private dentists, funded by the publicly owned health providers. There are, however, major inequities in access to and use of services. Most adult New Zealanders must pay for private dental treatment (or purchase health insurance for this). As a result, utilization rates sharply decline for those aged 18 years and over as a result of major cost barriers to care (Health and Disability System Review, 2020; see also Annex [Section 9.1 – Table 9.4]), and rates of inequality are particularly high compared with other countries (Mejia et al. 2018).

Limited dental services are available from most public hospitals for people on low incomes (though there may still be a part-charge) (Ministry of Health, 2021aa), and there are long wait times for care. People on benefits may also be eligible for some financial assistance for emergency dental treatment through Work and Income (Work and Income, 2022c). Dental treatment required following injury or accident is funded by ACC. The Department of Corrections funds prisoners’ oral health treatment and the New Zealand Defence Force pays for the dental treatment of personnel.

A major public health approach to dental care is water fluoridation. The naturally occurring level of fluoridation in New Zealand water supplies is not sufficient to be of benefit to dental health, so most of New Zealand’s public drinking water is fluoridated to levels between 0.7 parts per million (ppm) to 1 ppm. Hastings was the first community to have fluoridated water in 1954 (Moore et al., 2017a). Fluoridation of water supplies has been found to be cost saving (Sapere, 2016).
Until recently, district councils were responsible for public water supplies and make the decision as to whether to add fluoride to water supplies to improve drinkers’ oral health. The public supply of drinking water covers 3.8 million New Zealanders (equating to about 85% coverage). About 56% of people on public drinking water supply receive fluoridated water (Sapere, 2016). Not all communities’ water supplies are fluoridated, as some communities have held referendums that stop water fluoridation and some rural communities do not have access to fluoridated supplies. However, a Health (Fluoridation of Drinking Water) Amendment Act 2021 shifted decision-making on fluoridation from local councils to the Director-General of Health, who now has the power to require councils to fluoridate their water.

The Dental Council is the statutory body constituted under the Health Practitioners Competence Assurance Act 2003 for maintaining self-regulation of the dental profession. The main purpose of the Council is to ensure that oral health practitioners are safe and competent to practise. All oral health practitioners working in New Zealand must be registered with the Dental Council. In 2020, there were 5018 oral health practitioners registered with the Dental Council. Of these, 60% had qualified in New Zealand (Dental Council, 2020).

Two tertiary institutions provide training for dental professionals. The University of Otago’s Dental Faculty offers several programmes: five-year Bachelor of Dental Surgery (leading to registration as a dentist or, later, dental specialist), three-year Bachelor of Dental Technology (to register as a dental technician, responsible for producing prostheses prescribed by a dentist), and three-year Bachelor of Oral Health (leading to registration as a dental therapist or dental hygienist). Dental therapists provide oral health prevention, assessment and treatment for children and adolescents up to the age of 18 years, and dental hygienists provide oral health education for patients and nonsurgical treatment of periodontal diseases under the supervision of a dentist (University of Otago, 2022d).

The university AUT in Auckland offers a Bachelor of Health Science (Oral Health) for training oral health therapists (AUT, 2022).

5.13 Complementary and alternative medicine

Complementary and alternative medicine (CAM) is a group of diverse healthcare systems, practices and products that are not generally considered part of conventional medicine. Examples include chiropractic, acupuncture, homeopathy, dietary supplements, meditation and hypnosis.
There are an estimated 69 different CAM groups in New Zealand (Liu et al., 2021). CAM practitioners operate from a variety of settings, from multidisciplinary clinics that may also offer mainstream GP services to other practitioners that operate informally out of their own homes. There have been a number of attempts to create umbrella organizations for CAM practitioners, but these have not been particularly successful. The various professions still tend to work within their own educational standards and professional regulatory processes. There are, however, two organizations claiming an umbrella role for CAM groups: Natural Health Practitioners New Zealand (https://nhpnz.org/) and the Natural Health Council (naturalhealthcouncil.org.nz).

Chiropractors and osteopaths are regulated by the Health Practitioners Competence Assurance Act (2003). The purpose of the Act is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions (section 3). Other CAM providers are not regulated by specific legislation, though other regulations – such as the Fair Trading Act and the Code of Health and Disability Consumers’ Rights – do have an impact on how CAM practitioners can operate.

CAM products are regulated on the basis of how the manufacturer markets the product, either as a food or as a medicine. A product marketed as a medicine is subject to stringent regulations, while a product marketed as a dietary supplement is subject to minimal regulations. A natural health product is a medicine under the Medicines Act 1981 if its main purpose is therapeutic, as defined in section 4 of the Act. Dietary supplements – such as vitamin and mineral tablets – are regulated under the Dietary Supplements Regulations 1985. The commercial sale and promotion of natural health products are also regulated under general consumer legislation (Ministry of Health, 2021ab).

According to the most recent research in the area (Ministry of Health, 2008a), nearly one in five adults (18.2%) saw a complementary or alternative health worker in the previous 12 months. The most common therapist used was a massage therapist (55.8%), followed by a homoeopath or naturopath (25.8%), and an acupuncturist (18.5%). Women (22.3%) were significantly more likely than men (14.1%) to have seen a complementary or alternative health-care worker in the previous 12 months. Less than 0.5% of adults said they go to a complementary or alternative health-care worker before visiting a mainstream health professional.
A recent review of research into New Zealand mainstream healthcare professionals’ attitudes towards CAM found that, in general, such professionals have a positive attitude towards CAM (Liu et al., 2021). About 25% of GPs practise CAM, and 82.3% of GPs refer patients to CAM practitioners. GPs most commonly practised acupuncture and referred patients to acupuncturists. Further, when treating pregnant women, 48.4% of physiotherapists practise acupuncture, and 37.3% of midwives recommend CAM. Up to 58% of GPs and Plunket nurses wanted to receive further education on CAM, and up to 66.7% of GPs supported the idea that CAM should be included in medical curriculums. That said, health-care professionals had concerns regarding the scientific evidence, regulation, safety and financial costs of CAM.

5.14 Health services for specific populations
See Sections 2.3.7 and 2.3.8 for Māori and Pacific health services, respectively.

5.15 Disaster risk management for health (DRM-H)
The Civil Defence and Emergency Management Act 2002 outlines the roles and responsibilities of key government agencies, including the MoH, in an emergency. The Act is now administered by the National Emergency Management Agency (NEMA), which came into being on 1 December 2019 replacing the previous Ministry of Civil Defence and Emergency Management. NEMA works with other agencies, including the MoH, to facilitate and guide emergency planning activities in the country. Under the Act, local government authorities around New Zealand must establish regional Civil Defence and Emergency Management groups, tasked with establishing local emergency plans, as well as responding to and managing the adverse effects of emergencies in their areas.

NEMA has a National Civil Defence Emergency Management Plan for New Zealand (Ministry of Civil Defence and Emergency Management, 2015). Section 11 of the Plan details the responsibilities of the health sector. The Plan notes that the overall objective of the health and disability sector during an emergency is to provide services that minimize the consequences of the emergency to the health of both the community and individuals. In turn, this means that the health and disability sector must maintain an emergency management structure to respond to emergencies, provide services that meet the needs of patients during and after the emergency (while ensuring that responses do not create or exacerbate inequalities for particularly vulnerable or hard-to-reach populations) and ensure that health and disability services are as resilient to the consequences of hazards and risks.
Within the MoH there is an Emergency Management Team, which works on emergency management projects that will either lead or support a national response to emergencies. Since 2004, the MoH has published a series of emergency management-related documents to guide responses in a health-related emergency.

The MoH’s National Health Emergency Plan (NHEP) provides overall direction to the health and disability sector with regard to emergencies (Ministry of Health, 2015). The NHEP aligns with NEMA’s National Civil Defence Emergency Management Plan.

The NHEP discusses how health and disability sector organizations should work together and with other government agencies to respond to disasters and emergencies. The NHEP draws on experiences in New Zealand and overseas in preparing for, building resilience to, responding to and recovering from a range of hazards, including human disease pandemics, tsunami, terrorist incidents and earthquakes. The NHEP describes the strategic relationships for emergency management, summarized as the four Rs:

- **Reduction** (that is, avoiding or mitigating adverse consequences before they occur). Health sector organizations can do this via such strategies as health promotion, risk communication and advice.
- **Readiness** (that is, enhancing the capability of the health and disability sector to respond to emergencies). An important aspect of this is ensuring that hospitals can cope with surges in demand following emergencies by, for instance, transferring patients to hospitals in other areas and cancelling all elective/planned procedures. Likewise, other health providers can assist to increase capacity. Undertaking emergency exercises to test capability is also important.
- **Response** (that is, providing health services during an emergency). For instance, the MoH is deemed to be the lead agency in any all-of-government response to a health emergency such as a pandemic. The MoH has established the National Health Coordination Centre as a structure through which the MoH can nationally coordinate the health responses to and recovery from emergencies. The Centre is kept in a constant state of readiness for any emergency.
- **Recovery** (that is, regenerating the emotional, social and physical wellbeing of individuals and communities after an emergency and reducing future exposure to hazards). The delivery of medical, mental health and community health services is a key component of social recovery.
There are three action plans under the NHEP, covering specific events. These are for a mass casualty event (Ministry of Health, 2015), a multiple complex burn event (Ministry of Health, 2011b), and an influenza pandemic (Ministry of Health, 2017a). For instance, the mass casualty action plan notes that publicly owned health providers must consider how they can increase and maintain extra capacity should an incident involving a large number of patients take place and that health providers must undertake mock disaster exercises to ensure that agencies work together as planned when actual mass casualty events occur. The multiple complex burn event plan includes provision for patients to be triaged and cases sent to any of the four regional burns units located around New Zealand (located in Auckland, Hamilton, Lower Hutt and Christchurch). The influenza plan says that if community outbreaks of the disease occur overseas, New Zealand must move to screen travellers into New Zealand and isolate symptomatic ones.

The MoH has also developed a range of resources to support people through emergencies (Ministry of Health, 2019e), including mental health advice for coping after traumatic events (Ministry of Health, 2021ac).

Publicly owned health providers are required to develop, maintain, exercise and operate individual health emergency plans and regional health emergency plans. Furthermore, they must ensure that health-care providers and supporting organizations (through contractual arrangements) have the ability to plan, maintain, exercise and continue the delivery of health services in an emergency.

Health and disability providers must have plans in place to respond to major incidents and emergencies. While providers not covered by the act are not legally required to have emergency plans, typically their contracts with publicly owned health providers require them to have one.

New Zealand has experienced a range of disasters and emergencies in recent years. A selection of these events, and the response of the health and disability sectors, are now discussed.

5.15.1 Christchurch earthquake

A major earthquake took place in Christchurch on 22 February 2011. This disaster killed 185 people, injured several thousand and resulted in widespread destruction across the city. It was followed by after-shocks, which prolonged the levels of distress among people in the area (in fact, the earthquake itself was an after-shock of an earlier earthquake situated further away from the city). The main responders at the time were ambulance and hospital services, the fire service, Civil Defence and the Police. There is
an archive of the police’s media releases issued in the wake of the disaster and can be viewed here (see New Zealand Police, 2011).

An independent review of Civil Defence’s response to the disaster found that the health sector’s performance had been very good (McLean et al., 2012). The review found that the Canterbury DHB and the local MoH office were well-prepared to handle the emergency. Before the earthquake, the DHB had run an exercise dealing with a sudden large influx of trauma patients, a programme funded by the MoH. Commitment to the exercise had been high, with the DHB’s senior management having taken part. Further, important networks throughout the region had been developed as far back as the potential severe acute respiratory syndrome (SARS) epidemic in 2003 and these assisted the sector in its response, including the DHB and primary caregivers working well together, emergency managers in the health sector working well with their counterparts in the local Civil Defence and Emergency Management group, and important messaging to the community before and during the disaster about the importance of handwashing playing a key role in preventing any serious outbreaks of gastroenteritis, despite sewerage services having been compromised by the earthquake.

The review found that Christchurch hospital was not overwhelmed by the disaster, even though the hospital itself was damaged in the disaster. In part, this was because triage had sent less critical patients to local private hospitals, and health staff from DHBs outside the region were quickly brought in to increase capacity. The review commended the DHB for accepting an Australian-supplied field hospital as a contingency should the city’s main hospital subsequently be unable to function.

The only significant criticism made was that inspectors subsequently closed some welfare centres because their sanitation or running water had been compromised by the earthquake. The review felt that these centres should have been kept open, using emergency toilets and water supplies, to allow the people using those centres to remain there and be more easily fed and helped.

The disaster has had major effects on those who directly experienced it. For instance, those in the region who experienced serious adversity, both through earthquake events and their following consequences, were 40% more likely than those living outside the region to have at least one of several kinds of disorder, including: major depression, post-traumatic stress disorder or anxiety disorder. However, researchers found the psychological impact of the quakes could have been worse if community spirit were not so strong. The well-organized and responsive way in which the local community responded
to the disasters with widespread support for those families affected likely acted as a protective factor in mitigating the consequences for those with high levels of exposure to earthquake-related adversity (University of Otago, 2014).

There has been extensive redevelopment at Christchurch’s public health facilities in the years after the earthquake. A new hospital at Burwood (a suburb of Christchurch) opened in 2016, a new outpatient facility at Christchurch Hospital opened in January 2019, and the new “Waipapa” Inpatient Building at Christchurch Hospital opened in November 2020. Waipapa cost NZ$ 550 million and includes significant seismic protection (Ministry of Health, 2021ad).

5.15.2 Mosque shootings

On 15 March 2019, a lone gunman attacked two mosques in Christchurch, killing 51 people and injuring 40. He was arrested and later convicted on multiple charges, including murder, attempted murder and terrorism. He was sentenced to life imprisonment without parole.

Along with ambulance and hospital services, the Police was the main response agency at the time. There is an archive of police media conferences regarding the event (see New Zealand Police, 2019a).

In the aftermath of the atrocity, the MoH formulated a plan as to how it and the Canterbury DHB could support those affected, ranging from the families of those who had lost loved ones through to the wider New Zealand public traumatized by what had happened (Ministry of Health, 2019f). The MoH noted that it needed to take its own action and work with other agencies and groups, such as imams and spiritual leaders, the Police, Victim Support, the Ministry of Social Development and Kāhui Tu Kaha [an Auckland-based organization with a Muslim mental health support group].

The strategies developed included transporting staff from Kāhui Tu Kaha’s Auckland base to Christchurch to work with affected families, running community workshops (including facilitating access to clinical support), producing support booklets (in English, Arabic, Farsi, Indonesian, Malay, Somali, Turkish, Urdu, Sign Language and Easy Read) and promoting the national telephone-based Healthline as a source of support and advice.

5.15.3 Whakaari/White Island eruption

On 9 December 2019, Whakaari/White Island, a volcanic island off the east coast of New Zealand’s North Island, erupted. The eruption killed 22
people and injured 25. Those killed and injured were local and international tourists and their guides visiting the volcano at the time of the eruption. There had been 47 people on the island at the time of the eruption, 38 of whom were passengers on an excursion from an international cruise ship berthed nearby.

An improvised rescue operation transported survivors off the island, with tourist boats and commercial helicopters bringing people to the mainland. Paramedics from the New Zealand coastguard boarded one of the boats to give aid to the injured. There were 34 injured people taken off the island, but 9 subsequently died of their injuries. The two leading agencies in responding to the crisis were the Police and NEMA. The Police issued regular media releases and held news conferences as the disaster unfolded (see New Zealand Police, 2019b).

There has yet to be any independent review of the actions of health providers following the disaster, but treatment appears to have been swift and well-coordinated. The injured were initially taken to the local hospital at Whakatāne, where they were triaged and stabilized before being transferred to other hospitals. The hospitals at Whakatāne, Tauranga, and Hamilton all activated mass casualty plans. Some patients were transferred to the country’s four regional burns units. On 11 December, 13 injured Australian tourists were airlifted back to their homeland by the Australian Air Force and their treatment continued there (Lewis, 2019; Radio New Zealand, 2019a; Pearce, 2019).

Although health providers seem to have worked together to provide timely treatment for survivors of the disaster, serious questions have been raised about the broader regulatory environment. The news media has reported that minutes of the local emergency services coordinating committee in 2016 had noted concern about risk management duties on the island. The Police had tried for six years before the eruption to have a rescue exercise on the island, but this had not happened. The committee was still working on an emergency response plan when the eruption took place (Olley, 2019).

WorkSafe, the government agency tasked with investigating workplace incidents to determine whether those with health and safety responsibilities met them, has brought charges against numerous individuals and agencies following the eruption. All the charges relate to activity leading up to the eruption. Among those charged are the owners of the island, tourism operators and NEMA. WorkSafe’s chief executive said: “There were 47 people on the island at the time of the eruption, all of whom suffered serious injuries and trauma, and 22 of those have lost their lives. Those who went to the island, did so with the reasonable expectation that there were appropriate
systems in place to ensure they made it home healthy and safe.” If convicted, each defendant could face significant fines. The trial is yet to be held (Gay, 2021; WorkSafe, 2021).

5.15.4 COVID-19 pandemic

5.15.4.1 Overview of the government’s response

The first New Zealand case in the COVID-19 global pandemic occurred on 21 February 2020. The New Zealand government’s initial policy response to the COVID-19 pandemic was to go hard and go early, with the objective of eliminating the virus in the community (Cumming, 2021a; Cumming, 2021b). The government followed a policy of stringent lockdowns and border controls, aiming to keep the population safe until having a sufficiently high percentage of the population vaccinated. It could be argued, however, that since the entry of the Omicron variant into New Zealand in late 2021, with COVID-19 fatigue, economic concerns, and increasingly vocal opposition, the policy response has become less stringent.

There have been six main phases to the pandemic in New Zealand. The first phase (February 2020–July 2020) involved development of the overall approach to managing the pandemic and an Alert Level Framework. The entire country went into a Level 4 lockdown for around six weeks. By 11 August 2020, there had been 1200 confirmed cases, 350 probable cases and 22 deaths. By this date, the virus had been well eliminated in the local community: New Zealand had gone 102 days without community transmission.

The second phase (August 2020–early October 2020) saw an outbreak in the community in Auckland, and Auckland put into level 3 and level 2.5 lockdowns for much of August and September. By 8 October 2020, there had been 1508 confirmed cases, 356 probable cases and 25 deaths.

The third phase (early October 2020–July 2021) saw most infections among people entering New Zealand and a few community cases, with short, sharp regional lockdowns at various points in time. Some travel “bubbles” (i.e. with no managed isolation in New Zealand, especially with the Cook Islands and Australia) occurred, but when rates (especially in Australia) increased, managed isolation requirements were reimposed. The adult vaccination programme – with the Pfizer two-dose vaccine – began in February 2021.

The fourth phase (mid-August 2021–December 2021) saw the Delta variant enter New Zealand (17 August 2021). By this date, there had been 2750 confirmed cases, and 26 deaths. There had also been 1.61 million primary
vaccinations and 934,000 second doses by this time. Auckland was then in lockdown levels 4 and 3 until 3 December 2021, with the Waikato and Northland in shorter periods of lockdown. As vaccination rates rose (and adult booster shots began from 29 November 2022), a new COVID-19 Protection Framework (known as the “traffic light system”) was devised, giving more freedoms at “green” and to those who were vaccinated, with increasing limits on gatherings at “orange” and “red” settings. A large part of the North Island was in red from 3 December 2021, with the rest of the country in orange. All parts of the country excepting Northland (due to low vaccination rates) went to orange on 31 December 2021.

The fifth stage (December 2021–late February 2022) saw Omicron enter New Zealand, with the first community case on 30 December 2021. The child vaccination programme began for 5- to 11-year-olds on 17 January 2022. All of New Zealand moved to the red traffic light setting on 23 January 2022 as more cases became apparent. From 27 February, fully vaccinated New Zealanders returning from Australia and who tested negative for COVID-19 could come to New Zealand and self-isolate for seven days, without going into managed isolation and quarantine (MIQ). From late February, the public could test themselves using home rapid antigen tests. A large anti-mandate protest group occupied Parliament grounds from 8 February. Ignoring repeated requests to leave, the protesters were forcibly removed by police on 2 March.

The sixth stage (March 2022 onwards) saw New Zealand start to significantly relax controls, as vaccination rates rose and new cases numbers declined. From 2 March, vaccinated New Zealanders returning from Australia no longer had to self-isolate at all. From 4 March, vaccinated New Zealanders from anywhere in the world could enter the country without self-isolating. In both cases, arrivals had to test negative for the virus prior to boarding their planes. Self-isolation for those in New Zealand who contracted COVID-19 was reduced from 10 days to seven days from 11 March. Unvaccinated New Zealanders who tested negative could return to New Zealand without self-isolating as of 18 March. The legal requirement that vaccine passes be shown to enter certain premises was abolished on 4 April. The same day, the government removed the vaccine mandates for police, defence and education workers. Mandates remained for health and disability workers, prison staff, and border and MIQ staff. Businesses can have their own mandates if they wish. As of 12 April, vaccinated travellers from Australia could enter New Zealand without going into isolation. On 13 April, New Zealand moved to the orange setting, meaning that all restrictions on the numbers of people at gatherings were removed.
As at 28 September 2022, 90% (92%) of those 12 and over had been fully (partially) vaccinated, with a lower rate of 83% (87%) for Māori, and 90% (92%) for Pacific people. Rates of vaccinations for children (5-11) are lower – at 28% (51%) overall fully (partially) vaccinated, with the Pacific rate at 19% (46%) and the Māori rate at 14% (32%) (Ministry of Health, 2022c).

New Zealand completely reopened its borders on 31 July. On 12 September, the traffic light system was removed and the situations where masks must be worn were limited to medical facilities (e.g. visiting GP or hospital) and aged-care facilities. On the same day, isolation requirements were reduced, such that those who contract COVID-19 must self-isolate for 7 days, but household contacts no longer had to isolate.

By 27 September 2022, there had been a total of 1,779,476 COVID-19 cases in New Zealand. Females made up 54% of cases; males 46%. Most cases (74%) were under the age of 50. Looking at ethnicity, 59% of cases were amongst European/Other; 15% amongst Māori; 14% amongst Asian peoples; 9% amongst Pacific peoples; and 2% amongst MELAA peoples. Turning to hospitalizations, 13,769 people (0.77% of all cases) had been hospitalised, with 483 people needing ICU care. Males made up 51% of all hospitalizations, those aged less than 10 made up 13% and those aged 60 or more made up 54% of hospitalizations. Māori (19%) and Pacific peoples (14%) had a higher proportion of people hospitalized than cases (Ministry of Health, 2022c).

As of 27 September 2022, New Zealand had 2,959 deaths recorded of people dying within 28 days of being reported as a case, with 1,289 of these officially coded as the underlying cases, and the remaining cases under investigation. The great majority of deaths within 28 days of being reported as a case were among older people, with 84% of those who died aged 70 or more. Most deaths were among European/Other, accounting for 79% of all deaths, Māori were 10%, Pacific peoples 6% and Asian 4% (Ministry of Health, 2022c). The great majority of cases and deaths occurred towards the end of the period and were the result of the Omicron outbreak (Figure 5.2).
Using internationally comparable measures, New Zealand’s death rate was 592 deaths per 1 million population, meaning the country had the 125th highest death rate per capita globally. This was lower than many similar countries, e.g. the United States’ death rate was 3235 (ranked 16), the United Kingdom 2765 (29) and Canada 1169 (89). However, Australia, on 573 (127), had a slightly lower rate than did New Zealand (Worldometer, 2022).

5.15.4.2 Specifics of the government’s response

5.15.4.2.1 Planning

As mentioned above, prior to the pandemic, the New Zealand government had an influenza pandemic plan (Ministry of Health, 2017a). Although focusing on influenza, the plan was also applicable to similar pandemics, such as COVID-19. The plan, based on an all-of-government response, includes specific tactics, such as for keeping an international pandemic out of the country and stamping out clusters of the virus in New Zealand. In responding to COVID-19, the MoH was guided by aspects of the influenza pandemic plan, even though the plan was not formally invoked.

With the arrival of the COVID-19 pandemic, the New Zealand government issued an epidemic notice on 23 March 2020. The notice is a public policy tool to help government agencies respond swiftly and effectively to the rapidly evolving situation, including enabling the use of a number of special powers in legislation. Further, a piece of emergency legislation was passed, the COVID-19 Public Health Response Act 2020. This came into force on 13 May
2020. The Act gives the Minister of Health the power to make binding orders on the population to help stamp out COVID-19; it gives Police and others the power to stop and instruct people in light of COVID-19-related measures; and it allows for fines and imprisonment for non-compliance. Failure to comply with an order under the Act can result in a maximum penalty of six months’ imprisonment or an NZ$ 4000 fine (section 26(2)).

The COVID-19 Public Health Response Act 2020 has been used alongside existing legislation, such as the Health Act 1956 and the Epidemic Preparedness Act 2006. Under the Health Act, for instance, the Police have powers to compel, enforce or ensure compliance with the directions of a medical officer of health, such as a direction to go into self-isolation. For example, under the provisions of the COVID-19 Public Health Response Act 2020, in August 2020 a woman was jailed for 14 days for escaping from a managed isolation facility (Smith, 2020).

5.15.4.2.2 Responsibility for the government’s response

The government’s strategic response to the pandemic has been run by the Prime Minister and Cabinet (Coughlan, 2020), including the Chief Science Advisor.

A range of key ministries are involved in the response to COVID-19, in particular the MoH, which also has the Director-General, the Director of Public Health and an ad hoc Technical Advisory Group (and subgroups) providing advice. Other ministries involved include The Treasury (in terms of the economic response), the Ministry of Business, Innovation and Employment (running the MIQ system and supporting businesses), the Ministry of Social Development (welfare support), NEMA, the Police (enforcement), and the Defence Force (New Zealand’s Army, Navy and Air Force, supporting the running of managed isolation facilities). Part way through the pandemic, two joint heads of the MIQ system were established: one the deputy secretary of the Ministry of Business, Innovation and Employment and the other a brigadier in the Army. Later still, to enhance the government’s response, a new ministerial portfolio was created, the Minister for COVID-19 Response.

During COVID-19 outbreaks, senior government figures – usually the Prime Minister and the Director-General of Health – held daily media conferences to report on case numbers, the health response and other pertinent matters. The MoH’s website provides additional information and updates (Ministry of Health, 2022c).
5.15.4.2.3 Border closures

New Zealand’s borders closed on 19 March 2020. Only returning New Zealanders and a few others (such as those deemed essential workers, and some visitors that have been granted exemptions, e.g. sports teams) have been allowed to enter since. All those entering the country were placed into managed isolation, and into quarantine if they test positive (known as MIQ). Limited spots in MIQ severely limited the numbers of New Zealanders who could return home. A few travel bubbles with, for example, Australia, existed for a time, but these proved difficult to sustain as the Delta variant spread in Australia.

The MIQ system came under increasing pressure as other parts of the world began to open up in late 2021/2022; it was seen to be particularly difficult for those wishing to be with loved ones at difficult times, e.g. when family members were unwell or dying, and for pregnant women and their families who wanted to give birth in New Zealand. Travel began to recommence from late February 2022, starting with New Zealanders in Australia, who would be able to return home and to self-isolate. By March 2022, the MIQ system had begun to wind down in favour of self-isolation and self-testing. Borders were fully reopened on 31 July 2022.

5.15.4.2.4 Response frameworks

The government initially instituted a four-tier regime of response (Alert Level Framework), with the country (or parts thereof) being put on differing levels of lockdown depending on the situation with the virus. The least restrictive was level 1, in which, among other things, borders are closed, people can go about their daily lives but are encouraged to scan or sign in at the places they visit should contact tracing be required, masks must be worn on public transport and domestic flights, and people are encouraged to practise social distancing when around people they do not know.

The most restrictive was level 4, in which, among other things, borders are closed, people who do not work in an essential service must remain at home (they can go out to buy supplies and exercise), masks generally must be worn outside the home (unless exercise precludes this, in which case people must practise social distancing), and scanning or signing in are mandatory. (For more details on the alert levels, see New Zealand Government, 2022c). Various national and regional lockdowns were used during the outbreak, especially March–June 2020 (nationally), August–October 2020 (Auckland in particular), and August–December 2021 (especially Auckland, but also Northland and the Waikato for periods of time). Mandates were also imposed requiring workers in certain critical industries to be vaccinated or
be removed from their posts. In October 2021, the government also legally supported businesses that introduced their own mandate requirements. Additionally, customers were required to show a vaccine pass, proving they had been vaccinated, before they could enter certain premises, such as hospitality establishments.

A three-level Protection Framework (or ‘traffic light’ system) replaced the Alert Level Framework on 2 December 2021, giving greater freedoms to those who were vaccinated and placing greater restrictions on gatherings in red and orange settings. As the number of new cases and new deaths declined and vaccination rates rose, the traffic light system was abolished on 12 September. (For more details, see New Zealand Government, 2022d).

5.15.4.2.5 The vaccination programme

The first vaccines (the Pfizer COVID-19 vaccine) arrived in New Zealand on 15 February 2021. The vaccinators themselves were immunized first on 19 February 2021, to be followed by border and MIQ workers, their household members and health sector staff. On 8 March 2021, the government announced that it had purchased enough of the two-dose Pfizer and BioNTech COVID-19 vaccines to vaccinate the entire country, making the roll-out more streamlined and reducing the potential for confusion if multiple vaccines were in use. A phased roll-out of the vaccine to all eligible New Zealanders began, starting with those aged over 60 years on 28 July 2021, culminating with those aged 12 years and over beginning on 1 September 2021.

Third (booster) shots became necessary with the likelihood of the Omicron variant entering the country; these became available in late November 2021 for those who had had their second shot four months earlier; this was reduced to three months in early February 2022. Vaccines began to be administered to children (aged 5–11 years) from 17 January 2022.

The vaccine roll out was particularly criticized for not prioritising Māori and Pacific peoples, who often have long-term conditions at a younger age; as a result, and with a younger population profile, vaccine rates for Māori lagged behind those of other groups. Māori and Pacific providers, however, led the way in working closely with their communities to increase vaccine rates, with the government providing significant funding to support their work (see also Section 6.1.6.2).
Economically, New Zealand has also weathered the pandemic well, in part due to strong government support (e.g. a wage subsidy through businesses during the more significant lockdowns; financial support for key industries; and a strong emphasis on new government investment in, for example, construction and the environment to support employment). With the borders shut, moreover, New Zealanders were not travelling abroad and instead spent in New Zealand. However, the loss of international visitors has been keenly felt by the tourism sector. Tourism is New Zealand’s largest export earner, comprising 20% of total export receipts. The government agency representing the tourism sector, Tourism New Zealand, says the sector has been “devastated” by COVID-19 (Tourism New Zealand, 2020).

Although the tourism sector has struggled with the impact of COVID-19, the economy more generally has recovered well. In June 2020, the New Zealand economy contracted by 11% for the quarter, the largest fall since the statistical series began in 1987. This was partly due to economic activity being suppressed during the lockdown. Industries such as retail, accommodation and restaurants, and transport saw major declines in production because they were most directly affected by the international travel ban and the lockdown. Other industries, like food and beverage manufacturing, were essential services and fell much less. Most construction activity and some manufacturing were deemed non-essential and so temporarily shut under alert level 4. As a result, construction declined by 25.8%, and manufacturing fell by 13.0% (Stats NZ, 2022e).

However, following the lifting of the lockdown, the economy quickly rebounded, growing by 14% in the September 2020 quarter, the largest rise on record. The industries contributing the most to quarterly growth included retail and accommodation, up 42.8%; construction, up 52.4%; and manufacturing, up 17.2% (Stats NZ, 2022f).

As a result of significant new government expenditure and New Zealanders spending at home, overall economic activity fell by only 2.3% in the year ending March 2021, as measured by real GDP (Reserve Bank of New Zealand, 2022).

Unfortunately, as the Delta variant entered the country and spread, economic activity fell once more, by -3.7% in the July–September 2021 quarter. Economic activity has since recovered somewhat, with GDP growing by 1% for the year ended June 2022. Stats NZ said the main drivers of growth were the reopening of borders, easing of both domestic and international travel.
restrictions, and fewer domestic restrictions under the orange traffic light setting (Stats NZ, 2022g).

The key economic concerns for the future are inflation and labour market shortages, due to international and local supply pressures (The Treasury, 2022b). Indeed, in June 2022, New Zealand’s annual inflation rate was 7.3% per annum, the highest it had been in 32 years. The main drivers were the rising prices of house construction and house rentals, in turn caused by supply-chain issues, higher labour costs and higher demand (Stats NZ, 2022h).

5.15.4.2.7 COVID-19 impact on health and health services delivery

An international study of 37 countries found that only New Zealand and Taiwan had an increase in life expectancy during 2020 (Islam et al., 2021).

A number of reports have considered the impact of COVID-19 on health services delivery.

A HQSC report on Pacific health (Health Quality and Safety Commission, 2021a) pointed out that during the COVID-19 pandemic in 2020, the strengths, resilience and innovations of Pacific communities and the Pacific health workforce were strongly evident. The Pacific response was seen to turn on the strengths of communities and churches, the ability to address social issues with flexible support, and the deployment of strong communications plans. For instance, in areas with large populations of Pacific peoples, COVID-19 testing centres created a Pacific party atmosphere and had many Pacific health workers administer tests and vaccinations. As a result, during the first wave of COVID-19, although Pacific peoples had low case numbers, once alert levels escalated, they consistently had the highest rates of testing for COVID-19 of all ethnic groups in the country. By mid-December 2021, 94% of Pacific people had had at least their first dose, which was the same as for all ethnicities and ahead of the rate for Māori (87%) (Ministry of Health, 2021ae).

A later HQSC report focused on the impact on a broader range of services (Health Quality and Safety Commission, 2021b). It noted the impact on the following indicators, and showed that, in many cases, already existing inequities in access to and use of services became worse during the pandemic. They reported on:

- Childhood immunizations – these reduced for two-year-olds overall from 91% in March 2020 to 83% in September 2021, with Māori rates falling to an alarming 70%. 
• Breast cancer screening – the rate of screening for eligible women declined steeply in 2020, before recovering a bit in 2021; however, for Pacific women the screening rate continued to decline even in 2021.
• Cervical cancer screening – this followed a similar pattern as for breast cancer screening, with rates for Pacific and Māori women falling steeply and not recovering by the end of 2021 (although this continued a trend of falling rates since 2016).
• PHC visits – around a third of people reported that during lockdowns in 2020, they did not go to their GP as they usually would; for disabled people, this rate was 40%. Many used telehealth services instead or delayed care.
• Emergency Department (ED) visits – around 90 000 people (40 000 of them Māori) did not attend an ED by June 2021 when they usually would have [based on data from the previous three years]; and there was an increase in the acuity of cases later in 2020 as New Zealand emerged from lockdowns.
• Elective/planned services – there were around 16 000 fewer admissions for these services between March and June 2020 than would usually be expected (although there were more minor procedures delivered), and Māori and Pacific rates did not appear to have picked up again by late 2021.

The Cancer Control Agency Te Aho o Te Kahu monitored cancer services throughout the pandemic. It found that by May 2020, the number of new cancer diagnoses had fallen, but cancer services were largely maintained, in part due to a nationally coordinated approach. By the end of October 2020, the number of new diagnoses for 2020 was the same as for 2019, and the pandemic had not exacerbated inequities, except for lung cancer. By the end of 2021, there appeared to be few concerns over cancer services due to COVID-19. By the end of February 2022, however, there were increasing concerns over fewer new cancer registrations for Māori [Te Aho o Te Kahu, 2022].

Finally, in May 2022, it was noted by the Minister of Health that twice as many people had been waiting longer than four months to have their first specialist assessment as before the pandemic hit (35 942 in March 2022 compared with 14 787 in February 2020), while the number waiting longer than four months for treatment had trebled (26 764 in March 2022 compared with 8153 in February 2020). A national planning process is under way to assist in better managing such services in future [Little, 2022].
6. Principal health reforms

Chapter summary
During the 20th century, the New Zealand government gradually picked up the overall financing of hospitals, which were progressively amalgamated into larger units as hospital care became more technologically driven and birth rates fell. The first Labour government’s (1935–1938) aim of a comprehensive and integrated public health-care system was never fully achieved, with compromises including fee-for-service funding for independent general practitioners (GPs); user charges for GP care, which rose over time as subsidies did not keep pace with costs (raising concerns about equity of access); and hospital specialists able to practise privately. Health funding and service delivery continued to be fragmented.

Since the 1980s, the New Zealand health system has undergone a series of reforms. From 1984, fourteen area health boards (AHBs) were established, funded on a population basis and responsible for funding and providing secondary and tertiary health care and public health services; primary health care (PHC) funding remained with the Department of Health.

In the early 1990s, a National Party government introduced separation of funding and provision of services with four regional health authorities (RHAs) responsible for purchasing all personal health and disability services for their regional populations. They could purchase services, using formal purchasing processes and contracts, from both public and private providers. Twenty-three public Crown health enterprises (CHEs) ran hospitals, community and public health services as commercial entities. PHARMAC, the government’s community drug-buying agency, was also established in the early 1990s, and still exists today. As a result of the reforms, New Zealand saw the formation of independent practitioner associations of GPs to facilitate collective contracting, significant growth in the number of Māori health providers and in the scope of services they provided, and deinstitutionalization (particularly for mental health, disability and residential rest home services), with growth in the role of the private sector in delivering such services. Implementation of these reforms was costly and key aspects were very unpopular with both the public and with health professionals. As a result, CHEs became hospital and health services (HHSs), which were no longer required to make a profit, and,
in 1998, a single Health Funding Authority was formed to purchase services to provide greater national consistency.

These changes were short-lived, however, as a Labour–Alliance coalition government elected in 1999 introduced further reforms, returning to a model like that of the 1980s with AHBs. Thus, the New Zealand Public Health and Disability Act 2000 introduced 21 (later 20), majority locally elected, District health boards (DHBs), responsible for planning and providing hospital and public health services for their regions. From 2002 on, 80+ Primary health organizations (PHOs) (later 30) were established to coordinate PHC services for an enrolled population, funded on a capitation basis. Significant new funding initially reduced user charges and improved access to PHC.

The National Party-led government elected in 2008 kept the DHB model and focused on increased “frontline” services and reduced bureaucracy. It implemented a new National Health Board to plan and fund national health services, and a shared services agency to undertake administrative and support services on behalf of DHBs to reduce duplication. It sought improved collaboration between DHBs and reduction in the numbers of PHOs (down from over 80 to 30), and sought “better, sooner, more convenient”, and more integrated, services. However, the global financial crisis of 2007/2008 initiated a lengthy period of tight financial constraint on the health sector, and DHBs began to run up persistent deficits. During this time, other significant developments included the creation of a range of health targets, which evolved into a systems level measures (SLM) framework, used by new “alliances” (usually involving DHBs and PHOs but also others) to better integrate services.

The election of a Labour-led government in 2017 saw a dramatic change of policy, beginning with a major inquiry into mental health services. This resulted in the government introducing a NZ$ 1.9 billion funding boost for mental health services in 2019 and establishing an interim Mental Health and Wellbeing Commission (MHWC) in 2019, followed by the permanent Commission in 2021, to oversee and lead policy in the area.

The government initiated a major review of the health and disability system in 2018. It made a raft of recommendations in 2020, most of which the government subsequently agreed to. These changes were introduced from 1 July 2022. The MoH is continuing to lead policy development, with a new Public Health Agency embedded within it to strengthen public health. DHBs have been abolished in favour of a single national organization, Health New Zealand (HNZ), to manage the day-to-day operations of the publicly financed and publicly owned health system, and to operate regional public health
services. This was designed to make health service delivery more efficient, effective and consistent nationally. The Māori Health Authority (MHA) has been established to lead the strategic direction and funding of health services to Māori. This was part of measures to address inequities in health outcomes in New Zealand. PHOs will no longer have a formal place in the system and, instead, there will be a greater emphasis on locality networks, as part of plans to enhance the delivery of PHC throughout the country. A new agency, the Ministry of Disabled People (MoDP), has also been established to improve outcomes of people with disabilities and to deliver disability support services.

A major reform of New Zealand’s water services is also under way. In part, this is designed to improve the country’s drinking water standards following the worst outbreak of waterborne disease in the nation’s history.

6.1 Analysis of recent major reforms

This chapter provides an overview of the principal health-care reforms in New Zealand between 1970 and 2021. Earlier developments are discussed in Section 2.2. The reforms are summarized in Table 6.1 and discussed in more detail in the text, considering their aims and background, content and implementation.

Refer to Figure 2.1 in Chapter 2 for the organization of the New Zealand health system prior to 1 July 2022.

Table 6.1 Major health-care reforms, pre-1980s to 2022 onwards

<table>
<thead>
<tr>
<th>Date</th>
<th>Key reforms</th>
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<tr>
<td>Pre-1980s</td>
<td>Primary health care (PHC) funded on a fee-for-service basis with patient co-payments; services delivered largely by general practitioners (GPs) running independent businesses (general practices [GPCs]). Local hospital boards oversee a large number of small hospitals. These are amalgamated over time to 27 in the early 1980s. Public health services run by the Department of Health, through 18 District Public Health Units. From the 1960s, large psychiatric hospitals close through an increased emphasis on community care and services provided in general hospitals. Issues: Growing concerns over poor access to and the role of PHC; fragmentation of service delivery; need for greater focus on public/population health; inequities in access and in health.</td>
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<tr>
<td>Date</td>
<td>Key reforms</td>
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<tr>
<td>1983–1990</td>
<td>Reform 1: The Area Health Boards Act 1983 establishes 14 area health boards (AHBs) responsible for funding and providing secondary and tertiary health care and public health services. AHBs replace local hospital boards and incorporate Department of Health District Public Health Units. Population-based funding formula introduced. Key goals: To strengthen local planning and to focus more on public/population health. Impact: in place too short a time to assess effects. Key strengths seen as: Integrated, local service planning; community participation. Concerns: Lengthening waiting lists; lack of incentives in relation to efficiency; lack of responsiveness to different needs.</td>
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<td>1991–1996</td>
<td>Reform 2: The Health and Disability Services Act 1993 has the Department of Health become a Ministry of Health (MoH) and separates ownership, purchase and provision of health services. Four public regional health authorities (RHAs) are established to purchase all personal health and disability services for their regional populations from both public and private providers. Twenty-three publicly owned Crown health enterprises (CHEs) are formed from the AHBs to run hospitals, community and public health services as commercial entities. All disability services now part of the health system. RHAs contract with a wide range of providers, including CHEs, GPCs, pharmacists, laboratories and community providers (e.g. non-government organizations [NGOs], Māori and Pacific providers). PHC funding changes from having universal coverage to a more targeted approach, with those on lower incomes holding a community services card (CSC) and being eligible for a higher government subsidy and hence lower PHC user charges, while those without a CSC paid the full cost of their PHC care. Key goals: To improve efficiency and responsiveness of services, to make savings, reduce waiting lists and improve equity. Impact/Concerns: Highly unpopular, lack of local input and focus, costly to implement and run, waiting lists increased, some efficiencies and savings achieved. Did result in PHARMAC; increase in number of and support for Māori-led and Pacific-led providers; networking of GPCs; development of new contracts in PHC.</td>
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<tr>
<td>1997–1999</td>
<td>Reform 3: RHAs abolished, and a single purchasing authority formed, the Health Funding Authority. CHEs are converted into 23 Hospital and Health Services (HHSs), which continue to run hospitals, community and public health services, but are no longer required to make a surplus. Key goals: To streamline purchasing and enhance collaboration, increase consistency, reduce administrative costs. In place too short a time to assess effects. Concerns: Continued use of competition and contracting seen as costly and with an insufficient focus on collaboration; lack of local focus and input.</td>
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Reform 4: The New Zealand Public Health and Disability Act 2000 replaces the HHSs with majority locally elected district health boards (DHBs), responsible for planning and purchasing services for their region. DHBs contract for PHC and community services delivered by private providers and provide secondary services and some community services themselves. DHBs are funded according to a population-based funding formula.

Key goals: To restore the emphasis on being a public service, putting people (not profit) first; restore community involvement and restore the confidence of the public and workforce; build a partnership approach with Māori; empower professionals and communities through transparency; rebuild cooperation and collaboration; keep people out of hospital; take a population health approach and reduce disparities. Impact: Widespread support, greater community engagement; some signs of greater equity and better financial performance. Concerns: The number of DHBs is seen as high but there was little support for forced mergers; Central Government directives seen to limit local focus; DHBs have incentives to focus on own services to the detriment of effectiveness, responsiveness and efficiency.

Reform 5: A major Primary Health Care Strategy is introduced to strengthen PHC services. From July 2002, primary health organizations (PHOs) are established, responsible for the provision of PHC services (through a network of providers) for an enrolled population, funded on a capitation basis. Significant new funding is provided to support these reforms, and universal funding of PHC services is reintroduced.

Key goals: To strengthen role of PHC; work with local communities and enrolled populations; coordinate services; develop PHC workforce; remove inequities. Impact: Significant new funding; reduced user charges in the short term and increased consultation rates; establishment of new PHOs to oversee PHC; rise in nurse roles. Concerns: Too many diverse PHOs, with limited capacity and impact; few changes to models of care; little focus on coordination; user fees continue to result in barriers to access to PHC.

Reform 6: The global financial crisis initiates a lengthy period of financial constraint in the sector. From 2010 on, there is an emphasis on “better, sooner, more convenient” health services, including a focus on achieving greater integration and coordination of services.

Key goals: To build PHO capacity by encouraging amalgamation; reduce back-office costs; encourage DHB, PHO and other provider collaboration; deliver more integrated services closer to home; improve quality and safety. Impact: A reduced number of PHOs; some increased collaboration through Alliances; building towards system level measures (SLMs); Health Quality and Safety Commission (HQSC); development of the Health Care Home (HCH) model of care. Concerns: Rising deficits resulting from low levels of new funding; limited knowledge on integration; variable performance by Alliances.

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Key goals: To restore the emphasis on being a public service, putting people (not profit) first; restore community involvement and restore the confidence of the public and workforce; build a partnership approach with Māori; empower professionals and communities through transparency; rebuild cooperation and collaboration; keep people out of hospital; take a population health approach and reduce disparities. Impact: Widespread support, greater community engagement; some signs of greater equity and better financial performance. Concerns: The number of DHBs is seen as high but there was little support for forced mergers; Central Government directives seen to limit local focus; DHBs have incentives to focus on own services to the detriment of effectiveness, responsiveness and efficiency.  
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A review of mental health services results in the government introducing a NZ$ 1.9 billion funding boost for mental health services in 2019 and establishing the Mental Health and Wellbeing Commission in 2021.

A review of the health and disability sector leads to dramatic reforms from July 2022 on.

A major reform of New Zealand’s water services is started, in part designed to improve the country’s drinking-water standards.

Reform 7: Centralization and localization
The MoH continues as the government’s principal advisor on health policy, with a strengthened Public Health Agency sitting within the MoH.

DHBs are abolished in favour of a single national organization, Health New Zealand (HNZ), which is now running the publicly owned health system and purchase a range of primary and community services from privately owned providers. Its work is being overseen by a governing board appointed by the government. Around 80 000 people are employed by HNZ.

A new Māori Health Authority (MHA) is established, also governed by a board appointed by the Minister of Health. It works with the MoH on key strategies and commissions Kaupapa Māori services. It works with HNZ to co-commission primary and community services. Its aims are to enhance rangatiratanga for Māori over hauora Māori and reduce inequities.

PHOs no longer have a formal place in the system, but there will be an increasing focus on locality planning for primary and community services at a local level.

A new agency, Ministry of Disabled People (MoDP), is established.
Key goals: Equity; partnership with Māori; sustainability and prevention; person- and whanau-centred care; excellence. “A truly national system”, with an emphasis on PHC, less bureaucracy between regions, stronger focus on prevention/public health; a new independent voice for Māori, focussing on hauora Māori and leading change in the system.

### 6.1.1 1983–1990: Area Health Boards

The formation of area health boards (AHBs) in the mid-1980s was the first major reform of the New Zealand health system since the establishment of the welfare state under the first Labour government (1935–1949).
In the intervening period, the State had failed to achieve an integrated, national health service, with dual public–private provision continuing, and fragmentation of services (Department of Health, 1974). Thus, prior to the establishment of AHBs, New Zealand had a highly fragmented health system, with a national Department of Health overseeing policy and 18 regional public
health units; the gradual amalgamation of locally governed but nationally funded hospital boards, with 31 boards in existence in 1969; separately funded fee-for-service GP services; and a number of grants for other national service providers. Hospitals were managed by a “triumvirate” of three executives (a doctor, a nurse and an administrator), with shared authority and responsibility, and each with the power of veto; a system which the Gibbs Report claimed “stifles leadership, dilutes accountability and makes for poor management relationships at lower levels of the organisation” (Gibbs, Fraser & Scott, 1988).

The concept of regional health authorities was first proposed in a 1974 White Paper, *A Health Service for New Zealand* (Department of Health, 1974). It was suggested that 14 regional health authorities be established to coordinate all services in their geographical area, and also that there be a split between the funding and provision of services. No reforms were, however, enacted before there was a change of government in 1975. The new national government set up a Special Advisory Committee on Health Services Organisation, which also proposed the establishment of 14 regional “Area Health Boards” (Gauld, 2009). The government chose to pilot these in two areas and consult further with stakeholders rather than introduce them nationally all at once, before finally passing the Area Health Boards Act 1983, which allowed for the voluntary establishment of 14 AHBs (Gauld, 2009). These were formed between 1984 and 1989, during a Labour government.

AHBs were responsible for secondary and tertiary health care (mainly hospitals) and public health services, while the Department of Health maintained responsibility for subsidizing PHC and for funding services delivered by national providers. AHBs were organized around at least one large district hospital, from the merger of existing hospital boards and public health offices in the Department of Health.

Under the Area Health Boards Act, AHBs had three objectives: to promote, protect and conserve public health, and to provide health services; to provide for the effective coordination of the planning, provision and evaluation of health services between the public, private and voluntary sectors; and to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services (section 10). They were governed by boards of up to 14 members, the majority elected but with the option for some members to be appointed on the recommendation of the Minister of Health. From 1983, the government introduced a population-based formula to allocate funding to AHBs, replacing the earlier “cost-plus” funding model.
AHBs were formed during a period when the Labour government also undertook significant economic and public sector reforms. These included the State-Owned Enterprises Act 1986 (which restructured some government departments, separating trading activities into more business-like enterprises to promote their improved performance); the State Sector Act 1988 (introducing managerialism and performance objectives to State services); and the Public Finance Act 1989 (reforming public financial management systems to incentivize the effective and efficient use of financial resources by government departments).

The Labour government also commissioned two reviews of health policy in this period. The 1986 Health Benefits Review was “to ensure that the subsidisation of health services, particularly primary health services, contributes as effectively as possible to the government’s broad social and economic goals of equity and efficiency” and “to examine the existing system of health benefits, review the options open to government, and recommend broad principles and directions for reform of these benefits and related services” (Scott, Fougere & Marwick, 1986).

The report discussed existing arrangements and set out five possible options for the State as a funder of health services: modification of the existing system; two options where the State would be the residual funder of services (the State as residual funder operating a safety net for high-risk/low-income groups; or the State as regulator in a competitive system or health maintenance organizations); and two options where the State would be the dominant funder of services (either funding and directly providing services itself, or being the dominant funder but with services provided through a mix of State provision and contracts with private and voluntary agencies) (Scott, Fougere & Marwick, 1986). The Health Benefits Review had little immediate impact as the government was more concerned at the time with problems in the public hospital system, and a second review of this sector was therefore commissioned (Gauld, 2009).

The Hospital and Related Services Taskforce “conducted a review of the New Zealand hospital system and international developments in health economics and the management of health systems” (Gibbs, Fraser & Scott, 1988). The resulting Gibbs Report identified problems with equity of access, particularly with high and growing surgical waiting lists; low efficiency within hospital services, with a lack of incentives to change to less costly care options outside hospital settings, and poor integration between primary and secondary care; and a range of management deficiencies, including inefficient triumvirate consensus management by a doctor, a nurse and an administrator; lack of management information systems; lack of cost
consciousness in decision-making; and an absence of productivity monitoring (Gibbs, Fraser & Scott, 1988).

The Taskforce proposed separating the purchasing and provision functions of AHBs by establishing six Regional Health Authorities, which would be funded by the government to purchase health services for the people of their region from public and private hospitals, through a competitive contracting process. The Gibbs Report was delivered to a new Health Minister, David Caygill, who opted not to implement the Report’s proposals, but to further develop the existing AHBs, aiming to give them progressive responsibility for all health services in their region (including the primary care budget) (Caygill, 1988). Some management changes were introduced in the AHBs, including general management replacing the triumvirate system in 1988; installation of information systems; development of goals and targets for AHBs; preparation of the first operating and strategic plans by boards in 1989–1990, with these forming the basis of contracts between the boards and the Minister of Health; and internal restructuring within many boards, including the internal separation of purchasing and providing roles (Ashton, 1995).

One further important development in this period was the 1985 introduction of a $1 flat charge on all prescriptions (Bassett, 1993). In 1988, this increased to $5 for adults and $2 for children, beneficiaries and some other groups, with an individual exemption after 25 items and family exemption after 40 items. There was a further increase in 1991 to $15 for adults and $5 for children, beneficiaries and others, with an individual exemption after 10 items and family exemption after 15 items (Norris, 1992). Pharmaceutical co-payments were progressively reduced since July 2004 with the introduction of additional funding for PHOs.

Strengths and weakness of AHBs were identified in a 1991 study commissioned by Health Boards New Zealand, comparing the New Zealand health system with that of five other countries (the United States, Canada, the United Kingdom, the Netherlands and Germany) (Ashton et al., 1991). Strengths noted were a generally simple health system structure; low and relatively stable costs alongside increased throughput of patients in the previous decade; the government as dominant funder (said to allow greater control over total costs than in a multiple-funder system); integrated service planning by AHBs; community participation in the planning of health services; national health goals and targets; and accountability of AHBs via a business plan and contract with the Minister of Health. Weaknesses identified were the lack of integration of primary and secondary care; high user charges for primary care; long hospital waiting lists; the high proportion of expenditure on hospitals and pharmaceuticals compared with other
countries and a lower proportion on out-of-hospital care; perverse incentives for specialists working in both the public and private sectors not to reduce public sector waiting lists; lack of incentives for internal efficiency at the clinical level; and inadequate information about service costs and outputs, particularly in primary care.


During the 1980s, New Zealand economic and social policy focused on major reforms, aimed at improving the performance of the New Zealand economy. In spite of concerns over the performance of the health sector, and two major reports during the 1980s, the health system had escaped major reform by the end of the 1980s. However, the national government, elected in late 1990, assumed governance over a poorly performing economy and set up a number of social policy taskforces to consider further policy reform, including the Ministerial Taskforce on the Funding and Provision of Health Services (Gauld, 2009). The Taskforce’s recommendations were published by the Minister of Health as a “green and white paper” Your Health and the Public Health (Upton, 1991). [So-called as it had some “green paper” policy sections where public views were sought and other “white paper” sections setting out government decisions.]

The review identified a number of problems with the existing system:

- Lengthy public hospital waiting times.
- Conflict in the roles of AHBs as both purchasers and providers of services.
- Legislative constraints on the way AHBs could operate.
- Fragmented funding of services.
- Problems of access to services (including cost, geographical access and whether or not a person was entitled to ACC funding).
- Lack of financial incentives for doctors and patients to choose the most effective and affordable health services.
- Lack of consumer control.

Lack of fairness in funding and treatment criteria, and inequities in health status and access to services (Upton, 1991).

In response to these problems, the government had decided to reform the health system. It would separate the purchasing and provision of health services (rather than retaining AHBs with these joint roles). Four regional health authorities (RHAs) would be established to purchase health services
for their populations, some of which would be delivered by competitive Crown health enterprises (CHEs).

The new structure was intended 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-care professionals.
- Recognize 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 New Zealand society (Upton, 1991).

The AHB Boards were disbanded in July 1991, replaced by Commissioners, and two years of intensive activity followed in planning the transition to a new system (Ashton, 1995).

The Health and Disability Services Act 1993 was based upon the concept of separation between ownership, purchase, and provision. The Department of Health became the Ministry of Health (MoH). The Crown remained the owner and four RHAs were established (North Health, Midland Health, Central RHA and Southern RHA) whose Boards were appointed by the Minister of Health. The separate funding streams for PHC services and for hospitals were merged, all disability support services funding was brought into Vote Health, and each RHA was given a budget to purchase all personal health and disability services for their regional populations. RHAs could then purchase services from both public and private providers. This integration of funding was intended, first, to reduce cost-shifting between agencies and services and, second, to make it easier to redirect resources as appropriate from institutional to community care, from secondary to PHC, and from treatment to health promotion.

Funding for public health services was assigned to a new body, the Public Health Commission, which was responsible for coordinating and contracting for the provision of public health services, monitoring public health, and identifying areas of need to advise the Minister of Health.

The provider arms of the 14 AHBs were converted into 23 CHEs, which ran hospitals, community, and public health services. The CHEs were to function
as commercial entities, being established as limited liability companies with
government shareholders consistent with the 1986 State-Owned Enterprises
Act, with boards of directors appointed by government ministers. CHEs were
to make a surplus, with the surplus to be reinvested in health. The newly
created portfolio of Minister of Crown Health Enterprises, and later the
Minister of Finance, represented the ownership shareholding interest of the
government in the CHEs.

The legislation also provided for the establishment of a National Advisory
Committee on Core Health and Disability Support Services (the Core Services
Committee; later the National Health Committee [NHC]) to advise the
Minister of Health on the kinds of health services that should be publicly
funded, relative service priorities, and other matters that the Minister
specifically requested. At this time, the Department of Health was renamed
the Ministry of Health (MoH), focusing more on strategic policy advice and
monitoring of the health sector.

A separate operational unit of The Treasury, the Crown Company Monitoring
Advisory Unit, was set up in 1993, to represent the government’s interest as
a shareholder in all Crown companies, which included CHEs. It advised the
ministers of Health, CHEs, and Finance on ownership and monitoring aspects
of CHEs. The advice included protecting the Crown’s investment, setting
service targets, and considering the impact on CHEs of proposed policies.
It also advised ministers on how well the CHEs were performing against
government objectives and managed the appointment and performance
assessment of CHE directors.

The Health and Disability Commissioner (HDC) Act was passed in
1994. The HDC’s role is to promote and protect the rights of health and
disability services consumers, and facilitating the fair, simple, speedy,
and efficient resolution of complaints. The Act was passed to implement
the recommendations of Judge Cartwright in her 1988 report into cervical
cancer. Judge Cartwright had stated that there was a strong need for the
Commissioner as an independent complaints’ resolution and educational
body, and for a code of patients’ rights. Her inquiry had looked at unethical
research practices in the treatment of cervical cancer at a New Zealand
hospital (Health and Disability Commissioner, 2021).

The Public Health Commission was disestablished in late 1995, with its policy
advisory function being transferred to the Core Services Committee, renamed
the National Advisory Committee on Health and Disability (the NHC), and its
purchasing function to the RHAs.
There were a number of positive developments from these reforms (Ashton, Mays & Devlin, 2005; Cumming & Mays, 2002; Cumming, Mays & Daubé, 2010; Gauld, 2009).

First, the reforms resulted in better information being made available on the services provided and the resources used to provide them, allowing for better-informed purchasing decisions. Providers needed to be clear about the range and volume of services they were producing, and the relative resource costs involved. Such information supported their business decisions as well as contract documentation and performance reporting.

Second, the reforms did successfully achieve some competitive tendering, leading to savings in hospital services. Foster (1994) reported savings of about $300,000 and $365,000 for 1993–1994 and 1994–1995, respectively, as a result of tendering. Hoskins, Blaxall & Sceats (1996) reported on a joint private venture–CHE initiative, which reduced waiting times and increased the numbers of patients treated (although re-admissions increased). Lovatt (1996) notes that tendering allowed shortened waiting times for some services for residents in the Midland region.

Third, the reforms included the formation of the Pharmaceutical Management Agency (PHARMAC) in 1993 to manage the funding of community pharmaceuticals (those dispensed outside hospitals), which aimed to reduce pharmaceutical expenditure and maximize their health contribution. PHARMAC has been seen to be a significant success in New Zealand. PHARMAC operates within a fixed budget and a key component of its decision-making is the relative cost–effectiveness of medicines that might be publicly funded in New Zealand. PHARMAC also uses a range of tools – e.g. negotiations over price with pharmaceutical companies, sole-supply contracts, and reference pricing – to manage prices and overall expenditure on pharmaceuticals in New Zealand. Although its decisions have been controversial at times, very few decisions have been overturned and PHARMAC retains the support of a wide range of stakeholders in New Zealand (Cumming, Mays & Daubé, 2010). PHARMAC saved an estimated $328 million between 1993 and 2000 (PHARMAC, 2000).

Fourth, an unexpected gain was the formation of groupings of GPs into networks to facilitate collective contracting for primary health services, and to support quality improvement in GP care. Independent practitioner associations (IPAs) and other networks also survived the reforms and provide support for general practice services. They continue to play a key role in PHC policy and service delivery today.
Fifth, use of capitation and budget holding by IPAs led to some savings (e.g. in laboratory spending and pharmaceuticals prescribing) and paved the way for the wider introduction of capitation in the 2000s (Cumming & Salmond, 1998).

Sixth, the ability of the RHAs to allocate resources to any provider enabled them to better support by-Māori for-Māori health services. The number of such providers increased from about 20 in 1993 to over 220 in 2000 and such providers continue to play a key role in PHC and public health and community services. Increasing numbers of Pacific-led providers were also established during this time.

Seventh, the National Advisory Committee on Core Health Services (later, the National Health Committee or NHC) was established to define services that would be publicly funded, and although it did not achieve this goal, its work resulted in an increased focus on effectiveness and guideline development and led to the development of the elective/planned services priority-setting and booking system, which has provided greater clarity over elective/planned services treatment for many New Zealanders.

A number of difficulties and compromises also arose with the implementation of the reforms (Ashton, Mays & Devlin, 2005; Cumming & Mays, 2002; Cumming, Mays & Daubé, 2010; Cumming & Salmond, 1998; Gauld, 2009).

First, the implementation of these health reforms involved considerable financial cost (reports ranging from $80 million to $800 million) (Gauld, 2009), including on consultants involved in preparing for the new system; new RHA staff to manage the administration and monitoring of contracts; and remuneration of board members and CHE management. The overall cost of the reforms themselves thus became a major political issue for several years.

Second, the National Advisory Committee on Core Health Services, which was established to define which services would be publicly funded, found that explicit rankings and rationing of services were controversial, and firm decisions did not emerge. Over time, their work increasingly focused on clinical guidelines and an elective/planned services prioritization and booking system.

Third, the autonomy of CHE boards was in fact limited. Their ability to stop providing certain services was constrained by ministers due to the potential for high political costs, and to ensure continued access to services.
Fourth, the Health and Disability Services Act 1993 allowed for the establishment of “health care plans”, which would eventually compete with RHAs, with people able to choose between an RHA or a privately owned HCP to fund and organize their care. HCPs would also purchase health-care services from a range of providers, although it was also hoped they may become integrated purchasers–providers, as with Health Maintenance Organizations in the United States of America. However, HCPs were not in fact developed because of the risk that less-healthy patients would not be attractive to private funders and would be left to RHAs to manage, because of the failure to define a “core” of services that would have to be provided by all purchasers, and because of the major criticisms being made of the reforms generally.

Fifth, the model was seen to involve very high costs in contracting and enforcement. By 1997–1998, it was reported that there were around 4580 contracts in the sector (Mays & Hand, 2000). Some contracts were also criticized for having insufficient attention to quality.

Sixth, user charges for inpatient and outpatient hospital services, introduced in 1991, proved to have high administrative costs (exceeding the revenue they generated), in part due to the need to set up new collection systems, and public resistance. Inpatient charges were abandoned after only one year, and outpatient co-payments ceased in 1997.

Seventh, few CHEs made a surplus and deficit levels increased. The incentive to improve efficiency and contain costs was also considerably weakened by a lack of competition among providers for many services and by government deficit support for CHEs.

Eighth, one of the key goals of the reforms was to reduce long waiting lists and times, but the lack of efficiency gains and savings from the reforms meant that waiting lists and times actually increased. Between March 1993 and March 1995, waiting lists increased by 11.8% to 85,624, and increased further by 11.5% to 95,470 by March 1996 (Cumming & Salmond, 1998). In terms of waiting times, aggregate data on the number of months required to clear waiting lists showed some stability, at 7 months in 1991 (McKendry, Howard & Carryer, 1994), 6.1 months in 1993–1994, and 6.8 months in 1994–1995 (Ministry of Health, 1994b).

Ninth, political concerns over the work of the Public Health Commission led to its demise in 1995 (Hutt & Howden-Chapman, 1998), with a consequent reduced emphasis on public health.
Finally, there was reduced morale among health professionals and conflict between managers and clinical staff as a result of the reforms.

Overall, the reforms were very unpopular from their inception, with health continually in the media spotlight throughout the reform process. This led to increasing public concerns over the state of the publicly funded health system. Several ministers of health came and went during this time, but health remained a major concern in the mid-1990s, with changes consequently made following the election of New Zealand’s first coalition government under the mixed member proportional (MMP) representation system in 1996.

6.1.3 1996–1999: Health Funding Authority and Hospital and Health Services

Following the change to a new electoral system of mixed member proportional representation, or MMP, New Zealand’s first coalition government (National–New Zealand First) took office in 1996. The coalition document *Policy Area: Health* section described a health system in which “principles of public service replace commercial profit objectives”, with cooperation and collaboration rather than competition between services (New Zealand First & New Zealand National Party, 1996). The focus shifted away from a quasi-market model approach, acknowledging that strict competition was not viable in the health sector.

The coalition also wanted to reduce administrative costs and eliminate geographical inequities. For example, the four RHAs had proved administratively expensive for a small country, while the effects of market competition could not prevail since the government, as shareholder, had little choice but to meet the budgetary shortfalls of the CHEs (Gauld, 1999). CHE debts had risen from $189.4 million in 1993–1994 to $219.3 million in 1996–1997.

In mid-1997, the Transitional Health Authority was formed to oversee the amalgamation of the four RHAs into a single central purchasing agency, and in January 1998 (following amendment to the Health and Disability Services Act 1993), this became the Health Funding Authority (HFA). As a purchasing authority, the HFA continued the split between purchase and provision. It contracted with a range of providers for the provision of medical, hospital, public health, disability and other health services, and was also responsible for purchasing postgraduate clinical training. Its other functions were to monitor the need for health services and to monitor the performance of providers.
At the same time, the CHEs were converted into 23 companies called hospital and health services (HHSs), which continued to run hospitals and related services, community and public health services. These companies had independent legal and financial status and continued to operate in a framework of commercial law. A 24th HHS was established to manage blood services, being the only publicly owned national-level health provider. The HHSs contracted with the HFA for their funding. They were relieved of the requirement to make a surplus; however, as the HFA was committed to capping funding levels, HHSs continued to function in a profit-orientated way and sought to reduce service provision commitments (Gauld, 1999).

HHSs continued as by far the largest health-care providers, receiving about half of the government health budget each year (Poutasi, 2000). Other providers included community trusts (including Māori health providers), voluntary sector providers (such as church-sponsored services), private “for-profit” providers such as dentists, pharmacies and general practices.

In 1998, the National Advisory Committee on Core Health and Disability Services was renamed the National Advisory Committee on Health and Disability Services (National Health Committee, NHC) and given new terms of reference, continuing existing work and providing comment on the range, mix and quality of services that the HFA was funding (Gauld, 2009).

Other developments during this period of reform included the removal of universal PHC subsidies in favour of targeted funding, available only to those on lower incomes who held a community services card (CSC) or high-use health card (HUHC); the establishment of some integrated services projects; some budget devolution in primary care, particularly through independent practitioner associations (IPAs); and the development of a booking system for elective/planned surgery in response to lengthy waiting lists, lack of transparency in their management, and disparities in waiting times between different parts of the country (Gauld, 2009).

6.1.4 2000–2009: District health boards, the Primary Health Care Strategy and Primary Health Organizations

6.1.4.1 The New Zealand Public Health and Disability Act 2000 and District health boards

At the end of 1999, a Labour–Alliance coalition government was elected. The Labour Party’s health manifesto stated its objectives, which included the restoration of a non-commercial health system with the focus on the provision of quality services, the involvement of community representatives in decisions about their local health services, significant improvements in the effectiveness of health services delivery to Māori and Pacific peoples,
and well-integrated primary and secondary care (New Zealand Labour Party, 1999). The health services structure would be reorganized once again with the establishment of majority-elected district health boards (DHBs). This was in spite of some suggestions that the HFA model was beginning to work well and major concerns over having yet more substantial reforms in the health sector.

The health programme of the incoming government was swiftly enacted under the New Zealand Public Health and Disability Act 2000 (NZPHDA). In introducing the legislation to Parliament, the Minister of Health noted the following goals:

- Rebuild New Zealand’s public health service.
- Restore community involvement in, and ownership of, health at a local level.
- Restore the public confidence that has been battered and bruised by the previous government’s ideological experiment, an experiment that has cost some New Zealanders their lives.
- Restore the confidence of health professionals in a system that they have been leaving in depressed and disillusioned droves (King, 2000b).

In the speeches to Parliament as the Bill went through its various stages, the Minister criticized the previous emphasis on “the bottom line on hospital balance sheets”, the “appalling workforce shortages” and the level of “disillusionment and lack of morale” of those working in the health system. She noted the new emphasis on:

- A “genuine health service...that New Zealanders can trust”, putting “people and services first”.
- A partnership approach with Māori, through DHB appointments and at all levels of the system.
- Empowerment of health professionals and communities, including through elected representation, open board meetings, advisory committees, locally conducted community health needs assessments, and DHB performance information being publicly available.
- A collaborative and cooperative approach.
- An emphasis on keeping people out of hospital
- Achieving the best outcomes, taking a population health focus and working to improve the health of all New Zealanders, while reducing disparities, especially for Māori, Pacific peoples and those in lower socioeconomic groups, in particular, through targeted health programmes;
• the New Zealand Health and Disabilities strategies that would guide the sector;
• long-term workforce planning (King, 2000b, 2000c, 2000d, 2000e).

The objectives of the Act included the public funding and provision of health services to improve, promote and protect the population’s health; reducing health disparities for Māori and other population groups; and providing for community voice in health and disability services (section 3). The NZPHDA required the development of a New Zealand Health Strategy (King, 2000a) and a New Zealand Disability Strategy (Minister for Disability Issues, 2001) to provide frameworks for the government’s direction in these areas. Subsequently, a number of other strategies have been developed, including a Cancer Control Strategy, Health of Older People Strategy, Primary Health Care Strategy, and He Korowai Oranga: Māori Health Strategy.

The NZPHDA established 21 DHBs as Crown entities to replace the HHS, and the HFA was disestablished, its role being split between an expanded MoH and the new DHBs. The legislation allowed a phasing-in period during which the MoH took responsibility for existing service contracts until the new DHBs were set up and functioning. The shift to DHBs ended the purchaser–provider split for hospital services, as DHBs held the funding for and deliver such services, while also continuing the purchaser–provider split for a range of services they purchase from other agencies. This includes primary care, which was now largely coordinated through PHOs, which began to be established from 2002. DHB funding was determined by a population-based funding formula.

Community involvement in DHBs was achieved in a number of ways. DHBs were governed by boards consisting of both elected and appointed members. Seven members could be elected at the time of local body elections, up to four were appointed by the Minister of Health (who also selected the Board chairperson), and there had to be at least two Māori members on the Board. DHBs had to establish three committees – community and public health advisory committee, disability support advisory committee, and hospital advisory committee – whose meetings were generally open to the public. The NZPHDA required public consultation when DHBs developed their district strategic plans and district annual plan, but this requirement was removed in the Amendment Act 2010.

An evaluation of this restructuring (focused on the process of the reforms) was undertaken by an independent research team between 2002 and 2005, including key informant interviews, Board-member surveys and documentary
analyses (Mays, Cumming & Tenbensel, 2007). The research found the following.

- Widespread support for the new model, particularly the local focus of DHBs, the emphasis on community engagement, the focus on collaboration rather than competition between DHBs, and opportunities for greater integration among services.
- While some participants considered 21 DHBs too many for a population of only 4 million, there was little support for forced mergers, and in practice, a number of new forms of collaboration had developed such as shared services agencies, regional mental health networks and a national association of DHBs (District health boards New Zealand, later DHB Shared Services).
- In general, participants were reasonably positive about the new governance system, and it appeared to be functioning reasonably well.
- DHBs were engaging and consulting with their local communities as they were required to do, but DHB members argued that the government directed their foci, which were primarily aimed at minimizing deficits and implementing government priorities.
- Population-based funding was generally supported and considered likely to result in a more equitable allocation of funds than funding via contracts; however, there were some concerns about inequities due to differences in the cost of providing services by different DHBs, and concern about whether payments for interdistrict outpatient services provided by one DHB for another were adequate to meet these costs.
- DHBs had clearly moved towards a more strategic focus on population health goals and their population’s needs rather than focusing just on running public hospitals; strategic and annual planning, and prioritization, were undertaken in different ways by different DHBs and the research showed that plans were only indirectly related to the specific resource allocation and purchasing decisions made by DHBs.
- In terms of improving Māori health, key issues identified were ensuring sufficient resources for Māori health needs, good ethnicity data collection, and continued attention to improving skills and supporting the Māori health and disability workforce; the importance of effecting obligations for Māori health under the Treaty of Waitangi was reiterated.
- Improving Pacific health was one of the key goals of the New Zealand Health Strategy, supported by a Pacific Health and Disability Action Plan (King, 2002). The research found that, although it was difficult to say that the reforms have had a major influence on the overall health status of Pacific people, there are strengths in the NZPHDA model, which have had a major impact on service delivery for Pacific
peoples and there was also more representation of Pacific people at governance level.

- Assessing and comparing health system performance was not straightforward, but the researchers concluded that since the reforms, the public health system had shown some signs of greater equity of access to services; better financial performance in terms of deficit reduction; no obvious sign of efficiency improvements and possible reductions in some areas; some signs of an improvement in responsiveness in high-profile areas such as elective/planned surgery; and a higher level of public acceptability, all occurring against a background of substantial real-term expenditure increases.

### 6.1.4.2 The Primary Health Care Strategy and Primary Health Organizations

Prior to 2001, most primary medical care was provided by GPs in private practices (GPCs) (working with practice nurses), and a small number of community-governed providers. In February 2001, the Minister of Health published the *Primary Health Care Strategy* (PHCS) (King, 2001), which outlined a new vision for PHC:

*People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups (King, 2001).*

The PHCS would involve six key directions:

- Work with local communities and enrolled populations.
- Identify and remove health inequalities.
- Offer access to comprehensive services to improve, maintain and restore people’s health.
- Coordinate care across service areas.
- Develop the PHC workforce.
- Continuously improve quality using good information (King, 2001).

The reforms would involve moving to a system where services are organized around the needs of an enrolled population with a greater emphasis on population health, health promotion and preventive care. Funding was to be based on population needs rather than the then existing fee-for-service model, and the system would return to providing universal funding for all New Zealanders for PHC.
PHOs were the local structures designed to implement this new model of PHC. These are not-for-profit organizations that fund and manage a network of PHC providers. They are expected to involve their communities in their governing processes, with all providers and practitioners involved in the Organization’s decision-making. PHOs were funded by DHBs to provide PHC services (including services to improve, maintain and restore health) through their member network for their enrolled population.

Membership of a PHO was voluntary for both practitioners and patients, but new government funding could be accessed only through PHOs. The PHCS envisaged that PHOs would develop over five to ten years, but implementation occurred more rapidly. The first two PHOs were established in July 2002, increasing to 45 by July 2003 (covering about half the population), 68 by June 2004 (covering about three quarters of the population) (Ministry of Health, 2005b), with 80 in 2008 (Barnett et al., 2009), before declining through mergers to 30 by 2020.

The government was to make available significant new funding to implement the PHCS: $2.2 billion over seven years (Hodgson, 2005). Originally, there were two capitation-based funding formulae: an “access” formula for PHOs defined as serving high-needs populations (having 50% or more of their enrolled population being Māori, Pacific Islanders and people living in the 20% most deprived areas according to the New Zealand deprivation index) and an “interim” formula for all others. Access PHOs received more funding initially, but over time, successive groups of people enrolled with Interim PHOs became eligible for increased funding (6- to 17-year-olds in April 2004, over 65-year-olds in July 2004, 18- to 24-year-olds in July 2005, 45- to 64-year-olds in July 2006, and 25- to 44-year-olds in July 2007 (Raymont, Cumming & Gribben, 2013). At the same time, pharmaceutical co-payments were reduced.

The Minister of Health expected that the higher government patient subsidies would result in lower user charges, but in response to GP concerns that were slowing down the development of PHOs, eventually assured them that their existing right to set a user charge would not be removed and charges would not be fixed (King, 2003a). Following concerns in the early allocations of new funding, the government established a process by which an annual capitation payment adjustment was set and where PHOs must notify DHBs of their providers’ standard consultation charges. Where the DHB considered these unreasonable, they could refer them to a review committee to consider, as outlined in the PHO Service Agreement (version 18).
As well as capitation payments, PHOs also receive a number of other funding streams. Services to Improve Access (SIA) funding was allocated to PHOs on the basis of the number of enrolled patients who are Māori, Pacific Islanders or living in the 20% most-deprived areas according to the New Zealand deprivation index and is intended to reduce inequalities for these groups. “Care Plus” provides additional funding (for 5% of the population overall) to people with high health needs because of a long-term condition, acute medical or mental health needs, or terminal illness. In addition to reducing the cost of services for these users, it aims to improve long-term management of the condition, reduce inequalities and improve PHC teamwork (King, 2003b). Management services fees were paid to PHOs on the basis of their size (with additional funding for small PHOs) and a small amount of funding was available to PHOs for health promotion activities.

The PHO Performance Management Programme began in January 2006 and aimed to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs. Participating PHOs were eligible to receive payments for improvements in performance against agreed indicators. All indicators were measured against the total PHO population and for the “high-needs population”, defined as Māori or Pacific Island people or those living in lower socioeconomic areas. These groups have been shown to have poorer health and one of the Programme’s aims is to reduce the health “gap” between high-needs and other patients.

A review of the first year of PHO implementation was undertaken in 2003, followed by a full evaluation from 2003 to 2008 (Raymont, Cumming & Gribben, 2013; Cumming et al., 2005; Perera et al., 2003). Thirty-four PHOs were established in the first year, a period characterized by some teething difficulties in moving to new systems of PHO formation, patient enrolment and capitation funding. Patient co-payments decreased in all Access-funded practices over the period, and a wide range of new services was being provided or planned under the new model (Perera et al., 2003).

The first evaluation report presented findings from key informant interviews (Cumming et al., 2005). Most were positive about the goals of the PHCS and considered that reductions in user charges had improved access to primary care and that there were opportunities to improve patient care through more flexible service delivery with increased focus on prevention. Some informants were concerned by what they saw as imprecise targeting of the new funding, and some GPs were concerned about the financial implications of the new model for their practices and perceived that the government was moving towards greater control of general practice. Establishment
of new PHO structures had taken considerable time and money, but this phase was nearing completion and more focus would be going towards improving services and implementing new programmes. PHO boards had good community representation, but in some PHOs there was concern about medical dominance. Informants recognized that the strategy had increased the opportunities for an expanded nursing contribution in PHC, but practices differed greatly in how they were developing nursing roles, depending mainly on the preferences of GPs (who are largely the employers of practice nurses).

An evaluation of practice data between 2001 and 2005 (Cumming & Gribben, 2007) found that charges had generally fallen for the groups where new funding had been provided by the government (except for children, who had not benefited from higher capitation rates), although the fall was not always as high as the government had sought.

Later work examining changes between 2001 and 2007 pointed to the complexities involved in assessing the reforms, given that different groups (Access/Interim GPCs, age) became eligible for new funding at different times and the changes particularly reduced user charges for those not previously holding CSCs or HUHCs, and hence not previously eligible for government subsidies to part-fund their PHC services (Raymont, Cumming & Gribben, 2013). The evaluation found the following with respect to user charges.

At Interim practices in 2007:

- Charges for those aged 0–5 years were $1.91 on average but had increased over time from an average of $1.17, a 63.2% increase but from a very low base.
- Charges for those aged 6–17 years had increased by 26% compared with 2001/2002 from $12.19 to $15.40 on average.
- For those aged over 17 years, charges were between $22.55 and $24.06; they had decreased by about 14% compared with 2001/2002, except for those aged 65+ years, where charges were higher in 2007 ($24.06) than in 2001/02 ($22.33).
- The decrease in charges affected mainly those without a CSC. The difference between charges to those with and without a CSC diminished and became insignificant by the end of the study period.
- Increased funding produced one-off reductions in charges at Interim practices as new funding was rolled out by age group, but there was a background increase of about 4.5% per year.
At Access practices in 2007:

- Charges for 0- to 5-year-olds were very low ($0.64), an increase of 10.3% compared with 2001/2002.
- Charges for those aged 6–17 years were $6.42 and for the older age groups they were between $13.33 and $14.03. Charges had decreased by between 21.9% and 29.1% for those aged 6–64 years and by 15.4% for those aged 65+ years, compared with 2001/2002.
- Overall, Access practices showed a reduction in charges of about 5% per year.

Across the entire study, among adults, Māori, Pacific peoples and those from poorer neighbourhoods were charged lower amounts throughout the study period, but many of the differences reduced over this time.

In terms of GP, GP/nurse, and nurse consultation rates, the evaluation found the following:

- At Interim practices, rates of consultation increased for those aged 18–24 (19.2%), 45–64 (13%) and 65+ years (29.2%) and decreased for children (–11.2%).
- At Access practices, there was an increase in consultation rates for those aged 18+ years (between 10.2% and 21.4%), the increase being greater in the older groups.
- Overall rates of consultation were lower in Access practices than in Interim practices; in 2007, rates were about 50–60% of Access rates for the three younger age groups (0–24 years) and about 70–80% for the three older age groups (25 years and over).
- When patients with and without a CSC are distinguished, only those with a CSC at Interim practices and older adults with a CSC at Access practices experienced an increase in consultation rates over the entire study period, as a result of a drop off in consultation rates in 2006/2007.
- Compared with those of “Other” ethnicity, Māori consultation rates were higher [mean 115%] and increased significantly [by 30%]; Pacific peoples’ rates were lower [mean 74%] and decreased [by 14%]; Asian rates were lower [mean 60%] and increased significantly [by 35%]. With consultation rates among Māori rising faster than among the “Other” ethnic group, the ratio of Māori to “Other” consultations increased over the period. This is also true for Asian populations. However, worryingly, the ratio of Pacific to “Other” consultations fell over the entire study period.
• Compared with those living in NZDep 1–4 neighbourhoods, those living in NZDep 5 neighbourhoods and aged 0–24 years had lower rates of consultation (mean about 82%); rates for those aged 24+ years were comparable between the two groups. The increase in rates was slightly higher for those living in NZDep 5 compared with those in NZDep 1–4 neighbourhoods (mean 7% vs 4%) and aged 6–64 years.

Other findings from the evaluation highlighted the great diversity among PHOs, including their size, management support arrangements, governance, providers they work with and their views of their role (Barnett, Smith & Cumming, 2009; Smith & Cumming, 2009a). For example, PHOs ranged in enrolments from 1536 to 356,000 in July 2008 (Smith & Cumming, 2009a). Within general practice, there was clear support for the increase in funding for PHC and a greater role for nurses, but more muted support for other aspects of the PHCS such as the creation of PHOs, universal low-cost access, proactively approaching patients who do not present for care and the Care Plus programme for people with chronic conditions (Raymont & Cumming, 2009).

Despite the PHCS’s focus on population health and the move to capitation-based funding, many PHC professionals are still working under fee-for-service incentives. A 2009 study found that from the outset of the strategy, patient user charges have been a source of tension between the government and GPs, and the researchers believe that one of the challenges moving forward was to shift the focus from infrastructure and user charges to how the broader aims of the Strategy can be achieved (Croxson, Smith & Cumming, 2009).

Other issues that needed to be addressed include clarifying the roles of PHOs and DHBs; further development of clinical engagement and leadership within PHOs and strengthening the management and leadership of PHC more broadly; and integrated patient management IT systems (Smith, 2009; Smith & Cumming, 2009a).

The role of nurses was emphasized in the PHCS, with teamwork among nurses, community outreach, and general practice replacing the previous concept of doctors being the principal providers of primary care. The Strategy also asserted that “The concept of the PHC nurse needs further development with clarification of the appropriate capabilities, responsibilities, areas of practice, educational and career frameworks and suitable employment arrangements” (King, 2001). In response to this, the MoH established an Expert Advisory Group on Primary Health Care Nursing in 2001, which presented a framework for activating PHC nursing in New Zealand in

- **Aligning nursing practice with community need**: funding streams, employment arrangements and service delivery patterns will support nurses to adopt an integrated approach to practice and incorporate population and personal health strategies into service delivery.
- **Innovative models of nursing practice**: new and innovative models of PHC nursing practice should be followed, which improve access to PHC services and contribute to improved health outcomes and reduced health inequalities for individuals, families/whānau and communities/iwi.
- **Governance**: PHC nurses will be equal partners alongside other professional groups and community representatives in the governance of PHC organizations.
- **Leadership**: PHC nurses will have clear, accessible, integrated nursing leadership to encourage and promote change and facilitate the development of new roles and models of practice.
- **Education and career development**: postgraduate education will support all levels of PHC practice and be recognized in a national, standardized career pathway for PHC nurses.

The expert advisory group made a number of recommendations to the MoH, DHBs and PHOs for achieving these goals, including that the MoH should fund, monitor and evaluate innovative models of PHC nursing practice and disseminate examples of best practice to the wider sector (Expert Advisory Group on Primary Health Care Nursing, 2003).

In response to this, the Ministry allocated $7 million to fund nursing innovations between July 2003 and July 2006. Eleven of 139 proposals were selected for funding and were also independently evaluated. The evaluators found there were two broad models for the innovations, which they termed the “Leading Primary Health Care Nursing Development Model” (focused on leading broad-based change involving PHC nurses across DHBs and/or PHOs) and the “Primary Health Care Nursing Practice Model” (focused on the development of new, expanded or modified forms of nursing practice to deliver services to particular populations) (Primary Health Care Nurse Innovation Evaluation Team, 2007).

The former was effective in developing the nursing workforce and enabling nurses to be involved in policymaking, practice development and the organization of PHC service delivery, while the latter could be effective in reaching population groups known to have difficulty in accessing PHC and
reduce inequalities, but needed good support from other PHC providers to be successful (Primary Health Care Nurse Innovation Evaluation Team, 2007).

A broad evaluation of the implementation and intermediate outcomes of the PHCS included assessment of developments in nursing between 2001 and 2007. This found that there had been significant development of nurses’ roles and capability within the PHO environment, particularly with regard to managing chronic conditions and working with people in underserved and vulnerable populations (Finlayson, Sheridan & Cumming, 2009). The two most important factors that influenced the expansion of nurses’ roles were having practices and PHOs that embraced the Strategy’s intention to improve population health and having additional funding for specific programmes. Further development of nursing roles would require consideration of the funding model for PHC services (currently tied to GPs); expanded nursing education; leadership, governance and mentoring by and for nurses; and addressing recruitment and retention issues (Finlayson, Sheridan & Cumming, 2009).

6.1.5 2009–2017: the global financial crisis; “better, sooner, more convenient” services; health targets; a refresh of the New Zealand Health Strategy; pay equity; and the health care home

6.1.5.1 The global financial crisis and its effects

The 2007/2008 global financial crisis put considerable pressure on government revenue. The MoH said the weakening outlook for growth and its impact on the government’s finances would demand a stronger focus on value for money in the health and disability sector (Ministry of Health, 2008c). At that stage, two thirds of new funding was needed to maintain the quality and coverage of existing services, and the rate of cost increases would outstrip likely growth in available funding in the near future, the MoH said.

The government focused its immediate attention on getting full value from public services. This had significant implications for the public health sector, as it was one of the largest areas of government spending. The MoH reviewed its spending by conducting a line-by-line review and implementing spending constraints and contracting improvements. This realized total savings of NZ$178 million in the 2008/2009 year (Ministry of Health, 2011c).

Underfunding of the sector became an ingrained issue. In 2011, the MoH optimistically announced that the health and disability system had adapted to a lower rate of annual increases in spending over the past three years (Ministry of Health, 2011c). During this period, the MoH said, performance on
a number of measures had improved, and DHBs had reduced their deficits. Three years later, the MoH added that DHBs had reduced their deficits from a forecast of $200 million five years ago to approximately $19 million in 2012/2013 (Ministry of Health, 2014b). But by 2017, the MoH was saying that the track of DHB total deficits indicated that efficiency gains were becoming increasingly difficult (Ministry of Health, 2017d). Similarly, ongoing efficiency gains in the $2.4 billion of health services purchased by the MoH were becoming more difficult as demand and cost pressures bore down on those services too. As a result, DHB deficits began to rise (Figure 6.1).

**Figure 6.1 Combined DHB deficits, 2008/2009–2016/2017**

![Combined DHB deficits, 2008/2009–2016/2017](image)

Source: Briefing to the Incoming Minister of Health, 2017: The New Zealand Health and Disability System (Ministry of Health, 2017d)

As recently as 2020, the MoH said health funding had failed to keep pace with growing demand since the global financial crisis. Challenges such as the attack on Christchurch mosques and the Whakaari/White Island volcanic eruption (see Section 5.15) had stressed an already stretched system (Ministry of Health, 2020g). Nevertheless, in 2020, the government announced that $3.6 billion had been committed to health spending, including building new hospital facilities in Dunedin, Christchurch, New Plymouth, Auckland and Counties Manukau (Reddy, 2020).

### 6.1.5.2 “Better, sooner, more convenient” services

Following elections in November 2008, a new government was elected, led by the National Party, with confidence and supply agreements with the ACT party, the Māori Party and United Future. The National Party’s health
policy document going into the election – *Better, sooner, more convenient (BSMC)* – expressed concern about increasing health expenditure, decreased productivity in the public health system (first specialist assessments and surgical discharges having shown little increase in relation to increased health expenditure) and growing elective/planned surgery waiting lists (New Zealand National Party, 2007). Soon after, while pledging to continue the growth in health spending, which had been set out in the preceding Labour government’s budget, the National Party asserted it would spend the money “more wisely...as well as get more effective care from existing spending. We will deliver better, sooner, more convenient care and treatment for New Zealanders from the public’s investment in health” (New Zealand National Party, 2008). They sought less bureaucracy and more frontline care for patients; increased clinical leadership by doctors and nurses; more collaboration between DHBs; increased devolution of hospital-based services to primary care settings; and smarter use of the private sector (New Zealand National Party, 2008).

In January 2009, a Ministerial Review Group was established to review the public health system and recommend how its quality and performance might be improved. The group’s report, *Meeting the Challenge*, was released in July 2009 (Ministerial Review Group, 2009). The report set out a proposed “way forward”, which included the following:

- improved patient focus within the health system, shifting care “closer to home”, making greater use of primary and community care, and ensuring more continuity for patients accessing services across the health spectrum;
- stronger partnerships between clinical and management staff;
- improved patient safety and quality of care;
- strengthening the role of the National Health Committee to include assessing new services and procedures to determine which should be publicly funded and prioritizing them against existing interventions;
- better national and regional service configuration, with national services planned and funded by a national health board and delivered by DHBs; DHBs would also be required to produce regional service plans and work more cooperatively;
- improved structures and processes for workforce, capital and IT planning and funding;
- shifting resources to the “frontline” by creating a shared services organization to take over responsibility for common DHB “back office” services;
- improving hospital productivity and reducing variation in clinical and financial performance within and between hospitals.
The Review Group aimed to have minimal structural change within the existing legislative framework. The major proposed change was the establishment of a national health board (NHB), which would take over, from the MoH and DHBs, the function of planning and funding of national health services. Monitoring of DHBs would also shift to the NHB from the MoH. The focus of the MoH would be core policy and regulatory functions. The Review Group argued that the separation of Ministry and NHB functions would “provide clearer separation between the development of health policy and its implementation…and much clearer roles and accountabilities” (Ministerial Review Group, 2009). Other proposed changes were the establishment of a national shared services Agency, additional roles for the NHC, an independent national quality agency to replace the existing Quality Improvement Committee, and a two thirds reduction in the number of health committees (Ministerial Review Group, 2009).

The NHB was duly established in 2010 as a business unit within the MoH. It was tasked with coordinating the planning, funding and monitoring of DHBs and national services, and to undertake national capacity planning and funding for workforce, IT and capital in the disability and health sector. In line with the government’s intentions to reduce bureaucracy and shift resources to frontline services, the MoH reduced staffing levels. The MoH’s staffing cap on 31 December 2008 was 1675 full-time equivalent staff members, meaning the MoH was operating at approximately 200 fewer staff than its original cap (Ministry of Health, 2009).

Also in 2010, several new or reconstituted health sector bodies was created. These included the Health Quality and Safety Commission (established to create a sharper focus on service quality and safety) and Health Benefits Ltd (which put in place shared services and joint procurement so that more resources could be released for frontline services). At the same time, there was also rationalization of other entities. In 2012, the MoH implemented the government’s decisions to disestablish the Mental Health Commission (with its functions passing to the Health and Disability Commissioner) and merge the Alcohol Liquor Advisory Council and the Health Sponsorship Council to form a new Health Promotion Agency.

However, not all of these changes survived: the NHB was disestablished in 2016 and its functions folded back into the MoH, while Health Benefits Ltd failed to make the significant savings expected of it, and was disestablished in 2015, the work taken over by DHBs themselves through NZ Health Partnerships Ltd, still in operation in 2021 (Radio New Zealand, 2015; New Zealand Health Partnerships, 2021). The Health Promotion Agency was folded into HNZ in 2022 (see Chapter 6).
The National Party-led government’s BSMC policy was also interested in improving PHC. One key policy was to encourage PHOs to amalgamate, to reduce back-office costs and ensure that PHOs had the capacity and capability to best oversee PHC services. A related policy involved an expression-of-interest process, where nine “business case” collaborations (later called “alliances”) were selected to implement changes in PHC. These involved amalgamations of PHOs along with alliances between DHBs and PHOs to collaborate on improved PHC services. They were expected to offer more integrated care, including co-located GP, specialist, diagnostic, minor surgical services, extended opening hours and walk-in services via integrated family health centres (IFHCs), along with more nurse-led and nurse practitioner services, more multidisciplinary teams, and greater co-operation between PHC and hospitals (Middleton et al., 2018).

The alliances covered 60% of New Zealand’s population and began operating in July 2010 (Ministry of Health, 2021af). They did not receive new funding but were supported by enabling SIA, HP, Care Plus and PHO management funding to be used more flexibly, via a flexible funding pool. However, they generally met with only limited short-term success, with one commentator describing the alliances as “a rather dreary story of isolated areas of progress brought about by local leadership that did not diffuse through the system” (Scott, 2018). Among the reasons for this failure, according to Scott, was the complexity of the existing health system, which included 20 DHBs and no national funding mechanism. More recently, an assessment of recent integration initiatives shows how alliance programmes evolved over time, in response to key local issues and experiences (Cumming et al., 2021). One initiative that did spread towards the end of the 2010s, however, was the Health Care Home (HCH).

6.1.5.3 Health targets

Another outcome of the BSMC policy was the creation of a range of health targets, reflecting areas of public priority (Minister of Health, 2007). These targets were indicators of overall system performance. There were originally ten targets:

- Improving childhood immunization
- Improving adolescent oral health
- Improving elective services
- Reducing cancer treatment waiting times
- Reducing ambulatory sensitive (avoidable) hospital admissions
- Improving diabetes and cardiovascular services
- Improving mental health services
- Improving nutrition, increasing physical activity, and reducing obesity
• Reducing the harm caused by tobacco
• Reducing the percentage of the health budget spent on the MoH.

In 2010, the number of targets was reduced to six, shown in Table 6.2 below.

The MoH would routinely update and report on performance against these targets. For instance, in 2014, it reported that considerable progress had been made towards increasing infant immunization coverage in New Zealand. That year, the MoH, working with DHBs and PHOs, sought to achieve the target of 90% of infants receiving their scheduled immunizations by the time they were eight months old. At the end of June 2014, 92% of eight-month-old children were fully immunized. This exceeded the health target goal of 90% coverage by July 2014, with 15 DHBs successfully reaching the 90% target. At the time, 93% of two-year-old children were fully immunized. However, the targets did change over time and tracking progress overall is possible only for some targets, such as immunization, where ongoing routine data collections are in place.

These DHB targets remained in place until 2016/2017. From 2011/2012 to 2016/2017, there were matching targets for PHOs (Ministry of Health, 2021m), relating to the last three targets set out in Table 6.2, although in 2016/2017, the diabetes and cardiovascular services target was dropped.

Table 6.2 Government’s health targets, 2009

<table>
<thead>
<tr>
<th>Target</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shorter stays in emergency departments</td>
<td>95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.</td>
</tr>
<tr>
<td>Improved access to elective surgery</td>
<td>The volume of elective surgery will be increased by an average 4000 discharges per year (compared with the previous average increase of 1400 per year).</td>
</tr>
<tr>
<td>Shorter waits for cancer treatment</td>
<td>Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.</td>
</tr>
<tr>
<td>Increased immunisation</td>
<td>85 percent of two-year-olds will be fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012.</td>
</tr>
<tr>
<td>Better help for smokers to quit</td>
<td>80 percent of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012. Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.</td>
</tr>
</tbody>
</table>
| Better diabetes and cardiovascular services | a. An increased percent of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years.  
   b. An increased percent of people with diabetes will attend free annual checks.  
   c. An increased percent of people with diabetes will have satisfactory or better diabetes management. |

Source: Annual report for the year ended 30 June 2010 (Ministry of Health, 2010)
Also in 2010, the MoH began its involvement in the government’s Better Public Services programme. The policy was focused on seeking new and better ways to deliver public services, and continuing to contain and reduce costs (Mateparae, 2011). It set a number of key areas of focus for concerned government agencies to work together on. The areas of focus included (Public Service Commission, 2017a):

- Reducing long-term welfare dependence
- Supporting vulnerable children through increased participation in early childhood education improved immunization rates and reduced incidence of rheumatic fever; and reduced assaults on children
- Boosting skills and employment
- Reducing crime
- Improving interaction with government.

For the health initiatives, it has been reported that immunization rates increased by around eight percentage points between 2021 and 2016; while first rheumatic fever hospitalizations dropped by 23% (Public Service Commission, 2017a). The entire programme was seen to be successful, due to the following reasons (Public Service Commission, 2017b):

- Results being few, specific and worthwhile (appealing to a public service ethic)
- Targets conveying ambition and a sense of urgency
- Public reporting
- Participants feeling committed to improving what are seen as important priorities
- Participation focused on core agencies meant greater responsibility for each party
- Collective responsibility focused on achieving results
- Cascading collaboration means collective responsibility through agency hierarchies.

The Programme was stopped in 2018.

From 2012 on, work on a framework for improving the overall health system’s performance took place. This first resulted in an Integrated Performance and Incentive Framework based on outcomes and a desire for a more collaborative approach to achieving improvement in the health system. This then developed into a systems level measures (SLM) framework, with a final set of six agreed measures:

- Ambulatory sensitive hospitalization (ASH) rates for 0- to 4-year-olds (keeping children out of hospital)
• Acute hospital bed days per capita (using health resources effectively)
• Patient experience of care (person-centred care) – this is made up of adult inpatient and primary care patient experience surveys
• Amenable mortality rates (prevention and early detection)
• Babies living in smoke-free homes (a healthy start)
• Youth access to and utilization of youth-appropriate health services (youth are healthy, safe and supported). This SLM is made up of five domains with corresponding outcomes and national health indicators (Ministry of Health, 2021ag).

The MoH gave the Alliances established under the BSMC policy responsibility for designing annual, collaborative improvement plans aimed at working towards improving health based on the above measures (Sharma, 2021). The programme has been found to have mixed success, with the key being a strong understanding of the logic and aims of the programme, and a mature and functional alliance (Tenbensel et al., 2021). The programme is now called the Health System Indicators framework (Ministry of Health, 2021n), with an adjusted set of indicators which to the new health system after 1 July 2022 (Table 6.3).

Table 6.3 Health System Indicators framework, as at June 2022

<table>
<thead>
<tr>
<th>Government priority</th>
<th>High-level indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving child wellbeing</td>
<td>Immunization rates for children at 24 months</td>
<td>Percentage of children who have all their age-appropriate schedule of vaccinations by the time they are two years old</td>
</tr>
<tr>
<td></td>
<td>Ambulatory sensitive hospitalizations for children (age range 0–4 years)</td>
<td>Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community</td>
</tr>
<tr>
<td>Improving mental wellbeing</td>
<td>Those under 25 years able to access specialist mental health services within three weeks of referral</td>
<td>Percentage of children and youth accessing mental health services within three weeks of referral</td>
</tr>
<tr>
<td></td>
<td>Access to primary mental health and addiction services</td>
<td>In development</td>
</tr>
<tr>
<td>Government priority</td>
<td>High-level indicator</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Improving wellbeing through prevention</td>
<td>Ambulatory sensitive hospitalizations for adults (age range 45–64 years)</td>
<td>Rate of hospital admissions for people aged 45–64 years for an illness that might have been prevented or better managed in the community</td>
</tr>
<tr>
<td></td>
<td>Participation in the bowel screening programme</td>
<td>In development</td>
</tr>
<tr>
<td>Strong and equitable public health system</td>
<td>Acute hospital bed day rate</td>
<td>Number of days spent in hospital for unplanned care, including emergencies</td>
</tr>
<tr>
<td></td>
<td>Access to planned care</td>
<td>People who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the delivery plan</td>
</tr>
<tr>
<td>Better primary health care</td>
<td>People report that they can get primary care when they need it</td>
<td>Percentage of people who say that they can get primary care from a GP or nurse when they need it</td>
</tr>
<tr>
<td></td>
<td>People report being involved in the decisions about their care and treatment</td>
<td>Percentage of people who say they felt involved in their own care and treatment with their GP or nurse</td>
</tr>
<tr>
<td>Financially sustainable health system</td>
<td>Annual surplus/deficit at financial year end</td>
<td>Net surplus/deficit as a percentage of total revenue</td>
</tr>
<tr>
<td></td>
<td>Variance between planned budget and year-end actuals</td>
<td>Budget versus actuals variance as a percentage of budget</td>
</tr>
</tbody>
</table>

Source: Health system indicators framework (Ministry of Health, 2021n)

### 6.1.5.4 Update of the New Zealand Health Strategy

In 2016, the government published an update to the *New Zealand Health Strategy* (Minister of Health, 2016a). The new Strategy outlined the high-level direction for New Zealand’s health system over the 10 years. It laid out some of the challenges the system faced and identified five strategic themes for future changes to the system. Some of the challenges are given below:

- New Zealanders are generally living longer (keeping older persons healthy and independent can involve more health and social services than are needed for younger people).
Some groups in the population benefit less from the health and disability system (for instance, although New Zealanders overall are living longer, Māori and Pacific peoples still have lower life expectancies than the general population).

Funding the system will become increasingly expensive (assuming there are no changes to policy settings, government health spending would rise from about 7% of GDP in 2016 to about 11% in 2060).

New Zealand’s health workforce is ageing and includes a large unregulated workforce, including care and support workers (thus, the government must continually invest in training to ensure that the workforce has the skills needed).

The five themes to guide policy were as follows:

- People-powered, including ensuring that people understand their care and are able to make informed decisions
- Closer to home, such as delivering care as near as possible to where people live
- Value and high performance, such as seeking equitable health outcomes across the population
- One team, including using the health and disability workforce in an effective, flexible manner
- Smart system, including investing in new technology.

The government developed specific action plans aligned with these themes (Minister of Health 2016b). Plans for each theme included the following:

- People-powered: the MoH would use social media to support healthy living, giving authoritative information to help people make healthy food and activity choices.
- Closer to home: increase the use of telehealth services, such as telemedicine and telemonitoring to provide services to people nearer to their homes.
- Value and high performance: improve consistency across services funded by the MoH, ACC, the Ministry of Justice, Ministry of Social Development and the Department of Corrections.
- One team: the MoH would develop a systemwide leadership programme and strengthen skills and capability in the NGO/primary and volunteer sector.
- Smart system: the MoH would design and introduce a national electronic health record system, which, among other things, would give hospital-based health providers a common provider portal to access medical records.
6.1.5.5 Pay equity

A particularly important development in recent years was the lead role played by the MoH in the establishment of pay equity in part of the health sector (Ministry of Health, 2018c). The settlement acknowledged the work carried out by the predominantly female workforce in New Zealand’s aged and disability residential care and home and community support services. The reform began with E tū, a union representing low-paid workers, making a successful pay equity claim that a caregiver’s pay was less than would be paid to a male with the same set of skills in a different occupation due to the fact caregivers were predominantly female. In April 2017, the government announced a NZ$ 2 billion pay equity settlement for 55 000 care and support workers. The workforce, who were mostly paid on or around the minimum wage, received a pay rise of between 15% and 50%, depending on qualifications and/or experience. The MoH, as the lead agency, in partnership with the ACC, successfully implemented a project to ensure that 55 000 people working for 650 providers and covered by 1100 contracts received the correct wages from 1 July 2017.

In May 2022, a settlement was reached in a pay equity claim for health sector administrative and clerical staff, a workforce that is mostly female (Tilo, 2022). There are ongoing discussions in a pay equity claim for nurses (New Zealand Nurses Organisation, 2022a; New Zealand Nurses Organisation, 2022b).

6.1.5.6 Health care home

As part of the national-led government’s BSMC policy in the early 2010s, seed funding was made available for business cases in line with the policy. This, coupled with flexible funding for PHOs, led to the development of the health care home (HCH) model of care, which still exists today. HCH is a form of PHC service delivery and is based on the Patient Centered Medical Home model in the US (Middleton et al., 2018). It is a sector-based initiative, driven and funded by those health-care organizations involved, rather than by the government.

HCH seeks to address several of the major challenges facing PHC in New Zealand. These include the rising demand for PHC (due in part to a rising and ageing population), shortages in the health-care workforce, rising patient expectations regarding the quality of care they receive, persistent health inequities, technological advancements, and variation in the care patients receive between practices (Middleton et al., 2018).

HCH has four core elements: (1) prompt access to urgent care, (2) proactive care for those whose needs are more complex, (3) better preventive and
routine care, and (4) more sustainable and efficient business practice (Health Care Home Collaborative, 2017). Some of the specific health-care mechanisms HCH practices use include: having processes in place to ensure that same-day appointments are available for those people with the highest priority need; using telephone assessment and triage, in which clinicians manage appropriate patients by phone, including providing prescriptions, self-care advice, and referral for diagnostics; having other telehealth options in place, including email and video; having systematic processes to identify and target patients who would benefit most from primary care support; having a clear and structured pathway for introducing new innovations; and ensuring that all health professionals involved in service delivery provide culturally competent care to patients and their whānau, reflective of their practice population (Health Care Home Collaborative, 2021a).

At the national level, HCH is run by HCH Collaborative, an organization funded by its participating members. It provides national governance for the system, enables learning and other resources to be shared between different areas, and is responsible for the HCH certification process. PHO members of HCH include: (1) Tū Ora Compass Health, which has a network of 62 general practices providing PHC to around 318 000 people across the Wellington, Porirua, Wairarapa and Kapiti areas; (2) Pegasus Health, which provides services and support to general practices and community-based health providers servicing over 400 000 enrolled patients within Canterbury in the South Island; and (3) Te Tai Tokerau and Manaia, two Northland PHOs with a combined population of 47 000 (Health Care Home Collaborative, 2021a; Health Care Home Collaborative, 2021b).

There is evidence that the HCH model is effective. Ernst & Young undertook an evaluation comparing data from 14 HCH practices to that of nine comparable non-HCH practices with similar-sized enrolled populations (86 105 patients in the HCH practices, 85 256 in the control practices) between April and September 2017 (Ernst & Young, 2018). The evaluation found that the HCH practices had a significantly lower rate of ambulatory sensitive hospitalizations (20% fewer); a significantly lower rate of emergency department presentations (14% decrease), including a large difference among Māori (24% decrease) and older HCH patients (32% decrease).

Moreover, both the lower ambulatory sensitive hospitalizations and emergency department rates were particularly pronounced for people living in areas of the highest quintile of socioeconomic deprivation. Patient portal use was significantly higher in the HCH practices, with 12% of HCH patients accessing the patient portal, compared with about 1% of patients in the control practices. Triage at the HCH practices also appeared effective, with
62% of requests for care being managed by means other than a same-day visit to the practices (such data were not collected at the control practices). The evaluation concluded that the HCH model “appears to be an effective innovation on the traditional model of general practice service delivery” (Ernst & Young, 2018).

6.1.6 2017–2019: Mental health, inequities in health delivery, and a health and disability sector review

6.1.6.1 Mental health

September 2017 saw a change of government, with a Labour-led coalition government being elected. It immediately signalled greater investment in the health sector, declaring that health would be a top priority. “This government will restore funding to the health system to allow access for all. It will invest in the health system to provide the highest levels of care, support and treatment, wherever people live in New Zealand” (Reddy, 2017). The government noted that a particular focus would be mental health, with a ministerial inquiry into mental health set up and the Mental Health Commission re-established.

In announcing the review of mental health services in New Zealand, the Prime Minister, Jacinda Ardern, said: “We need fresh thinking and I look forward to recommendations on how we can make our care, support and other resources more accessible, effective and responsive to community need” (Kirk, 2018). The inquiry’s terms of reference noted that service users, their families and whānau, people affected by suicide, people working in health, media, iwi and advocacy groups had called for a wide-ranging inquiry and that major concerns included stubbornly high suicide rates, growing substance abuse and poorer mental health outcomes for Māori. He Ara Oranga: report of the government inquiry into mental health and addiction (He Ara Oranga) was the resulting report, published in late 2018 (Government Inquiry into Mental Health and Addiction, 2018).

The inquiry noted that many people in the mental health system receive good care and there was a skilled and committed workforce. But the inquiry also found that the system was unsustainable in its current form. Warning signs included escalating demand for specialist services, limited support for people in the community, and difficulties in recruiting and retaining staff. The inquiry found that outcomes for Māori were worse than for the overall population, and that Māori were subject to much greater use of compulsory treatment and seclusion. There were also unmet mental health needs for Pacific peoples, disabled people, rainbow communities, the prison population, and refugees and migrants. The estimated reduction in life expectancy of people with severe mental health or addiction challenges was 25 years. The
inquiry was particularly concerned about New Zealand’s persistently high suicide rates.

The review made numerous recommendations, including that the PHC workforce needed to be enhanced, with additional mental health and addiction training for general practitioners, practice nurses and community health workers; stronger action needed to be taken on alcohol and other drugs, such as enacting a stricter regulatory approach to the sale and supply of alcohol; and the criminal sanctions for the possession of controlled drugs for personal use should be replaced with civil responses. Other recommendations included the need to urgently complete and implement a national suicide prevention strategy, with a target of a 20% reduction in suicide rates by 2030; and that a new Mental Health and Wellbeing Commission be established to act as a watchdog and provide leadership in the sector. The inquiry noted that since the disestablishment of the original Mental Health Commission, there had been a general lack of confidence in leadership of the mental health and addiction sector over many years. The inquiry felt a new commission was needed to act as the institutional mechanism to hold decision-makers and successive governments to account.

The government generally accepted the mental health review’s recommendations, including boosting access to publicly funded mental health and addiction services, widening the types of services available, urgently completing a national suicide prevention strategy, and establishing an independent commission. However, the government rejected the recommendation to establish a suicide reduction target, with the Minister of Health saying: “We’re not prepared to sign up to a suicide target because every life matters and one death by suicide is one death too many” (Radio New Zealand, 2019b).

The inquiry’s work was followed in 2019 by an MoH key government strategic document on suicide, called Every Life Matters – He Tapu te Oranga o ia Tangata: the Suicide Prevention Strategy 2019–2029 and Action Plan 2019–2024 for Aotearoa New Zealand (Ministry of Health, 2019d). The Strategy outlines the government’s plan for further work in the mental health and addiction space. Noting the high suicide rates in New Zealand, the Plan called for the establishment of a Suicide Prevention Office to strengthen national leadership around suicide prevention, suicide education programmes, a free suicide bereavement counselling service and similar tools to help reduce the suicide rate, especially among Māori.

Ultimately, the government’s 2019 budget invested NZ$ 1.9 billion to support New Zealanders’ mental wellbeing, including a significant increase in funding
for mental health and addiction services. The money was spread across numerous government agencies, with 57% going to Vote Health, 24% to Vote Housing and Urban Development, 9% to a commission investigating the historical abuse of children while in State care, 7% to Vote Corrections and the remaining 3% to five other government agencies for various initiatives. A Suicide Prevention Office was established within the MoH in 2019; an Interim Mental Health and Wellbeing Commission operated between November 2019 and February 2021; and the permanent independent Mental Health and Wellbeing Commission was established in February 2021 (Implementation Unit, 2021; Ardern, 2019; Mental Health and Wellbeing Commission, 2021).

The government’s 2020 Budget invested another $25 million to build on and accelerate the roll-out of youth-specific primary mental health and wellbeing support in tertiary institutions. It was intended that access would expand as funding increases from $2 million in 2020/2021 to $10 million per annum in 2023/2024 and beyond (Ministry of Health, 2021ah).

In September 2021, the MoH published an update on its progress in carrying out the recommendations of the mental health review, called *Kia Manawanui Aotearoa Long-term pathway to mental wellbeing* (Ministry of Health, 2021ah). It listed a long series of achievements.

As well as mentioning the new Mental Health and Wellbeing Commission, the report noted that the NZ$ 1.9 billion package included $455 million over four years to expand access to and choice of primary mental health and addiction services in a programme called Access and Choice. This involved the national roll-out of integrated primary mental health and addiction services accessed via general practice, as well as services directed at Māori, Pacific and youth. The services were supporting over 10 000 people per month who may not have otherwise had mental health assistance. By the end of the five-year national roll-out in 2023/2024, the programme was expected to provide access to services for an additional 325 000 people per annum.

Progress had also been made with other initiatives focused on increasing access to support for people with mild-to-moderate needs, including expanding school-based health services, increasing capacity for telehealth contacts by 58 000 contacts per annum and investing in additional primary addiction services.

An independent government-commissioned review on how well the mental health package had been put into practice noted that progress was strong, and most initiatives were on track (Implementation Unit, 2021). The review did, however, recommend a stronger governance structure, led by the MoH,
to ensure that service delivery across all the government agencies involved in the package worked together appropriately. The government’s 2022 budget announced further government investments in mental wellbeing, including $100 million for a specialist mental health and addiction package and $89 million to expand mental wellbeing support for primary and secondary school students [Ministry of Health, 2022t].

But not all recent assessments of the government’s record on mental health have been so positive. In 2021, Shaun Robinson, the chief executive of the Mental Health Foundation, an organization independent of the government, said: “The whole sector has been pretty disappointed in the Office of Suicide Prevention. I think it’s difficult to point to anything they’ve actually done” [Wade, 2021]. Likewise, high-profile mental health advocate Mike King, who was awarded the New Zealand Order of Merit honour for services to mental health awareness and suicide prevention in 2019, returned the honour in protest in May 2021, saying he was disappointed that so little had been done since the announcement of the $1.9 billion package. He said the mental health system was still “broken and it seems to our most vulnerable Kiwis and their families that no one is trying to fix it” [Sadler, 2021].

6.1.6.2 Inequities and the Waitangi Tribunal

Along with mental health, another issue long identified in New Zealand has been inequities in health care. In 2008, the MoH had noted that long-term conditions such as heart disease, cancer, diabetes, obesity, and tobacco-related conditions were the leading cause of ill-health and early death in New Zealand and, further, that these conditions disproportionately affected low-income earners, Māori, and Pacific Island peoples [Ministry of Health, 2008c].

The incoming Labour-led government in 2017 agreed. It noted that the government intended to work with Māori communities and other New Zealanders to support them to pursue their aspirations for better health, better housing, and better education for their young people. The government also said it would review the Whānau Ora delivery model so it could achieve its full potential [Reddy, 2017]. However, Came, Cornes & McCleanor [2018] pointed out that the Treaty of Waitangi was not embedded in health policy and would likely play a part in Waitangi tribunal claims.

From early on, but increasingly since the 1970s, Māori have sought to have their claims about breaches of the Treaty addressed. In 1975, the Waitangi Tribunal was established for this purpose. It is a standing commission of inquiry, which makes recommendations on claims brought by Māori relating to legislation, policies, actions or omissions of the government that were alleged to breach the promises made in the Treaty of Waitangi [Waitangi
Tribunal, 2021a). Successive governments have settled historical claims with Māori. District settlements typically involve an agreed historical account and apology from the Crown, financial redress, cultural redress (e.g. regarding sites of historical significance and management of key conservation sites), and commercial redress (vesting of Crown property to Iwi ownership) (Te Arawhiti, 2022; Waitangi Tribunal 2021a). National claims can also cover Kaupapa (thematic) areas, such as broadcasting rights, or flora and fauna.

A number of health-related claims have been brought before the Tribunal. In 2016, the chairperson of the Tribunal prioritized an inquiry into nationally significant health issues. This was the start of the Health Services and Outcomes Kaupapa Inquiry (“Hauora Inquiry”) (WAI 2575 claim). The claimants, essentially Māori health providers, alleged that the PHC framework had failed to achieve Māori health equity. The claimants raised concerns about the role of, and resourcing for, Māori PHOs and health providers, broadly arguing that Māori were not able to exercise tino rangatiratanga (governance) in the design and delivery of PHC.

The inquiry, which at the time of writing is ongoing, is in three stages:

- Stage One inquired into the legislative and policy framework of the PHC system.
- Stage Two will cover three priority areas – Māori with disabilities, Māori mental health (including suicide and self-harm), and issues of alcohol, tobacco, and substance abuse.
- Stage Three will cover the remaining significant national and historical issues.

Thus far, only stage one has been completed and the Tribunal’s report was published in 2019 (Waitangi Tribunal, 2019). The Waitangi Tribunal has a set of key principles, based on the Treaty of Waitangi, and in its recent health inquiries those principles include the following:

- Tino rangatiratanga – autonomy and self-government for Māori to the fullest extent possible.
- Partnership – where one party is not subordinate and each respects the other’s status and authority.
- Equity – requiring the Crown to commit to achieving equitable health outcomes for Māori.
- Active protection – requiring the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori, e.g. making available services for Māori to close inequitable gaps in health outcomes.
• Options – requiring the Crown to provide for and properly resource kaupapa Māori health services and ensure that they are provided in a culturally appropriate way, supporting hauora Māori models of care (Waitangi Tribunal, 2019).

The Hauora report addressed claims concerning the way the government has legislated, administered, funded, and monitored the PHC system in New Zealand since the passing of the New Zealand Public Health and Disability Act 2000. The Tribunal noted that it had received uncontested statistical evidence demonstrating that, despite reform and readjustments, Māori health inequities had persisted in the nearly two decades since the Act was introduced. The Tribunal added that all parties involved, including the government, did consider the poor state of Māori health outcomes to be unacceptable. The Tribunal observed that the determinants of health were complex, and that the government could not be held totally responsible; nevertheless, the Tribunal investigated whether the persistent inequitable health outcomes experienced by Māori were a breach of the Treaty.

The Tribunal found that the PHC framework failed to state consistently a commitment to achieving equity of health outcomes for Māori. It found that the Treaty clause in the Public Health and Disability Act does not go far enough in ensuring that the whole health system complies with the Treaty. The Tribunal found that the provisions in the Act intended to provide for greater Māori participation in DHBs did not work effectively to afford Māori Treaty-consistent control of decision-making in relation to health design and delivery.

The Tribunal also found that Māori PHOs had been underfunded from the time they were initially set up. Further, the funding arrangements for the PHC system disadvantage organizations that predominately serve high-needs populations, particularly Māori. The Tribunal also found that Māori were significantly underrepresented across a range of health professions and in the MoH. Indeed, the Tribunal found that the governance arrangements for DHBs did not reflect the Treaty partnership, with Māori members always in the minority and not necessarily reflecting local interests nor the Māori populations they serve.

Among its recommendations, the Tribunal recommended that the legislative and policy framework of the New Zealand PHC system properly recognize and provide for the Treaty of Waitangi and its principles, including amending the Public Health and Disability Act to include a new Treaty of Waitangi clause. Further, that the government commit itself and the health sector to achieve equitable health outcomes for Māori. The Tribunal also
recommended that the government commit to exploring the concept of a stand-alone Māori Primary Health Authority and that it conduct an urgent review of funding for PHC, to align it more closely with the aim of achieving equitable health outcomes for Māori.

A government report released the same year reached similar conclusions. *He Matapihi ki te Kounga o nga Manaakitanga a-hauora o Aotearoa 2019: A Window on the Quality of Aotearoa New Zealand’s Health Care 2019*, published by the Health Quality and Safety Commission, found that over New Zealanders’ entire lifespans, health services were less likely to be accessible to Māori compared with non-Māori (Health Quality and Safety Commission, 2019a). This begins at birth, with evidence that maternity services do not serve the needs of Māori mothers as well as those of non-Māori mothers. Pregnant women in New Zealand must choose a lead maternity carer (typically a midwife) to coordinate their maternity care. The percentage of Māori women registered with a lead maternity carer is markedly below that for non-Māori women (the gap was 17 percentage points in 2016). Such inequities continue through childhood (for instance, Māori children have less access to oral health services). Māori were more likely than non-Māori to cite cost as a barrier to seeing a GP.

Hospital appointments were also less accessible to Māori adults than non-Māori adults, and specialist appointments have unacceptably long wait times and occur less frequently for Māori. In older age, Māori with disabilities were more likely to have unmet needs for specialist equipment compared with non-Māori. And although older patients in general tend to present at emergency departments more often than do younger people, this pattern starts about 10 years earlier for Māori compared to non-Māori. Communication was another issue, with Māori adults consistently responding less positively to questions about the experience of communication with hospital staff and doctors.

In terms of finding a solution to such inequities, the Commission argued that the Treaty of Waitangi was key. The Commission said that the Treaty could underpin the sustained, systemic and multilevel approaches needed to improve the health system for Māori. In particular, the health system requires Māori leadership and partnership to improve access, service and treatment quality. Further, Māori were needed in every aspect of the health system to ensure that Māori strategic input is well implemented.

An urgent claim on the response to the COVID-19 pandemic was also made to the Waitangi Tribunal in 2021. The Tribunal found that the Crown had breached key Treaty principles. This included that “Cabinet’s decision to reject advice from its own officials to adopt an age adjustment for Māori
[an alternative spelling of Māori] in the age-based vaccine rollout breached the Treaty principles of active protection and equity” (Waitangi Tribunal, 2021b). The Tribunal also found breaches relating to the inadequacy of data and that it did not engage fully with Māori. Key recommendations included that the Crown urgently provide further funding, resourcing, data, and other support to assist Māori providers and communities; improve its collection of ethnicity data and information relevant to Māori health outcomes; strengthen its monitoring regime to one that is more timely; partner with Māori on monitoring and reporting; partner with Māori for a more equitable child and booster vaccine programme; and engage with Māori more effectively and based on Treaty principles (Waitangi Tribunal, 2021b).

### 6.1.6.3 Health and disability sector review

A major review of the health sector began in 2018. The then health minister David Clark declared that the review was designed to future-proof New Zealand’s health and disability services. “New Zealanders are generally well served by our health services, particularly when they are seriously unwell or injured. Overall, we are living longer and healthier lives,” the minister said. However, he added, the country’s health sector also faces major challenges. “We need to face up to the fact that our health system does not deliver equally well for all. We know our Māori and Pacific peoples have worse health outcomes and shorter lives. That is something we simply cannot accept. We also need to get real about the impact of a growing and aging population, and the increase in chronic diseases like cancer and diabetes. Those issues in turn create pressure on services and the health workforce that need to be addressed for the long-term sustainability of our public health service.” The minister said that the review would “include a strong focus on primary and community-based care. We want to make sure people get the health care they need to stay well. Early intervention and prevention work can also help take pressure off our hospitals and specialist services” (Clark, 2018).

The review panel issued its interim report in 2019, in which it described the current state of the health sector and indicated the panel’s directions for change. The report noted that overall, the system is good, delivering outcomes and spending in line with other OECD countries, with a dedicated staff, and good examples of innovation, achieving sustainable improvements in health. However, it was noted that the system could be better, if it attended to the following:

- The complexity and fragmentation of the system from a service user’s perspective, leading to a lack of trust and confidence
- Lack of leadership at all levels, lack of clear decision-making frameworks, confused accountabilities with little enforcement
• More consistent implementation of key strategies
• Inequities
• Improved recognition of mātauranga Māori and rights under Te Tiriti o Waitangi/the Treaty of Waitangi
• Designing the system for service user wants and needs rather than around provider interests
• Providing more control for disabled people in their lives, along with more flexibility and inclusion in the system
• Greater collaboration across organizations and disciplines, more flexibility in employment arrangements and less resistance to change
• Dealing with a wide range of barriers to access, including cost, transport, time, and culturally appropriate services
• Providing solutions for rural communities that work for them.

The report also recognized the important role of the social and economic determinants of health, and the need for these to be also dealt with if inequities are to be reduced (Health and Disability System Review, 2019).

The panel’s final recommendations were published in its final report in 2020 (Health and Disability System Review, 2020). The main recommendations, and their rationale, were as follows.

First, a Māori Health Authority (MHA) should be established as an independent departmental agency, reporting directly to the Minister of Health. The authority would have responsibility for advising the minister on all aspects of Māori health policy. It should monitor and report to the minister on the performance of the health sector regarding Māori health outcomes and equity. The authority would also manage the development and implementation of a Māori workforce strategy. This recommendation arose from the review’s finding that Māori continue to experience poor and inequitable health outcomes relative to non-Māori, and that the Treaty of Waitangi was not fully incorporated into health policy.

Second, a new Crown organization, Health New Zealand (HNZ), should be established to ensure consistent operational policy and lead the delivery of health and disability services across the country. HNZ should be run by a board with 50:50 government–Māori representation. The number of DHBs should fall to between 8 and 12 within five years of the establishment of HNZ. The provision to elect DHB members should be abolished. Instead, the government should appoint all members, and members should display an appropriate range of governance and health sector competencies and reflect the Treaty partnership between Māori and Pākeha.
The MoH would remain as the government’s principal adviser on health policy and strategy. These recommendations were driven by the review panel, concluding that the health system needed to be simplified, more cohesive and equitable, with decisions based on supporting the best use of available resources across the entire system, rather than by regional or individual organizational factors.

Third, the health system should be guided by a long-term health outcomes and services plan, derived from the New Zealand Health Strategy. This plan would set out the overall parameters for planning in the system and be the basis for capital, digital and workforce planning. The MoH would have overall responsibility for developing the plan. The MHA would provide leadership on Māori outcome measures. HNZ should lead on service planning. The DHBs would develop five-year strategic plans consistent with the proposed long-term health outcomes and services plan, based on detailed population-needs analysis. The Health Promotion Agency should be disestablished, and its roles folded into the MoH, HNZ and the MHA. The essential rationale of these recommendations was a wish to make decision-making in the sector more transparent and long term.

Fourth, the provisions that relate to the principles of the Treaty of Waitangi should be updated in health legislation. DHB–iwi partnership arrangements should be strengthened, and DHBs should be required to specifically address improving the equity of Māori health outcomes in their planning. These recommendations were based on a need to enhance Māori health and wellbeing.

Fifth, PHC services should be provided using a population-health perspective with a focus on addressing identified needs and achieving equitable outcomes. As part of this, DHB funding for PHC services should be ringfenced to ensure that it was not diverted to other services. The rationale here was that using a population health approach will improve the accessibility and effectiveness of PHC services.

Sixth, the New Zealand Health Plan should provide a systemwide view of secondary and tertiary health-care services. While most such services should continue to be delivered by DHBs, more complex services should be led by agreed providers. The review panel felt that efficient and effective hospital and specialist care needs to be available to all New Zealanders regardless of where they live in the country.

Seventh, HNZ and DHBs should engage with disabled people and their families, and funding for most disability support services should ultimately
be devolved to DHBs. The argument here was that, as the population ages and the prevalence of neurological conditions increases, the proportion of the population living with some form of disability was likely to grow. The system must be more focused on ensuring a non-disabling approach to service delivery.

Eighth, the MoH, working with the MHA and HNZ, should lead the development and implementation of a sector-wide workforce strategy designed to deliver on the goals set out in the New Zealand Health Plan. It should ensure that specific workforce strategies for Pacific peoples and disabled people are developed. Furthermore, the MHA should lead the development and implementation of the Māori workforce strategy. As part of this, the health system should develop more learn-as-you-earn options and shorter cumulative training courses to encourage non-traditional participation. The argument here was that the future system will not be successful unless the workforce was planned and managed more effectively than has been the case in the past.

Ninth, HNZ should develop a long-term investment plan for facilities, major equipment and digital technology derived from the New Zealand Health Plan. Each DHB should have a long-term rolling capital plan to deliver service requirements in their area. The argument here was that safe, fit-for-purpose facilities and equipment were essential for a well-functioning health and disability system, but the current systems for capital planning, designing and construction were piecemeal.

6.2 Future developments

6.2.1 Major reform of the sector from 1 July 2022

The Labour government was re-elected in 2020 in a landslide victory, resulting it being able to govern alone. (Although Labour did form a governmental partnership with the Green Party, this was not a formal coalition.) This was the first time that a party had been able to govern alone since proportional representation was introduced in New Zealand in 1996. The strong position Labour found itself in made it easier for the party to begin profound reform in the health sector.

In April 2021, the government responded to the Health and Disability System Review by announcing massive changes in the New Zealand public health system, largely, but not completely, in line with the review’s recommendations (Little, Henare & Verrall, 2021; Department of Prime Minister and Cabinet, 2021a). The key system changes were introduced on 1 July 2022. The Pae Ora (Healthy Futures) Act 2022, replacing the Health
and Disability Act 2000, reformed the structure of the health system and set new expectations and health principles for the health entities. The reforms emphasize the following points:

- a truly national health system, providing consistent, high-quality services for everyone (especially those traditionally underserved), removing the postcode lottery (whereby the health services available to a patient differ depending on where the patient lives in the country) in favour of a better balance of national consistency for hospital and specialist services and local tailoring of primary and community care – improving quality and equity, with services received closer to home reflecting the needs of local communities;
- an emphasis on PHC – treating people before they get sick, taking pressure off hospitals;
- ensuring fairer access for all, with the kind of treatment people get not determined by where people live;
- doing away with duplication and unnecessary bureaucracy between regions, to allow health workers to focus on keeping people well;
- ensuring that the system can cope with an ageing population, an increasingly diverse population and respond more quickly to unexpected events such as pandemics;
- strengthened expertise and a strategic focus on prevention/public health, to address long-standing challenges (diabetes, cancer, heart disease), with a joined-up national public health service to better fight future outbreaks and pandemics;
- a new independent voice for Māori, focusing on hauora Māori and leading change in the system.

A health system that achieves Pae Ora must focus on delivering:

- **equity**, tackling the gap in access and outcomes between New Zealanders, particularly for Māori, Pacific peoples, disabled people, and vulnerable groups;
- **partnership** with Māori in how health care is designed and delivered and empowering everyone to help design systems that work for them;
- **sustainability**, preventing and reducing health need instead of just addressing illness, and promoting efficient, high-quality care;
- **person and whānau-centred care** that empowers everyone to manage their own health and wellbeing, giving people, their carers, and whānau meaningful control;
- **excellence**, ensuring consistent, high-quality care everywhere, supported by clinical leadership, innovation and new technologies to continuously improve services.
The government’s 2022 Budget provided a total of $14.9 billion in new funding for Vote Health over the upcoming four years, with up to $13.4 billion in new operating funding and up to $1.5 billion in capital investment. The Budget allocated $1.8 billion to the new health entities in 2022/23. There is also an additional $1.3 billion in 2023/24 to address historical and future cost pressures. This was the first budget to take a multi-year approach toward funding the health system. The public health system will move to a three-year funding cycle from Budget 2024 onwards, which will align with the first three-year New Zealand Health Plan due in 2024 (Ministry of Health, 2022t).

In practice, this looks like a system where:

- the health system reinforces Te Tiriti o Waitangi principles and obligations, with rangatiratanga shaping care design for Māori, so Māori models of care flourish;
- everyone can access a wider range of support to stay well in the community, with more services designed around people’s needs and that better support self-care;
- emergency and specialist care is accessible and consistently outstanding, with a national network ensuring that excellent care does not depend on where a person lives;
- digital services are far more accessible, with care close to home being far more common;
- health and care workers are valued, supported and well-trained, supported by shared values, better long-term planning, and collaboration between health organizations.

The main reforms, and the government’s rationale in each case, were as follows. The reformed model was established formally on 1 July 2022.

First, a new organization, HNZ, was created. It now manages the New Zealand health system day to day. All 20 DHBs have been abolished. PHOs no longer have a formal position in the system but may reconstitute themselves as management service organizations serving new entities (localities). HNZ plans and commissions health services for the entire population, although it may establish four regional divisions and a range of district offices so that decisions could continue to be made at the local level. This would address the shortcoming of the present system, the government said, which was characterized by limited national planning and decisions that could be made once for the whole population being repeated multiple times. A national approach would also make it easier to facilitate a population-based approach to health. This, the government said, would help ensure that the system was able to cope with the effects of an ageing population.
Second, there have been structural changes at all levels of health care. In terms of primary and community-based care, GP services will no longer need to be funded through a PHO. Instead, there will be new options for how communities want to coordinate and manage care for their needs. Each area will have one or more locality networks of health-care providers. Each network will include professionals like GPs, maternity carers, district nurses and optometrists. The new system could tighten the connections between care providers, so that records and care pathways follow patients between all those contributing to their care and lead to better use of digital technology to enable care closer to home, and more self-management of health care. The government said the public health system was under stress and that a greater emphasis on PHC had the greatest potential to improve New Zealanders’ health. The health minister said the reforms “herald a change in focus for the health system – we will treat people before they get sick, so they don’t need to go to hospital, thereby taking the pressure off hospitals”.

New Zealand’s hospitals and specialist services were stretched, the minister added. “That’s largely because people are not getting the health care they need, when they need it, to stop them becoming seriously unwell” (Little, Henare & Verrall, 2021). There will also be structural changes to secondary and tertiary care. This will take the form of wider regional networks. Instead of decisions about care being made in isolation from that in surrounding regions, hospital and specialist services should be funded where they will have the biggest effect on New Zealanders’ care. The government said such changes would remove what it described as the “postcode lottery”, where the care an individual receives depends on where they live, and on which DHB and PHO covers them.

Third, a new organization, the MHA, has been created. The Authority supports the MoH in shaping Maori health policy and works in partnership with HNZ to commission care across New Zealand, ensuring that the needs and expectations of Māori communities were central to service delivery. The Authority can directly commission and fund health care that was grounded in Māori culture and delivered by Māori health providers. The Associate Health Minister (Māori Health) has said: “We will legislate for a new independent voice – the Te Aka Whai Ora/Māori Health Authority – to drive hauora Māori [Māori health and wellbeing] and lead the system to make real change...It will have joint decision-making rights to agree national strategies, policies and plans that affect Māori at all levels of the system and it will work in partnership with HNZ to ensure that service plans and the commissioning of health services drives improvement” (Little, Henare & Verrall, 2021).

Fourth, there is now much stronger expectations on all health agencies and care providers to deliver better care for Māori and other vulnerable groups.
As part of this, partnerships with Māori are being strengthened to act as an influencing and decision-making voice, so that the Treaty partnership operates at every level of the health system. The government has said this was to address a current health system characterized by “inequitable outcomes for Māori, Pacific communities, disabled people and others” (Department of Prime Minister and Cabinet, 2021a).

Fifth, the MoH’s role is changing to one where it will focus on stewarding the health system and providing advice to ministers on health strategy and policy, including a focus on New Zealanders’ holistic wellbeing. The government has said this would shift the focus of the health system to prevention. The Associate Health Minister said: “A Ministry of Health with strengthened expertise and a strategic focus will mean we can address our long-standing challenges like diabetes, cancer and heart disease” (Little, Henare & Verrall, 2021).

Sixth, the Health Promotion Agency has been folded into HNZ. The government has said this was to ensure the objective of keeping people well for longer was embedded in the heart of the reformed health system. By moving the Health Promotion Agency, the government is seeking to ensure that it retains capability and expertise in population health, which would be available to both HNZ and the MHA.

Seventh, the MoH now hosts a new Public Health Agency to provide national leadership on public health policy, strategy and intelligence. The existing Regional Public Health Units have been brought together as a national public health service within HNZ. This was to ensure that the country was better able to coordinate public health services, responding to threats like COVID-19, measles outbreaks, and smoking. The government has said New Zealand’s response to the pandemic had shown that the country’s public health system was proactive, innovative and closely connected to local communities. But New Zealand’s experiences with COVID-19 had also been seen to highlight weaknesses, particularly that the country’s dispersed Public Health Units needed better national coordination and leadership when responding to nationwide threats. The Associate Health Minister said: “We are also building on the lessons learnt from COVID-19 with a new Public Health Agency providing the technical expertise in the Ministry, and Public Health Units acting as a joined-up national service, so we are better equipped to fight future outbreaks and pandemics” (Little, Henare & Verrall, 2021).

The government later announced the establishment of a new Ministry of Disabled People (MoDP). This Ministry, established in July 2022, has the leading responsibility for improving the outcomes of people with disabilities.
across government and delivering disability support services. This role resulted in the transfer of some disability services functions and roles from the MoH to the MoDP. The MoH, and the new health entities, still remain responsible for the health outcomes and health services for people with disabilities.

### 6.2.2 “Three Waters” reforms

Another reform process now under way concerns New Zealand’s water supplies. In the main, individual councils around the country are responsible for water services, including drinking water, wastewater and stormwater. The quality of New Zealand’s drinking water was brought into sharp focus in August 2016 when the drinking water in Havelock North, a rural township in the North Island, became contaminated with *Campylobacter*. The likely cause was heavy rain that washed sheep faeces from neighbouring paddocks into the bores that supplied the township’s water. The resulting gastroenteritis outbreak led to an estimated 5000 people falling ill (about half the area’s population), 45 people being hospitalized and three people dying (all three had other medical conditions and the waterborne illness was unlikely to have been the sole cause of death). This was the largest recorded outbreak of a waterborne disease in New Zealand’s history (Department of Internal Affairs, 2021b; Moore et al., 2017b).

A government-commissioned two-stage review into the Havelock North incident included a consideration of the wider regulatory context of water supply (Government Inquiry into Havelock North Drinking Water, 2017a; Government Inquiry into Havelock North Drinking Water, 2017b). The review found widespread systemic failure of water suppliers to meet the high standards required for the safe supply of drinking water. Although 80% of people served by network supplies that serve 100 people or more have access to water that meets all current standards, concerns were raised about the other 20%. The review also found that the enforcement of statutory obligations on water suppliers was insufficient. The review’s main recommendations were that all water supplies should be treated and that a dedicated drinking water regulator should be established.

The government’s response broadened the scope of reform to cover the so-called three waters – drinking water, wastewater and stormwater. The government points to the 20% of the population without good-quality water, the 34,000 people who get sick each year from drinking water, as well as the over 3000 sewage overflows that occur. It also points to the $120–$185 billion needed over the next 30 years to maintain, replace and upgrade ageing assets and to provide for growth, a level of investment seen as needing a
national approach, with small councils in particular likely to find it difficult to manage that level of investment (Department of Internal Affairs, 2021b).

In July 2020, the government launched the Three Waters Reform Programme – a three-year programme to reform local government water service delivery arrangements. The government announced that it intends to establish four statutory, publicly owned water services entities to provide safe, reliable and efficient water services. Governance is to be shared between councils and mana whenua (local iwi). The scale of these organizations will allow them to borrow the billions of dollars required to upgrade water infrastructure.

The reforms will also see the establishment of a stronger regulatory regime, with a new water regulator, to ensure efficient delivery of the three waters with effective consumer protection. By doing this, the government said, it wished to ensure that all New Zealanders had access to affordable three waters services, improve transparency and accountability surrounding the delivery and costs of three waters services, and move the supply of three waters services to a more financially sustainable footing (Department of Internal Affairs, 2021b).

The reforms have been highly controversial, with concerns at local council level over the centralization of decision-making, as well as over ownership, governance, local democratic input into decisions, and the longer-term potential for privatization, which has also proved controversial (Matthews, 2022).

Given the removal of water assets from their balance sheets, councils faced significant financial upheaval from the reforms. In July 2021, the government announced a $2.5 billion package to support local government through the transition and to provide capital for councils’ future investment in urban development and community wellbeing (Ardern & Mahuta, 2021).

A Working Group was established in late 2021 to discuss key concerns. It has recommended that councils hold shares in the new entities on behalf of their communities (giving them ownership and, as all councils would have to agree to sell, making privatization unlikely). It has also recommended that local advisory groups feed into high-level regional representation groups (Department of Internal Affairs, 2021b). In April 2022, the government agreed to many of the Working Group’s recommendations (Palmer, 2022).

A National Transition Unit (Department of Internal Affairs, 2021c) was established in November 2021 and will oversee the reforms process. The new water entities are due to commence operations on 1 July 2024.
7. Assessment of the health system

Chapter summary

The New Zealand Public Health and Disability Act (2000) (NZPHDA) set the strategic direction and goals for the health and disability sector in New Zealand prior 1 July 2022, when it was replaced by the Pae Ora (Healthy Futures) Act. The NZPHDA required the responsible ministers to develop overall health and disability strategies for the country, originally the New Zealand Health Strategy (2000) and the New Zealand Disability Strategy (2001). Several other major strategies, such as the Primary Health Care Strategy (2001) (PHCS), He Korowai Oranga: Māori Health Strategy (2002), and the Pacific Health and Disability Action Plan (2002) sit below the statutory strategies. All set out key priorities and directions and most have been updated in recent years. A range of other action plans also exist for key parts of the health system, e.g. health of older people/healthy ageing; suicide prevention; and mental health. However, implementation has not always been strong and there is often ad hoc reporting on progress.

Performance indicators were used in both primary health care (PHC) and secondary care to assess district health board (DHB) and primary health organization (PHO) performance against set targets. Recent targets have focused on keeping people out of hospital through measuring ambulatory sensitive hospitalization and acute hospital bed days; patient experience; prevention and early detection of illness measured by amenable mortality rates; babies having a healthy start to life measured by babies living in smoke-free homes; and youth access to appropriate services.

There are recurring high-level goals across the strategies, action plans and targets that have been developed over the past twenty years. These include emphasizing more holistic conceptions of health and wellbeing; greater leadership and participation in decision-making, especially for Māori, but also for Pacific peoples and the disabled; a greater focus on equity; a stronger focus on prevention and PHC; greater integration; delivering timely care; and delivering more services closer to home, in part to reduce pressure on expensive hospital services. These often sit within a long-standing set of goals relating to the system acting as a public service, there to support the whole population, while also emphasizing financial sustainability and expenditure control.
Overall, New Zealanders have very good coverage of their health and disability needs through publicly financed health services. User charges for PHC and co-payments for pharmaceuticals have been regularly identified as barriers to access. These charges did fall for a time when additional government funding was made available through the Primary Health Care Strategy (PHCS), but they have continued to rise, and cost is still a barrier for many. There are also some key gaps in coverage, which means some families may face higher overall costs than others.

New Zealand measures people’s experiences with hospital and PHC services. Generally, most people give high scores for the services they receive. People report issues in hospitals in terms of communication, and staff not involving family/whānau/someone close in discussions about their care. In PHC, people report that staff are not always knowledgeable about what they should do if they experience side-effects, that staff do not always discuss what is important with patients, and do not always make contact after a treatment or care plan is developed. There are often lower scores for Māori and Pacific populations.

Health inequities are a major issue in New Zealand. People of Māori and Pacific ethnicity, those with lower socioeconomic status, and disabled people have consistently poorer health status and poorer access to health and disability services. A long-standing goal of the health and disability system is to reduce such inequities. However, there is often insufficient focus on ensuring that key policies do indeed support their reduction. New Zealand needs to better recognize the needs of “new” New Zealanders, given that Asian and Middle Eastern, Latin American and African populations have been growing in recent years. Differences in coverage between the government-funded health and disability system and the accident compensation system (ACC), and differences in who makes claims to ACC, also raise significant equity issues in New Zealand.

International comparisons on health outcomes, health service outcomes, and quality of care give a mixed picture in terms of how New Zealand’s health and disability system performs compared with other countries. Overall, New Zealand does achieve good outcomes (in terms of life expectancy) from its health and disability expenditure compared with other Organisation for Economic Co-operation and Development (OECD) countries. OECD and Commonwealth Fund data suggest that New Zealand does well internationally on some key measures, such as adults’ rating of their own health, some key preventive measures, and in relation to care processes. New Zealand does less well in terms of cancer incidence, infant mortality and mental health, and the data suggest that New Zealand falls behind in terms of PHC care, which may keep people out of hospital.
The Ministry of Health (MoH) reports annually on the state of public health in New Zealand. The report for 2019 showed continuing improvement in life expectancy and health expectancy; decreases in the rates of death from cancer and cardiovascular and cerebrovascular disease; a continuing reduction in smoking rates; and stabilizing obesity and diabetes rates. While New Zealanders are living longer, they are spending more time in poor health, while adults reporting their health as good, very good or excellent are reducing; rates of psychological distress are increasing; suicide rates remain higher; and communicable diseases remain an issue. However, in all cases, Māori (and, where reported, Pacific) outcomes were poorer than non-Māori. This inequity has been decreasing at least in life expectancy but remains a focus for improvement throughout the New Zealand health and disability system. For Māori, recent reports have emphasized the need for better honouring of Te Tiriti o Waitangi/the Treaty of Waitangi and a focus on building on key strengths, for Māori to find their own solutions. For Pacific peoples, recent reports have emphasized the need to implement new initiatives that are known to work, and to systematically reduce barriers across care pathways, while developing more holistic, integrated and comprehensive services, along with more authentic engagement with Pacific communities.

There is a good focus in New Zealand on improving quality. The establishment of the HQSC, which works collaboratively across the health and disability system, has resulted in some significant improvements in the quality of care.

A series of emergencies in New Zealand in 2016 and early 2017 called into question the efficacy of the country’s emergency management and response. As a result, a number of changes have been made to the emergency arrangements. A National Emergency Management Agency, charged with supporting communities to reduce the impact of emergencies across all hazards and risks, and to better respond to, and recover from, emergencies was established in 2019 within the Department of Prime Minister and Cabinet.

The worldwide pandemic of COVID-19 struck New Zealand early in 2020. New Zealand chose to go “hard” and “early” in its response, with one of the most stringent border closures and lockdowns internationally. During 2020, it largely succeeded in keeping cases and deaths low. However, when the Delta variant arrived in mid-2021, it proved difficult to continue this “elimination” strategy. The Omicron variant arrived in late 2021. With very high vaccination rates, restrictions began to be loosened in early 2022, and the number of cases and deaths has ballooned as a result, but still
remain low in comparison to other countries. Māori and Pacific peoples were particularly affected by the virus in later 2021, and Māori and Pacific providers worked extremely hard to support their communities. The country has learned many lessons from the pandemic, and it is to be hoped that it is much more prepared for any future outbreaks, requiring a better-resourced nationwide public health response, and greater connection with community-based organizations (e.g. Māori- and Pacific-led providers) who are crucial in reaching key populations.

Assessing allocative and technical efficiency rigorously is difficult, but New Zealand does have a range of processes that aim to support efficiency. An overall set government budget seeks to contain costs and expenditure, while the government is also able to direct resources to key priorities and set targets to encourage providers to achieve key goals and objectives. A population-based funding formula that funded DHBs and capitation payments used for PHC both sought to keep costs down and encourage a focus on technical efficiency, although the continuation of fee-for-service user charges in PHC blunted such incentives somewhat.

A significant amount of publicly available data and information, including an Official Information Act that enables people to request government information, means that there is a high degree of transparency of the New Zealand health system. But there are significant gaps in our understanding of how the system performs and there can be long delays in data being reported. Accountability arrangements within the New Zealand health and disability system are complex. Much has been made in recent years of the need to significantly improve accountability for a raft of areas (e.g. reducing inequities, maternity care); but formal accountability can be a blunt instrument and attention might be paid to better understanding how to successfully bring about change in a large and complex system.

7.1 Stated objectives of the health system
There are many stated goals and objectives for New Zealand’s health and disability system, deriving from a mix of sometimes changing strategies, targets, and directives from government, including, at times, new funding allocations to be spent in fairly prescribed ways.

It has been recognized that New Zealand governments and agencies produce excellent strategies, but that actual implementation can be patchy (Health and Disability System Review, 2019, 2020). It is indeed very difficult to track strategy implementation: it is often not clear what funding has been allocated, what initiatives are under way and how they are progressing.
Often, there is no clearly linked reporting on, or monitoring or evaluation of, strategies, and it is particularly difficult to identify the improvements in health and independence gained as a result of key strategies.

Ideally, the following sections would discuss New Zealand’s key health and disability strategies and explore their impacts over time. This is not easy to do, however, due to a lack of comprehensive information. Targets can be easier to track over time, but they, too, often change, and reporting does not always easily allow comparisons across time. It is also difficult to identify the policies, programmes or initiatives that might be supporting the actual achievement of key targets.

There are many potential goals and objectives that could be explored in this chapter to give a comprehensive picture of the performance of New Zealand’s health and disability system. It is not possible to cover them all here. Rather, the focus is on key aspects of how the New Zealand health and disability system performs, what has been achieved in recent years, and immediate future challenges.

### 7.1.1 Key strategies

The New Zealand Public Health and Disability Act (2000) (NZPHDA) set the strategic direction and goals for the health and disability system, up until its repeal in mid-2022. Key goals were:

- improving health and disability outcomes for all New Zealanders;
- reducing disparities by improving the health of Māori and other population groups;
- providing a community voice in personal health, public health, and disability support services;
- facilitating access to, and dissemination of information for, the delivery of health and disability services in New Zealand (New Zealand Government, 2000).

The NZPHDA required the responsible ministers to develop overall health and disability strategies for the country. Five key long-standing strategies are listed below:

- *The New Zealand Health Strategy* (King, 2000a).
- *He Korowai Oranga: Māori Health Strategy* (King & Turia, 2002).
- *Pacific Health and Disability Action Plan* (King, 2002).
7.1.1.1 New Zealand Health Strategy

The New Zealand Health Strategy identified seven fundamental principles that the government believed should be reflected across the health sector.

- Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
- Good health and wellbeing for all New Zealanders throughout their lives
- An improvement in health status of those currently disadvantaged
- Collaborative health promotion and disease and injury prevention by all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- A high-performing system in which people have confidence
- Active involvement of consumers and communities at all levels (King, 2000a).

The Strategy set out 10 key goals and 61 objectives, of which 13 population health objectives were chosen as the immediate focus. Two factors supporting their selection were the degree to which they could improve the health of the population, and their potential for reducing health inequities.

These priority population health objectives are listed below:

- Reduce smoking.
- Improve nutrition.
- Reduce obesity.
- Increase the level of physical activity.
- Reduce the rate of suicide and suicide attempts.
- Minimize harm caused by alcohol and illicit and other drug use to both individuals and the community.
- Reduce the incidence and impact of cancer.
- Reduce the incidence and impact of cardiovascular disease.
- Reduce the incidence and impact of diabetes.
- Improve oral health.
- Reduce violence in interpersonal relationships, families, schools and communities.
- Improve the health status of people with severe mental illness.
- Ensure access to appropriate child health-care services, including well-child and family health care and immunization.
The New Zealand Health Strategy was refreshed in 2016, as the New Zealand Health Strategy: Future Direction (2016) and New Zealand Health Strategy: Roadmap of Actions (2016) (Minister of Health, 2016a, 2016b). The Strategy outlined the direction for the country’s health system over the coming 10 years. It identified key challenges the system faced, including that because New Zealanders are generally living longer in future they will need more health services, the system is inequitable (for instance, Māori and Pacific peoples have lower life expectancies than the general population) and that funding the system will become increasingly expensive.

The refreshed Strategy established five strategic themes to guide policy. These were that the Strategy be people-powered, deliver health care as close to home as possible, be high performing, have a cohesive health and disability workforce, and be based on smart new technology.

7.1.1.2 New Zealand Disability Strategy

The vision of the New Zealand Disability Strategy is one of a fully inclusive society. According to the Strategy, New Zealand will be inclusive when people with impairments can say they live in “a society that highly values our lives and continually enhances our full participation” (Minister for Disability Issues, 2001). Fifteen objectives were set out to advance this vision, supported by actions.

The New Zealand Disability Strategy was also updated in 2016 (Ministry of Social Development, 2016). The Strategy is designed to guide the work of government agencies on disability issues from 2016 to 2026. The Strategy has eight outcome targets, including that disabled people receive an excellent education and achieve their potential throughout their lives, have the highest attainable standards of health and wellbeing, are treated with respect and dignity, and have choice over their lives. An accompanying Disability Action Plan 2019–2023 (Office for Disability Issues, 2019) sets out the key actions that government agencies are undertaking to improve the lives of disabled people.

The Office for Disability Issues has been developing an outcome framework to measure progress against the Strategy (Office for Disability Issues, 2022a). It reports biannually on the Action Plan (Office for Disability Issues, 2022b). This work has become the responsibility of the new Ministry of Disabled People (MoDP), established from 1 July 2022.

7.1.1.3 Primary Health Care Strategy

The Primary Health Care Strategy was released in 2001. Its release followed concerns over poor access to primary health care (PHC) services (in part due
to costs arising from the co-payments charged to patients), and recognition
that better PHC in New Zealand may improve health, reduce inequalities
in health, and reduce pressure on hospitals (King, 2001; NHC, 2000). The
Strategy’s vision is that: “People will be part of local PHC services that
improve their health, keep them well, are easy to get to and co-ordinate their
ongoing care. PHC services will focus on better health for the population,
and actively work to reduce health inequalities between different groups”
(King, 2001). The Strategy envisages a greater focus on population health
and prevention; greater community orientation; and increasing teamwork.
Although the Strategy itself has not been updated, government policy
has continued to prioritize PHC, through the 2007 Better, Sooner, More
Convenient National Party election manifesto on health (see Section
6.1.5.2), and through the updated New Zealand Health Strategy (Minister of
Health, 2016a).

### 7.1.1.4 He Korowai Oranga: Māori Health Strategy

The Māori Health Strategy, *He Korowai Oranga*, advocates the concept of
*Whānau Ora*: healthy Māori families supported to achieve their maximum
health and wellbeing (King & Turia, 2002). To achieve this, four pathways have
been identified: Pathway one, the development of *whānau, hapu, iwi* (families,
clans and tribes) and Māori communities; Pathway two, Māori participation in
the health and disability sector; Pathway three, effective health and disability
services; Pathway four, working across sectors.

Accompanying *He Korowai Oranga* was *Whakatātaka – Māori Health Action
Plan 2002–2005* (Ministry of Health, 2002). This has been built on by the
sets objectives for Māori health over the next five years. *Whakatātaka Tuarua*
provided a framework for the MoH, DHBs and key stakeholders to take a
leadership role in improving Māori health outcomes (Minister of Health &
Associate Minister of Health, 2006).

*He Korowai Oranga* was updated to a living (web-based) strategy from 2014
on (Ministry of Health, 2020e). It is a high-level strategy that supported the
MoH and DHBs to improve Māori health. DHBs were expected to consider
*He Korowai Oranga* in their planning. It also assisted Māori providers to
(Ministry of Health, 2020i) set out a range of outcomes and objectives for
action. The primary four are (1) Māori communities exercise their own
authority to improve their health, (2) the health and disability system
delivers more equitable outcomes for Māori, (3) the health and disability
system addresses racism and discrimination, and (4) Māori knowledge is
included and protected in the health and disability system. An evaluation of Whakamaua commenced in 2022.

### 7.1.1.5 Pacific Health and Disability Action Plans

Pacific peoples experience significant health inequalities in New Zealand. The 2002 *Pacific Health and Disability Action Plan* set out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities (King, 2002). The principles underpinning the Plan are that Pacific peoples should receive excellent health and disability services and that the government support the active participation of Pacific peoples in all levels of health and disability services. Accordingly, the strategic priorities outlined in the Plan included promoting healthy lifestyles and wellbeing and focusing on provider and workforce development.

Updates for Pacific Health include ‘Ala Mo’ui: *Pathways to Pacific Health and Wellbeing 2010–2014* (Minister of Health & Minister of Pacific Island Affairs, 2010), subsequently updated as ‘Ala Mo’ui: *Pathways to Pacific Health and Wellbeing 2014–2018* (Ministry of Health, 2014c). This Plan was part of the national government’s Better, Sooner, More Convenient health policy. As such, although the principles underlying this Plan generally echo those of the earlier plan, including that Pacific people should receive quality health care, the strategic priorities included that more services be delivered locally in the community and in primary care.

Following the election of a new Labour-led government, the Plan was replaced by *Ola Manuia: The Pacific Health and Wellbeing Action Plan 2020–2025* (Ministry of Health, 2020f). This is the government’s new national plan for improving the health and wellbeing of the Pacific population in New Zealand. It is a tool for the health sector to use to inform the development of health policy and action. *Ola Manuia* (which in a number of Pacific languages means “living well”) sets out three high-level priority outcomes for Pacific peoples over the next five years:

- Pacific people lead independent and resilient lives.
- Pacific people live longer in good health.
- Pacific people have equitable health outcomes.

### 7.1.1.6 Government targets

As discussed in Section 6.1.5.3, recent governments have, until 2017/2018, emphasized the achievement of a range of targets. The most recent targets for DHBs were:

- shorter stays in hospital emergency departments;
- improved access to elective/planned surgery;
• shorter waiting times for cancer treatment;
• increased immunization rates;
• better help for smokers to quit;
• better diabetes and cardiovascular services/more heart and diabetes checks;
• raising healthy kids.

Progress against each of these targets is shown in detail in the Annex (Section 9.1). Generally, there have been improvements in the short-to-medium term but maintaining performance and continuing to make improvements appears difficult to achieve.

PHO targets at the time covered the last three of the DHB targets, with the second-to-last of these dropped from 2016/2017 on. Information about each target was available on the MoH website, along with quarterly DHB performance data.

From 2013 on, a set of system level measure targets also began to be applied, covering:

• ambulatory sensitive hospitalization (ASH) rates for 0- to 4-year-olds (keeping children out of hospital);
• acute hospital bed days per capita (using health resources effectively);
• patient experience of care (person-centred care) – this is made up of adult inpatient and primary care patient experience surveys;
• amenable mortality rates (prevention and early detection);
• babies living in smoke-free homes (a healthy start);
• youth access to and utilization of youth-appropriate health services (youth are healthy, safe and supported).

From 2022 on, a similar set of health system indicators will apply, continuing to measure immunization and ASH rates (for both adults and children), acute hospital bed days and patient experience, while adding in a focus on mental health (including for young people), participation in the bowel cancer screening programme, access to planned care, and financial targets relating to surpluses/deficits and variances across budgets (see Table 6.3).

There are common goals and objectives across the strategies, action plans and targets that have been developed over the past twenty years. These include the need for a more holistic conception of health and wellbeing; greater leadership and participation in decision-making, especially for key population groups; a greater focus on equity; a stronger focus on prevention and PHC; greater integration; delivering timely care; and delivering more services closer to home, in part to reduce pressure on expensive hospital
services. These often sit within a long-standing set of goals and objectives relating to the system acting as a public service, there to support the whole population’s health and wellbeing, while also emphasizing financial sustainability and overall expenditure control.

7.2 Financial protection and equity in financing

7.2.1 Financial protection

The New Zealand health system is largely government funded (80.1% in 2020). The rest of the funding is private. Private user payments contributed 12.9%, while private health insurance contributed 7.9% of expenditure in 2018/2019 (see Chapter 3).

All citizens and permanent residents are covered for a wide range of services. A range of other populations are also covered, although not for all services (see Chapter 2). Those not covered, therefore, must purchase private health insurance while in New Zealand or pay out of pocket. It is not known how many people living in New Zealand are ineligible for publicly funded care.

The New Zealand health and disability system therefore provides excellent overall financial protection. Most New Zealanders are unlikely to end up having to pay significant sums of money for their health and disability care. There are, however, several areas of poor coverage, and some families may spend more on their health and disability services as a result.

User charges for PHC are a formal part of the publicly funded New Zealand health system. They have been regularly identified as a barrier to access over many years. These charges did reduce as a result of additional government funding made available during the 2000s, with the introduction of the Primary Health Care Strategy in 2001. They have, however, increased during the later 2010s, reaching a median adult charge of $39 in 2016/2017 (Jeffreys et al., 2020). There is also a pharmaceutical per item co-payment of $5.

There are concerning rates of unmet need for PHC due to these costs (see Section 7.3.2). The overall impact of these costs on family expenditure is, however, not known. One obvious question is why there is an overall cap on pharmaceutical prescription charges (of 20 items per family per year) but no such cap for other PHC services, on which families will be spending larger amounts of money.

Other key gaps in coverage include potentially limited access to elective/planned procedures and waiting times for those procedures; long waiting times for mental health services (including alcohol and drug services); virtually no coverage for adult dental care and optometry services; and
concern over access to home support services and funding to support family carers. Some newer and expensive pharmaceuticals may also not be funded through PHARMAC. Families with members with disabilities, especially those not covered by the ACC, may suffer financially from lost earnings as well as from higher health and disability service costs. Adults with assets over the set limit and who need residential rest home care will also pay for care themselves, incurring high costs.

New Zealanders may choose to fund some of these services themselves or purchase private health insurance, but even then, not all the above are covered by private health insurers, and the availability of such insurance increases inequities in access to care.

7.2.2 Equity in financing

New Zealand’s health and disability system is financed through a range of taxes that are paid into a central consolidated fund. Although income tax rates are progressive (with higher marginal tax rates for those who earn more), the goods and services tax brings in a regressive element, as lower income people spend a higher proportion of their income, while the lack of taxation for capital gains also reduces progressivity. The recent Tax Working Group noted that progressivity arises more through government transfers to those on lower incomes (Tax Working Group, 2019).

The separate ACC scheme has its own financing arrangements, with a variety of levies paid by employees, employers, the self-employed and car owners. It is not clear how equitable these financing arrangements are, but there are increasing concerns about how equitable access to its services are and how its focus on accidents likely benefits some (e.g. working men) more than others.

7.3 User experience and equity of access to health care

7.3.1 User experience

7.3.1.1 Patient experience surveys

New Zealand has a range of measures of people’s experiences with the health system, and recent work, especially by the Health Quality and Safety Commission (HQSC), has systematized the available measures (Health Quality and Safety Commission, 2022d). Thus, surveys of a random selection of those admitted to hospital over a particular period now take place regularly. Although response rates are low, research has shown that those not responding do not generally have different views from those responding to the survey (Thomson et al., 2018). Questions focus on a raft of experiences,
particularly around communication, respect, trust and confidence, and coordination. Some key findings from recent surveys are set out in the Annex (Section 9.1 – Section 9.1.7). In general, the New Zealand health and disability system performs fairly well with respect to patient experiences, but there are some key areas of concern, along with inequities in those experiences.

The HQSC hospital inpatient survey from November 2021 demonstrates the highest scores (over 80%) are in relation to staff treating people with respect, kindness and understanding, listening to views and concerns and explaining things in ways that people can understand; people having trust and confidence in staff; and cultural and spiritual needs being met. However, Māori and Pacific scores are lower than European New Zealand populations on some measures (e.g. for Māori, with respect to cultural and spiritual needs being met, and trust and confidence in nurses; for Pacific peoples, with respect to cultural needs being met and having the confidence to ask questions) but also higher on some measures (e.g. asking people how to pronounce their names, and explanations being given in ways that people could understand).

The lowest scores suggest that more needs to be done to include family/whanau in discussions; people being kept informed and being given consistent information as well as being involved in decisions about treatment and care; and around discharge processes.

The HQSC PHC survey for November 2019 shows the highest scores relate to staff treating people with kindness, understanding and respect; and people following instructions when they take medication. The lowest scores are in relation to whether people are being told what to do in relation to side-effects; being asked what is important; and being contacted after a care plan was made. There were, however, lower overall scores in a number of DHBs for Māori, especially in terms of meeting physical and emotional needs and coordination. There were also lower scores for several DHBs relating to Pacific peoples’ experiences of care.

The 2019/2020 New Zealand Health Survey also shows high levels of satisfaction with aspects of PHC services ([Ministry of Health, 2022b] and Annex [Section 9.1 – Table 9.4]), such as people having trust and confidence in their GP; people saying that their GP is good at providing explanations about conditions and treatment; and people responding that GPs involve people in decisions about care. There are, however, lower rates for Māori, those living in the most deprived areas, and disabled people on some scores.

7.3.1.2 General population views on the health and disability system
There is limited information on how the general public views the health system. Commonwealth Fund data from 2010 showed that some 37% of New Zealanders felt that the health-care system worked well, while 51% felt major change was needed, and 11% felt that the system needed to be completely rebuilt. By 2013, these figures were 47%, 45%, and 8%, respectively, showing some improvement over time (Osborn & Schoen, 2013). The Gallup World Poll (2020) has satisfaction with the availability of quality health care in the area where they live at 77% for New Zealand, compared with 71% across the OECD; with 93% in Norway, 83% in the USA and Australia; 78% in Canada; and 75% in the UK (Gallup, 2020). These surveys do not allow us to understand the basis for these views, however.

The State Services Commission administers a continuous survey, Kiwis Count, measuring New Zealanders’ satisfaction with frequently used publicly funded and provided services. The 2019 survey of just over 2000 people shows that key health services (e.g. outpatient and child GP services) are viewed as the most important of a range of available public services. Satisfaction scores for those receiving some specific health services are shown in Table 7.1, including the 2012 scores from the 2014 HiT. Overall, the scores are reasonably good, except for mental health services. There have been small improvements in the scores over time.

Table 7.1  Kiwis Count health service quality scores, 2012–2019

<table>
<thead>
<tr>
<th>Service used</th>
<th>Service quality scores (maximum score: 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
</tr>
<tr>
<td>Taken a child in your care to see a doctor/GP</td>
<td>Not app</td>
</tr>
<tr>
<td>Stayed in a public hospital</td>
<td>73</td>
</tr>
<tr>
<td>Received outpatient services from a public hospital</td>
<td>73</td>
</tr>
<tr>
<td>(includes Emergency Departments)</td>
<td></td>
</tr>
<tr>
<td>Received help for mental health or substance abuse</td>
<td>Not app</td>
</tr>
<tr>
<td>problems from a doctor or nurse at your local</td>
<td></td>
</tr>
<tr>
<td>medical centre</td>
<td></td>
</tr>
<tr>
<td>Used an 0800 number for health information</td>
<td>70</td>
</tr>
<tr>
<td>Sector score – public health</td>
<td>72</td>
</tr>
<tr>
<td>Overall service quality score</td>
<td>72</td>
</tr>
</tbody>
</table>

Note: Overall service quality score covers 43 government-funded services. Not app=Not applicable
Source: Kiwis Count survey – 2019 (Public Service Commission, 2019)

A 2014/2015 attitudes and values survey of nearly 16,000 people found high levels of satisfaction with access to health care when needed (68.6%), while
nearly a third of people (31.4%) indicated some form of dissatisfaction – 25.3% were moderately satisfied and 6.1% had low satisfaction. Europeans showed higher rates of satisfaction (71.8%) and lower rates of low satisfaction (4.8%), while Māori demonstrated the lowest rates of high satisfaction (61.1%) and the highest rates of low satisfaction (11%). Pacific peoples had slightly higher rates of high satisfaction (63.4%) and slightly lower rates of low satisfaction (9.7%) than Māori. Asian peoples showed that 62.2% were highly satisfied and 6.3% had low satisfaction (Lee & Sibley, 2017).

7.3.2 Equity of access to health care

Māori and Pacific peoples, those living in the most socioeconomically deprived areas, and disabled people have consistently poorer health outcomes in comparison with the rest of the population (see Section 1.4). There are also inequities in relation to access to care, usually with the above population groups having worse access to, and lower rates of, service use than other New Zealanders. A long-standing key goal of the health system has been to reduce these inequities.

7.3.2.1 Policy and funding for equity

The New Zealand Public Health and Disability Act was enacted in 2000. It has in place a number of provisions that are designed to promote partnership with Māori, and the involvement of key population groups in decision-making, each in part with a view to such processes supporting reductions in inequities.

For Māori, the provisions under the Act require that DHBs: have Māori representation on the boards and their committees; involve Māori in decision-making and in the delivery of health and disability services; improve Māori health outcomes and thereby reduce disparities between Māori and other New Zealanders; and build the capacity of Māori to participate in the health and disability sector and to ensure that it responds to the needs of Māori. The 2000 legislation also aimed to reduce health inequities between Māori and non-Māori but did not offer preferential access to services or Māori control over their own separate health and disability system (Pere et al., 2007). The recent Health and Disability System review found significant shortcomings, however, in terms of participation and partnership with Māori. There have been, for example, up to five DHBs with fewer than two Māori board members, and up to eight DHBs with a lower proportion of Māori on them than in their local population (Health and Disability System Review, 2019). The Review also noted that the involvement of Māori in partnership boards varied by district, and not all were involved in decision-making at a
governance level, with some seen as tokenistic or just a “tick box” exercise (Health and Disability System Review, 2019).

In addition to strategies focusing on issues relating to inequities (see Section 7.1), funding allocations recognize the need for additional funding to support meeting the health needs of groups with lower health status. Thus, the main funding formula for DHBs (the population-based funding formula) included weightings that provide additional funding for Māori, Pacific peoples and those in the more deprived areas, along with those in rural areas. However, there was no accountability in relation to this funding being spent on these groups’ health and disability services.

New funding was also originally allocated through the PHCS to reduce the user charges that people pay when they use PHC services, with the funding shifting from a targeted approach to a universal one, where all New Zealanders would once again have funding to support their use of PHC services. Inevitably, this resulted in much new funding being allocated to those who were wealthier, as prior to the PHCS they had been paying the full cost of PHC themselves.

In relation to PHC funding, through the PHCS introduced in 2001, government funding changed from fee-for-service payments for GP services, to capitation funding paid to PHOs, who in turn passed on most of the funding they receive to GPCs. This shift to capitation funding can be seen as equity-enhancing, as it meant that payments are no longer available only for those who see a GP; so long as people were enrolled with a PHO, there was funding available to provide services for them.

Unfortunately, as has been noted earlier, the funding formula (see Section 6.1.4.2) for first-level services does not adequately adjust for the higher needs for Māori and Pacific peoples, and for those living in the more socioeconomically deprived areas. Such adjustments could take into account that higher needs groups should have more services being delivered to them (to reduce inequities in actual health status); recognize that these groups have more complex needs (e.g. from multiple long-term conditions that develop at younger ages than in other populations); recognize the time and resources needed to best support people with more difficult lives (e.g. through concerted outreach); and recognize the different cultural needs of such groups (e.g. the importance of developing high levels of trust and rapport). No such weighting occurs, however.

There is some additional funding (services to improve access or SIA) aimed at increasing the use of services for high-needs groups, and this funding (along
with health promotion funding) is weighted for Māori and Pacific peoples, and for those living in more socioeconomically deprived areas. SIA and health promotion funding, however, make up a small proportion of the total funding being provided for PHC services, and have had various requirements attached to them before being paid out to GPCs, and therefore require more time and planning to access (although these arrangements also provided some accountability to ensure that the funding was actually spent on services to support higher-needs populations).

This inadequate weighting for high needs has been a long-standing criticism of the PHCS funding arrangements, making it difficult to properly support service delivery to high-needs groups and putting the health and disability providers that support such groups at significant financial risk. The Waitangi Tribunal has ruled that the funding arrangements for Māori through the PHCS have breached the Treaty of Waitangi and has recommended that the government compensate Māori for this underfunding.

7.3.2.2 Inequities in access to, and use of, services
There remain significant differences in access to and use of health services across the country. This section examines some of these key inequities, and the effectiveness of some recent attempts to reduce them, across key services.

7.3.2.2.1 Primary health care
PHC is the main entry point to the health and disability system. GPCs provide the first port of call for services, and many other services are not available without a referral from GPCs (e.g. community prescription medicines, diagnostic services, and specialist referrals). Policymakers and other commentators have for many years sought an enhanced role for PHC services, and the PHCS introduced in 2001 has brought about significant changes to PHC services.

Initial effects included the change to capitation mentioned above, which allows more flexibility in service delivery and a greater role for nurses; new funding to support reduced user charges and an expansion of service delivery; and an increase in consultation rates, especially relatively so for Māori, but, concerningly, not so for Pacific peoples (see Section 6.1.4.2). Levels of unmet need for GP services (including unmet need due to cost) fell as a result of the PHCS, although not by as much for Māori (Ministry of Health, 2008a). However, overall service delivery in PHC did not change as much as expected as a result of the PHCS (see Section 6.1.4.2).
There are now, in 2022, a number of challenges facing PHC.

First is to do with enrolments. One important aspect of the PHCS is that it requires a formal enrolment with a GPC. With a capitation payment system in place, the government needs a way of ensuring that funding for individuals is paid only once; hence, people need to formally enrol with a PHC provider. Those not enrolled face significantly higher user charges as casual patients. Enrolment rates have, unfortunately, fallen in recent years and there are key inequities in who is enrolled (Irurzun-Lopez et al., 2021). In many parts of the country, GPCs have closed their books, i.e. will not take on new patients for enrolment. This is leaving increasing numbers of New Zealanders without a PHC provider as a first point of regular contact with the health and disability system, and such people are likely to be paying significantly higher user charges as casual patients.

Second is the ongoing issue of unmet need for PHC. The New Zealand Health Survey tracks a number of measures relating to unmet need, including overall unmet need for PHC; the reasons for unmet PHC need (e.g. whether it is due to being unable to get an appointment; cost; lack of transport; or lack of childcare); and unmet need for after-hours care, prescriptions, and dental care. It also enables the analysis of inequities by gender, age, ethnicity, and socioeconomic and disability status, as well as by health status.

The Annex (Section 9.1 – Table 9.4) provides details on the overall rates for some of these measures for 2011/2012 and 2019/2020 (to show changes over this period of time), as well as inequities for 2019/2020 (prior to the arrival of COVID-19).

The data show an increase in the overall rate of unmet need for adults between 2011/2012 and 2019/2020, driven by an increase in the proportion of people unable to get an appointment within 24 hours. Rates of unmet need due to cost for adults have not changed over this time period (in spite of new funding to better support access to services), but they have reduced for children.

The data also show high levels of unmet need generally for PHC in 2019/2020, with inability to get an appointment the most common reason for such unmet need. Unmet need for adult dental care due to cost is particularly high across the population.

The data show significant inequities with respect to unmet need, with women, Māori, Pacific, those in the most socioeconomically deprived quintiles and disabled people having much higher rates of unmet need than European/
Other populations, those in the least socioeconomically deprived quintile, and those who are not disabled. Māori and the disabled tend to have the higher rates of unmet need across a range of measures.

Third relates to the use of PHC. The Annex (Section 9.1 – Table 9.4) includes information on the percentage of people seeing a GP, a practice nurse and a dental health worker, and the mean number of GP and practice nurse visits. The rates for seeing a GP have stayed remarkably similar between 2011/2012 and 2019/2020 at 78.3% and 78.9% for adults, respectively (and these rates in turn are similar to those for 2002/2003 and 2006/2007) (Ministry of Health, 2008a).

However, again there are significant inequities. Adult men have lower rates of GP and nurse consultations than adult women (but boys’ rates are similar to girls’ rates). The percentage of Māori adults and children visiting GPs and nursing professionals is similar to European/Other populations, but the mean number of visits is slightly higher. The percentage of Pacific adults seeing GPs and nurses is low, and the mean number of visits is only just a little higher than for the European/Other population. The Asian adult population has particularly low visit rates for GPs and practice nurses and low mean numbers of visits. The disabled are more likely than the non-disabled to visit GPs and nurses and to have higher mean numbers of visits.

These inequities in terms of enrolment, access to, and use of, PHC services are in practice, more concerning than these data show, given that rates of PHC use for higher needs groups should be higher than other groups, given the former groups’ lower levels of health status.

A fourth important key measure of access relates to immunization rates. Its importance is demonstrated by its regular inclusion as a target in the health and disability system. In 2005, the national two-year-old immunization rate was 77.5% (Ministry of Health, 2021ai). The original national immunization target was for 85% of two-year-olds to be fully immunized by July 2010; 90% by July 2011; and 95% by July 2012 (National Health Board and Ministry of Health, 2011). By mid-2012, the average immunization rate for two-year-olds had risen to an impressive 93%, with eight DHBs having hit the target, four on 94%, with a further five DHBs on over 90% (Ministry of Health, 2012c).

In 2012/2013, the target became that 85% of eight-month-olds would have their primary course of immunization at six weeks, three months and five months on time by July 2013, 90% by July 2014 and 95% by December 2014 (Ministry of Health, 2021ai). The data for April–June 2013 showed that overall, DHBs had achieved 90% full immunization of eight-month-olds (range
83–96%); 18 of the 20 DHBs had exceeded the 85% target. By the end of June 2014, 92% of eight-month-olds were fully immunized (Ministry of Health, 2021a). By March 2020, this rate had fallen back to 91.2%; by March 2021, it had fallen further to 85.1% as a result of COVID-19. Few DHBs hit the target in recent years (Ministry of Health, 2022u).

Returning to immunization rates for two-year-olds (which will be the target in the new Health System Indicators framework commencing in July 2022) (Ministry of Health, 2021n), rates across all ethnic groups were at their highest in 2015 (see Annex Section 9.1 – Table 9.1-9.2). The rate has been falling slowly since then. At the end of March 2020, prior to COVID-19, immunization coverage for New Zealand children at two years of age was 91.7%. It fell to 83.9% for the three-month period ending 31 December 2021. By then, immunization rates were 86.5% for New Zealand European children, 69.7% for Māori, 83.6% for Pacific children, 95.4% for Asian children, and 76.7% for those in the most socioeconomically deprived areas (Ministry of Health, 2022u).

For five-year-olds, rates were at their highest in 2017, and have slipped since then. The overall rate fell to 83.5% for the three-month period ending 31 December 2021. Immunization rates were 87% for New Zealand Europeans, 73.5% for Māori, 84.2% for Pacific children, and 89.6% for Asian children (Ministry of Health, 2022u).

A fifth area of concern is access to and use of dental services. According to the 2019/2020 New Zealand Health Survey (see Annex Section 9.1 – Table 9.4), the majority (79.8%) of children between 0 and 14 years saw a dental health worker at least once during the previous 12 months, whereas only 48.2% of adults saw a dental health worker during the same period. The proportion of adult European New Zealanders who saw a dental health worker was 53.4%, for Māori the figure was 44.6%, Pacific 36.0% and Asian 31.7%. A similar pattern emerged for children, but the differences are less stark: with 83.5% of European children seeing a dental health worker, against 81.3% for Māori, 73.1% for Pacific and 68.9% for Asian children. Rates of unmet need for dental care due to cost are high overall for adults (42.3%) and are higher for the disabled (54.7%), Māori (53.7%), and Pacific peoples (51.8%). Rates of unmet need for dental care for children are low (2.6%); unusually, being highest for European/Other children (2.8%).

A sixth area of concern relates to screening for cervical and breast cancer. Both are formal programmes. Cervical cancer screening is largely organized through GPCs, while eight providers deliver the breast cancer screening
programme (as a result of the technology needed to do so). Cervical cancer screening involves a user charge, while breast cancer screening is free.

The PHO performance management programme originally included targets for both screening programmes, and measured progress for both those eligible and those with higher needs (Māori, and Pacific women and women living in the most socioeconomically deprived areas). Cervical cancer screening rates improved from 57.7% in January to June 2006 to 66.6% in January to June 2011; for lower needs women, the rates increased from 68.9% to 74.4% over the same period. For breast cancer screening, for higher needs women, rates improved from 43.7% in January to June 2006 to 62.8% in January to June 2011; for lower needs women, the rates increased from 55.4% to 69.1%. Thus, there was a slightly greater increase for higher needs women for both programmes. When the PHO performance management ceased, the formal reporting on both higher and lower needs women ceased.

As in December 2020, coverage sat at 70.6% of eligible women overall for cervical screening, with 76% of European/Other women screened, compared with 63.9% of Pacific women, 62.1% of Māori women, and 61.5% of Asian women. Thus, the equity gap sat at −14% for Māori women, −12% for Pacific women and −15% for Asian women. For breast screening, the rate for Māori was the lowest, with a −7% equity gap compared with non-Māori; and Pacific women having a higher rate of screening than non-Māori women [+1% pro-equity achievement]. National (soft) targets have never been achieved for either programme; each just falls short; by 9.3 percentage points for cervical cancer screening where the target is 80%; and by 1.9% percentage points for breast cancer screening, where the target is 70% (Shea et al., 2021).

Finally, a measure that has been used recently to assess the adequacy of PHC relates to ambulatory sensitive hospitalization (ASH) rates. These are important in potentially indicating acute hospitalizations that might be avoided if good PHC is available, although other factors (such as hospital admissions policies, health literacy, etc.) can also have an impact. They account for around 30% of children’s admissions to hospital (Health Quality and Safety Commission, 2022f).

MoH data show these fluctuate somewhat over time. Of key importance here are the ethnic differences, with rates considerably higher for Pacific children. The rates have also clearly been affected by COVID-19, falling during the initial 2020 lockdowns before rising again (Figure 7.1).

**Figure 7.1** Ambulatory sensitive hospitalizations, 0- to 4-year-olds, 2017–2021
The HQSC (2022f), reports the following with respect to such rates:

- They vary twofold between DHBs; threefold for otitis media/upper respiratory tract infections and cellulitis/skin infections.
- Young children (0–4 years) are significantly more likely than 5- to 14-year-olds to be admitted for infectious conditions: otitis media/upper respiratory tract infections, gastroenteritis, pneumonia and cellulitis/skin infections.
- Admission rates for Māori and Pacific children are higher for dental conditions, asthma and cellulitis/skin infections, while Pacific children have significantly higher admission rates for pneumonia compared with all other ethnic groups.

The HQSC (2022f) notes that care needs to be taken with these rates, and that health-care providers should consider: might these rates be affected by more intensive PHC; and could health literacy, service provision, PHC access, and prevention programmes reduce these rates? Such rates are included in the new Health Systems Indicator framework (Health Quality and Safety Commission, 2022c).

7.3.2.2 Other services
In terms of hospital services, it was earlier noted (Section 5.4.1) that level 1 services with advanced trauma care and intensive care units are available in the main population centres to 58.9% of New Zealanders within 60 minutes; while adding level 2 resuscitation services available in provincial centres brings the total to 84.6%. However, for Māori, the figures are 45.6% and 78.7%, respectively. People of Asian ethnicity had the best access, with 0.78% more than 90 minutes from hospital care, while Māori had the worst access, with 4% living more than 90 minutes from services (Lilley et al., 2019).

A recent report by the HQSC pointed to a raft of inequities for Māori compared with non-Maori, all along the life-course and throughout care pathways (Health Quality and Safety Commission, 2019a). In addition to inequities already covered in this report, the HQSC report notes the following:

- Although Māori mothers’ access to maternity care has been improving, it still is below that of non-Māori, with 17 percentage points lower rates of registrations with lead maternity carers (LMCs) than non-Māori mothers.
- Around 20% of children aged 5–14 years receiving a treatment inhaler for asthma were not dispensed a preventer in the same year, and there is a small degree of inequity for Māori children aged 5–9 years, but not 10–14 years. This is reflected in a higher rate of hospital admissions for Māori children in the younger age group.
- Testing for chlamydia is similar for young Māori and non-Māori men and higher for young Māori women, but the higher rates of disease among young Māori suggest that levels of treatment and subsequent treatment are inequitable.
- The rate of hospitalization for self-harm is higher for Māori young people and is increasing; these rates may indicate barriers to access to preventive or primary mental health care.
- More adult Māori wait more than three months for specialist appointments, with fewer also seen between one and four weeks. (But there is no information on those who did not access the system at all or who did not receive a referral at all.)
- Inaccessible appointments as measured by so-called “did not attend” rates sat at 16% for adult Māori between 2011 and 2014, compared with just 6% for non-Māori.
- There are much higher rates of hospital bed-days following an acute admission for Māori than non-Māori.
- Adult Māori have consistently noted less positive experiences relating to communication; i.e. always getting answers that they could understand, feeling that doctors always listen to what they had to say, and feeling that nurses always listen to what they had to say.
As noted earlier, Māori develop diabetes at up to 10 years earlier than non-Māori, and progress faster to more serious disease. There is a significant gap for Māori in not receiving proper HbA1c monitoring, nor receiving renal screening to test for early kidney disease in those with diabetes. Arguably, monitoring for Māori should in fact be better than non-Māori to reflect the risk to Māori. The overall rates of monitoring for both tests have been falling in recent years, with Māori rates declining more than non-Māori rates.

For those older people admitted to hospital twice a year or more, the rate of bed-days per 1000 population is much higher for Māori than non-Māori. The non-Māori rate has been falling, but the Māori rate has not. The suggestion is that Māori have much less effective community care. The rate of bed-days for those presenting at an emergency department rises with age for both Māori and non-Māori, but it begins for Māori at younger ages than non-Māori (by 10 years).

Older people 65 years and over with a hip fracture resulting from a fall should be operated on within 48 hours. The rate for non-Māori has steadily increased between 2012 and 2016, but the Māori rate has fallen and now sits below the non-Māori rate.

There is a clear age difference between Māori and non-Māori in receiving hip or knee arthroplasty, with Māori having issues 10–15 years younger.

On a more positive note:

Rates of vaccination for human papillomavirus (HPV) for young women appear to have improved for Māori girls and inequities in the programme seem to have reduced in recent years (although there has been a recent increase in young girls not completing the vaccine course, for both Māori and non-Māori girls).

There was a higher rate of responding positively about experiences of communication, agreeing completely that a member of staff told them about medication side-effects to watch for at home.

There were no reported differences in waiting times for specialist appointments between Māori and non-Māori for those aged 65 years and older. (But there is no information on those who did not access the system at all or who did not receive a referral at all.)

The HQSC seven-year surgical site infection programme for orthopaedics has seen consistent improvements in compliance and a fall in surgical site infections, with the equity gap disappearing as a result of the programme.
There are many reasons for the inequities we persistently see for Māori. The effects of colonization, land loss and alienation over many years contribute to an overall lack of trust in government. Socioeconomic factors play an important role, with poor housing a key factor in poor respiratory health; and lower incomes and issues of affordability affecting food and nutrition, as well as access to key services. Where people live relative to where services are located, and a lack of affordable transport are also contributing factors.

Discrimination/racism has been found to be a major issue in many New Zealand health organizations, and can operate at the institutional level (e.g. in terms of overarching policies and practices) and at the health provider level (including in relation to quality of care). A lack of cultural understanding and rapport are similarly key factors in whether or not Māori feel comfortable using key services. Health and disability services tend to focus only on medical issues, rather than the broader determinants of health, and this, coupled with services not being generally well integrated, disadvantages those with a mix of needs. Many services, too, are highly focused on individuals, rather than families or whānau. Finally, a woeful lack of Māori health-care provider organizations (that understand local needs and cultures) and of Māori health professionals are major ongoing problems in New Zealand.

- The HQSC undertook similar research on Pacific health inequities in 2021 (Health Quality and Safety Commission, 2021a). Some of the key findings include the following:
- Fewer than half of pregnant Pacific women were registered with an LMC in 2018, compared with 81% of non-Māori, non-Pacific women, though the rate has been rising over time. In some DHBs, the rate is even lower.
- Pacific women aged 15–24 years have the lowest rates of regularly dispensed oral contraceptives, a more than fourfold difference between Pacific and European/Other rates.
- Pacific families are nearly 10 percentage points less likely than non-Māori, non-Pacific families to receive their first full core Well Child/Tamariki Ora contact on time, and a 22 percentage-point gap for receiving all core contacts in the first year.
- Pacific children are more likely to be regularly dispensed an asthma reliever but no preventer, with consequently higher rates of hospital admissions; even after a hospital admission for asthma, Pacific children were less likely than non-Māori, non-Pacific children to be dispensed a preventer.
- Many children with permanent hearing loss or acute otitis media are likely to be Pacific. They are also less likely at ages 0–4 years to have
grommets inserted, although this reverses at ages 5–14 years of age, suggesting delays in identifying hearing or ear conditions.

- Pacific children have significantly higher hospitalizations for skin infections, including a six times higher rate for cellulitis, and a 5.4 times higher rate for dermatitis and eczema.
- Rates of use of PHC were lower in the previous year among Pacific young people who died of suicide; they were also less likely to be dispensed mental health medication.
- Lower bowel cancer screening rates were seen in the pilot programme and during the roll-out.
- Pacific adults have a disproportionate burden of long-term conditions, including gout, cardiovascular disease, kidney disease, cancer and diabetes, along with multimorbidity.
- A third of bed-days occupied by people with a diagnosis of diabetes are from Pacific peoples, there is earlier onset of disease and major complications from diabetes, and kidney replacement therapies are needed more often and earlier than in other ethnic groups.
- Pacific adults have the highest rates of hospitalization with gout.
- Pacific adults have the highest rates of heart attacks and unstable angina, but the lowest rates of some key treatments, and the highest rates of death or recurrent heart attack following an initial incident.
- Pacific peoples have the lowest rates of use of hospice services among all ethnicities, although the rate is rising slowly.

On the positive side:

- Young women have high rates of HPV vaccination.
- Rates of flu immunization are high among Pacific peoples.
- HBA1c testing for Pacific peoples living with diabetes are good compared with other ethnic groups, but diabetes levels remain above the target range.
- Hospitalization of Pacific peoples aged 65 years and over has shown a recent decline.

Other work has shown that Pacific peoples’ GP utilization rates are similar to non-Māori non-Pacific people, but rates of ambulatory sensitive hospitalization, which include conditions that are considered reducible through preventive or therapeutic primary interventions, are substantially higher in Pacific peoples compared to the rest of the population. Further, adult and childhood obesity rates are around double in Pacific people (67% and 30%, respectively) compared to the total New Zealand population (32% and 12%, respectively), yet there are significant inequities in access to
bariatric surgery, with the highest rates for NZ Europeans and the lowest for Pacific peoples (Ryan, Grey & Mischewski, 2019).

Many factors are responsible for these inequities. In addition to the socioeconomic factors that apply for Māori, housing that does not work well for multi-generations leads to much crowded housing for Pacific peoples. Language issues are a major barrier to access. For example, although they are available, interpreters do not appear to be well used by Pacific families, and it has been argued that services offered by phone or video are unlikely to involve the same interpreter; this may inhibit building trusting, confidential relationships. Cost, location and availability of services, along with family and other commitments are factors that create barriers to care. The very limited Pacific workforce and limited availability of culturally appropriate services are also key barriers to access to care (Ryan, Grey & Mischewski, 2019; HQSC, 2021a).

7.3.2.2.3 Rural access
A number of factors may impede people’s access to health and disability services in rural areas, including socioeconomic deprivation, geographical barriers and distance, transport, telecommunications, the cost of accessing services, and service acceptability (Fraser, 2006; NHC, 2010). A National Health Committee report on rural health concluded that better rural health service delivery would require comprehensive PHC, supportive technology, visiting services and transport support for patients who need to travel, increased scopes of practice, and flexible, sustainable and efficient contract and funding arrangements (NHC, 2010). Overall, however, little attention is particularly aimed at rural health; for example, there is no national rural health strategy.

7.3.2.2.4 Other populations
As was noted in Section 1.1, the New Zealand population is coming increasingly diverse, with growing numbers of people from Asia and from the Middle East, Latin America, and Africa (MELAA). Much data are reported in an aggregated way, making it difficult to determine the health and health issues faced by particular population groups within the Asian and MELAA groups. A 2012 report (Mehta, 2012), however, found that key unmet needs for Asian people identified by interviewees were:

- more targeted health promotion around preventive behaviours and specific health issues, and further health education around the structure of the New Zealand health system;
• greater prioritization of the health needs of Asians where appropriate, including adequate monitoring;
• improved cultural competence;
• development of the Asian health workforce;
• improved availability of and access to mental health services;
• greater coordination of disability services and availability of culturally appropriate respite care;
• increased awareness of and early intervention for family violence;
• greater awareness and availability of culturally appropriate care for older Asian people;
• greater collaboration between health services regarding care for Asian people in Auckland, particularly around evaluation and planning of services;
• improved opportunities for overcoming social isolation among Asian migrants.

Further sustained work is needed to understand the health needs of these groups and their subpopulations and to track progress with making improvements.

A similar report for MELAA in Auckland (Perumal, 2010) found the following unmet needs. For Middle-Eastern people:

• targeted diabetes and CVD preventive strategies within mainstream services – CVD modifiable risk factors that should be reduced include smoking prevalence;
• better access to primary oral health services in adults and children;
• effective culturally appropriate antenatal and family planning education;
• improved use of primary health services to decrease ASH and Emergency Department utilization;
• better access to and earlier engagement with mental health services;
• improved coverage of cervical screening.

For African people:

• better education and health promotion on sexual health, family planning and antenatal care;
• improved access and earlier engagement with secondary mental health services;
• better access to oral health services (children);
• improved access to breast cancer and cervical cancer screening (women);
• targeted diabetes education and prevention strategies.
For Latin American people:

- better sexual health and family planning education with an emphasis on the use of condoms;
- better education on asthma prevention, but it is unclear why they have higher rates of respiratory conditions than Others;
- improved coverage for cervical screening (women);
- better monitoring of diabetes prevalence for this community.

### 7.3.3 Equity of access to accident-related care

The accident compensation scheme have faced increasing criticism in recent years, with claimants feeling that the Accident Compensation Corporation (ACC) processes have become more complex (Sepuloni, 2021), as claimants often feel they have to “battle” ACC to accept their claims (Anonymous, 2017). Reviews have shown that the balance of power lies with ACC, and that claimants do not feel that they are heard as a result (Dean, 2016).

Recent work has focused on a range of inequities within ACC. For example, women are disadvantaged as a result of the definitions of “injury” (which are more relevant for male-dominated occupations), excluding birth injuries that are seen to arise from birthing rather than injury, and not covering cumulative stresses that might arise from, for example, nursing or caring occupations. It has been found that there being fewer claims from women, women have slightly higher decline rates than men, and women receive less compensation than men. Women also have slightly longer lengths of time on weekly compensation (Powell, 2021a). Women’s unpaid work is not covered at all, creating further inequities (St John, 2021). Recent changes have now covered birthing injuries and will lead to an increase in coverage for women (Bradley, 2021; Sepuloni, 2022).

There are also documented inequities for Māori, who are more likely to suffer injuries (including severe injuries) but are less likely to lodge claims for less serious injuries, less likely to be referred for key treatments, and more likely to suffer poorer longer-term outcomes. Claim rates for Māori women are particularly low, and they were less likely to receive weekly compensation (Powell, 2021b).

In terms of Pacific peoples, there are also lower claim rates for these populations, in particular Pacific women, but return to work is faster for Pacific peoples, although this could be because of the economic issues they face generally leading them to return to work more quickly (Powell, 2021c).

ACC is currently reforming many of its processes to improve outcomes and experiences, and to build trust and confidence in the organization (ACC, 2020b).
7.4 Health outcomes, health service outcomes and quality of care

7.4.1 International comparisons

International comparisons show the key strengths and weaknesses of the New Zealand health system compared with other countries, and the health service outcomes that contribute to key health outcomes. Overall, the system performs well internationally, but there are clear areas where New Zealand’s performance could be improved.

The OECD’s most recent international comparison of health system performance (see Figure 7.2) shows that New Zealand just falls into the top right-hand quadrant – indicating good outcomes from health spending for life expectancy. Some countries that have better life expectancy do spend more (e.g. Australia, Sweden, Japan), but there are countries with better outcomes that spend less (e.g. Israel, Republic of Korea, Italy and Spain). New Zealand also does well in relation to avoidable mortality, sitting in the bottom-right quadrant (i.e. lower rates of avoidable mortality in relation to spending), with Israel, Republic of Korea and Italy having lower rates while spending less on health care than New Zealand.

In terms of specific components of the health system, it was earlier noted that OECD data show that New Zealand does less well than other countries in some key areas (see Annex Section 9.1 – Section 9.1.6). With respect to health outcomes, health-care outcomes and quality of care, these include:

- cancer incidence – which is the second worst in the OECD, with Australia the worst – and cancer mortality; oesophageal cancer five-year net survival;
- infant mortality;
- death by suicide; excess mortality from bipolar disorder and schizophrenia;
- obstetric trauma;
- asthma and chronic obstructive pulmonary disease admissions among adults; including with respect to effective PHC relating to avoidable chronic obstructive pulmonary disease admissions, with 298 per 100 000 people compared with an OECD average of 171 per 100 000 people;
- hospital admissions for diabetes among adults;
- waiting times for hip replacement (from assessment to treatment).
New Zealand has a better rate than the OECD average (i.e. it is in the top 10 countries; in the top five countries if not all countries included; or close to the best-performing country):

- melanoma five-year net survival;
- premature deaths attributable to ambient particulate matter pollution;
- adults rating their own health as good or very good;
- percentage of children at 1 year vaccinated for diphtheria, tetanus and pertussis, measles and hepatitis B;
- mammography screening (close to the OECD average);
- people with diabetes prescribed recommended antihypertensive medication in the past year in PHC (New Zealand on 89% compared with an OECD average of 83%);
- effective secondary care relating to 30-day acute myocardial infarction mortality, with 4.3 cases per 100 000 people compared with an OECD average of 6.6 per 100 000 people;
- waiting times for cataract surgery from assessment to treatment (New Zealand had the lowest waiting times for cataract surgery and knee and hip operations in 2020 among seven countries).
The latest Commonwealth Fund report (Schneider et al., 2021), comparing the performance of 11 countries, places New Zealand sixth overall, behind Norway, the Netherlands, Australia, the United Kingdom, and Germany. New Zealand’s performance is given below:

- Fifth overall in terms of access to care. This score is made up of affordability and timeliness. New Zealand was seventh in terms of affordability, as a result of higher rates of cost-related access issues for medical and dental care. It scored fourth on timeliness of care, due to 42% of people reporting difficulties accessing after-hours care and only 41% receiving the mental health care they wanted.
- Best, with the highest score, for Care Process
  - scoring well in relation to preventive care, in particular, in relation to talking with a doctor about smoking, but less well in terms of avoidable admissions;
  - top scoring in relation to safe care (e.g. few errors);
  - top scoring in relation to coordinated care (e.g. information is shared, few gaps in discharge planning);
  - scoring third in relation to engagement and patient preferences (e.g. regular doctor having information, spending enough time with patients, showing courtesy and respect).
- Ninth in relation to income equity between high- and low-income populations, demonstrating inequities across affordability, timeliness, preventive care, safe care, and engagement and patient preferences.
- Eighth in relation to health-care outcomes – performing less well on measures such as number of chronic conditions, infant mortality, mortality amenable to health care, preventable mortality and in-hospital mortality rates for stroke, maternal mortality deaths, suicide), but performing well with respect to a 10-year trend in avoidable mortality, and in-hospital mortality for myocardial infarction.

These comparisons suggest that although New Zealand does well in some areas, it can improve its performance, particularly with respect to preventing cancer, improving infant health, and enhancing mental health, along with increasing access to PHC, which may keep people out of hospital.

### 7.4.2 Population health

As noted earlier (see Section 1.4), New Zealand continues to show improvement in many population health indicators – for example, life expectancy is increasing, mortality rates (including infant mortality rates) are falling; mortality from cancer and cardiovascular and cerebrovascular disease are falling; smoking rates are falling; and obesity and diabetes rates appear to have stabilized in recent years, although they contribute
significantly to health loss. In the boxes below are three case studies on recent interventions to improve population health.

However, there are areas of concern: while New Zealanders are living longer, they are spending more time in poor health; fewer adults are reporting their health as good, very good or excellent and more are rating it as only fair or poor; rates of psychological distress are increasing; suicide rates are high; and communicable diseases remain an issue. In addition, there are the many persistent inequities in health, shown throughout this report (see also Section 7.4.3 below).

**Case study 1: Smoking**

Reducing smoking has long been a key goal in New Zealand. Key initiatives are set out in Figure 7.2. Currently, a major initiative is under way to reduce smoking rates: Smokefree 2025, with an updated Action Plan released in December 2021 (Ministry of Health, 2021aj). Smoking rates are trending down, but there are significant inequities. In 2020/2021, 10.9% of adults were current smokers. Smoking was higher among Māori (25.7%) than among Pacific Islanders (19.9%) and those of European descent (9.4%). Indeed, Māori were 2.9 times as likely to be current smokers than their non-Māori counterparts, and Pacific adults were 1.9 times as likely to be current smokers as non-Pacific adults (Ministry of Health, 2022b).

**Figure 7.3 Smoking prevalence in New Zealand, 1983–2020**

![Figure 7.3 Smoking prevalence in New Zealand, 1983–2020](image)

*Source: Progress to Smokefree 2025, History of Smokefree Aotearoa 2025 (Ministry of Health, 2021aj)*
Case study 2: Healthy Eating – Healthy Action

There have also been recent strategies aimed at encouraging healthier eating and more physical exercise. A Healthy Eating – Healthy Action strategy was developed in 2003 (Ministry of Health, 2003c) and an independent evaluation of the strategy began (Mann et al., 2009; McLean et al., 2009), but the National Party-led government made major changes to the implementation of the strategy in 2009 (reducing funding and programmes) and the strategy did not continue. Since 2015, a Healthy Families initiative, targeted at 10 particularly high-needs communities, is now in place instead. This initiative brings community leadership together, and it not just focused on a single health risk factor, but on multiple risk factors for chronic disease, with an emphasis on “improving health promoting environments across the community that enable people to make good food choices, and be physically active, smoke-free and free from alcohol-related harm” (Matheson et al., 2018). The initiative has a strong equity focus. A 2018 evaluation found that the initiatives have become well established in their communities and there were indications of a strengthened focus on disease prevention as a result (Matheson et al., 2018). Further evaluation results are due in 2022.

Case study 3: Healthy Homes

Another major initiative has been the Healthy Homes Initiative (HHI). This started in 2013, focused on 11 DHB districts and on rheumatic fever; but it was expanded in 2016 to cover pregnant women; low-income families with children aged between 0 and 5 years who have been hospitalized with a specified housing-related condition; and families with children also between 0 and 5 years for whom at least two of the social investment risk-factors apply. It will be expanded further in 2022 (Ministry of Health, 2021ak). The aim is to create warmer, drier and healthier homes. It includes a housing assessment and then supporting families to get “insulation, curtains, beds, bedding, minor repairs, floor coverings, ventilation, appropriate heating sources, full and correct entitlement assessments through Work and Income, support with power bills, and finding alternative accommodation as needed”. The MoH reports that there have been over 24 000 children referred, with over 74 000 interventions; that 75% of referrals have been Māori or Pacific; and that key outcomes shown to have been achieved include that “for every 10 children referred to the HHI, there is estimated to be one fewer hospitalization, six fewer GP visits and six fewer filled prescriptions over the following 12 months” (Ministry of Health, 2021ak).

7.4.3 Health service outcomes and quality of care

Overall, the proportion of recent improvements and deteriorations that should be attributed to the health system is uncertain, but one measure of health service performance is amenable mortality, defined as “premature deaths that could potentially be avoided given effective and timely care… [that is] deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75)” (Nationwide Service Framework Library, 2021b). Reducing amenable...
mortality is one of the system-level measures that Alliances focus on as a key goal in reorienting health services. Data show that rates of amenable mortality have been reducing but that the downward trend has been muted in the past few years. As of 2018 (most recent data available), rates for Māori and Pacific peoples remain much higher than for the non-Māori, non-Pacific population (Figure 7.4).

**Figure 7.4 Rates of amenable mortality, 2009–2018**

![Graph showing rates of amenable mortality, 2009–2018](image)

Note: Rates per 100 000, age-standardized
Source: Amenable mortality SLM data (Nationwide Service Framework Library, 2021b)

Recent work has also been completed on avoidable mortality, which includes both amenable and preventable mortality (those deaths that “could have been avoided through addressing the wider upstream determinants of health, such as individual-level health risk factors, socioeconomic status and environmental factors” (Walsh and Grey, 2019). This research found that between 2013 and 2015:

- overall, of 92 196 deaths, 25 210 (27.3% of all deaths and 68.2% of deaths among those aged between 0 and 74 years) were potentially avoidable;
- for Māori, of 9717 deaths, 5152 (53.0% all deaths and 74.5% of deaths in the 0–74 years age group) were potentially avoidable;
- for Pacific, of 3720 deaths, 1761 (47.3% all deaths and 71.3% of deaths in the 0–74 years age group) were potentially avoidable;
- for non-Māori/non-Pacific, there were 78 759 deaths of which 18 297 (23.2% all deaths and 68.0% of deaths in the 0–74 years age group) were potentially avoidable;
- Māori and Pacific populations had significantly more avoidable deaths than the non-Māori, non-Pacific populations.
Compared to other high-income countries in the OECD, in 2019 [the most recent figures available], New Zealand on 106 cases per 100 000 of preventable mortality and 62 cases per 100 000 of treatable mortality performed better overall than the OECD averages of 126 per 100 000 and 73 per 100 000, but substantially worse than first-ranked Luxembourg (41 per 100 000 preventable mortality), Switzerland (39 per 100 000 treatable mortality) and Australia (93 and 46), but better than the United States (177, 88) and the United Kingdom (119, 69) (OECD, 2021).

One significant development in recent years has been the establishment of the Health Quality and Safety Commission, set up in 2010 (see Sections 2.1.5, 2.3.2, 2.9.5, 5.4.6, 7.3.1). It has a specific focus on health quality and safety within the health system in New Zealand, a key strength being its independence and work at arm’s length from the MoH. Its overall goal is to enhance the triple aim of improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health system resources (HQSC 2011). Thus, almost all of the topics in this report are relevant to quality of care under this broad definition.

The HQSC takes a lead role in analysing and reporting on data on health quality and safety from across the sector (including an atlas of variation, patient experience surveys for hospital services and PHC), partners with a range of key organizations on particular programmes and initiatives, emphasizes the development of capacity and capability in health quality and safety, and has established a programme “Partners in Care” to improve consumer engagement and participation in care (see Section 2.9.5) [Health Quality and Safety Commission, 2020].

Some of the HQSC’s key successes have been in:

- reducing central line-associated bloodstream infections – preventing 260 such infections between 2012 and 2016, with direct savings of $5.2 million to the health system and $106 million of value in additional years of healthy life to patients;
- reducing hospital falls leading to a broken hip; the rate has been halved from 2 patients per week to 1 patient per week, saving an estimated $6.4 million and providing an extra 1.6 years of healthy life per avoided broken hip valued at $39.6 million;
- preventing 352 cases of deep vein thrombosis leading to pulmonary embolism through a safe surgery programme, with savings of $7.4 million in hospital care, and $38.3 million in additional years of healthy life;
- reducing by a quarter surgical site infections after orthopaedic and cardiac surgeries, with 108 fewer infections between August 2015 and
December 2018, eliminating inequity, and saving up to $4.3 million and $9.7 million of healthy life-years;

- reducing cardiac surgical site infections (around 30 between March and December 2018), saving up to $1.2 million and giving back $2.7 million in healthy life-years;
- reducing 98,000 bed-days valued at $76 million for those over 75 years admitted twice or more as an emergency (Health Quality and Safety Commission, 2019b).

The HQSC’s work on patient experience surveys has been important in ensuring that patient views on services are well documented, while its work on building consumer capacity and capability is important in strengthening consumer input to decision-making. The HQSC has also taken the lead recently on reporting on major inequities, particularly for Māori and Pacific peoples, aiming to explore such inequities throughout the life-course and through service pathways.

In its briefing to the incoming government in 2020, the HQSC pointed to a number of key issues relating to health quality and safety in New Zealand, such as: lack of collective and individual leadership for quality; variable understanding of how to provide governance for health quality and safety that puts the consumer/whānau front and centre; monocultural systems and structures; inequity in access, treatment and outcomes for different population groups and geographically; slow change in the safety culture towards resilience and restorative practices; and financial goals trumping quality goals (Health Quality and Safety Commission, 2020).

The HQSC is also involved with a new, national health system indicators framework, for assessing the performance of the reformed health system from 1 July 2022 (see Table 6.3).

### 7.4.3 Equity of outcomes

This report has identified many, many differences in the health of Māori and Pacific peoples, in the health of those living in the most socioeconomically deprived areas of the country and relating to the health of the disabled (see Chapter 1.4 and Annex Section 9.1). Some of these inequities arise from differences in socioeconomic status. Others, however, are the direct responsibility of the health and disability sector, with many inequities in access to, the use of, and quality of services delivered contributing to inequities in health status (see Chapter 1, and Annex Section 9.1).

As noted earlier (see Chapters 6 and 7.1), reducing inequities in health status has been a recurring key objective for the New Zealand health sector,
through major health reforms, and through national strategies and action plans. It is often difficult to report directly on the key actions taken within such strategies, and evaluations of progress are often not undertaken in New Zealand. This means that it is difficult to know where the problems lie in terms of reducing inequities – i.e. whether initiatives are simply never undertaken, or are never supported sufficiently, or if they simply do not work. What is clear, however, is that significant inequities have continued, in spite of, in theory, being key priorities over many years.

The persistence of these inequities in health were a major focus of the recent Health and Disability System Review reports (2019, 2020). For Māori, the reports emphasize the importance of honouring Te Tiriti o Waitangi/the Treaty of Waitangi, including in relation to partnerships, but also in relation to leadership, the Māori workforce, cultural competence and reducing racism, and the protection of Māori cultural concepts, values and practices. A key aspect of the 2019 Interim Report was the emphasis on building on key strengths, and for Māori to find their own solutions. This included building on the current Whānau Ora programme and developing whānau-centred models of care. The Review recommended the establishment of a new Māori Health Authority (MHA) to lead Māori health initiatives; an organization that was established in 2022.

For Pacific peoples, the HQSC (2021a) report recommended a transformative approach to Pacific health. This included, firstly, a call for the health and disability system to pay careful attention to data and to new implementing initiatives that work. Second, it recommended that careful attention be paid to systematically reducing barriers to access along all care pathways, that funding to support, for example, successful self-management programmes be more sustainably funded and supported, and that Pacific voices be better heard, understood, and acted upon. Third was a renewed focus on cultural safety, to reduce the negative experiences Pacific peoples have with health and disability services, and a stronger focus on the cultural aspects of services that allow Pacific peoples to feel safe and to build trusting relationships. Fourth, the report recommended paying greater attention to health literacy and communication. Fifth, it was recommended that services be more holistic, integrated, and comprehensive, to better meet the needs of people with multiple conditions, and to work more with families as opposed to individuals. Sixth is the need for a “strong, supported and resilient” Pacific workforce. Finally, there is the need for more authentic engagement with Pacific communities, building on existing strengths and resilience.

Similar work could usefully inform policies and strategies to improve the lives of those living in the more socioeconomically deprived areas of the
country, and for disabled people, as well as for rural populations, for men (who live fewer years than women) and women (whose experiences of the health and disability service are often worse than for those of men), as well as for younger people.

7.4.4 Disaster risk management for health

A series of emergencies in New Zealand in 2016 and early 2017 called into question the efficacy of the country’s emergency management and response. For instance, in the days after major fires broke out in hills near Christchurch in February 2017 (in which a pilot fighting the fire died), there were criticisms over delays in the time it took for an emergency to be declared and the fact that a rural local authority had been in charge of the response to fires in an essentially urban area (Truebridge & Sherwood, 2017). As a result, the government commissioned an independent team to undertake a review on the most appropriate operational and legislative mechanisms to support effective responses to natural disasters and other emergencies in New Zealand. The panel published its report in 2017 and presented a range of recommendations for reform. These included that a national emergency management agency be established to provide national coordination and support in local emergencies, a cadre of professionals be established to act as “fly-in teams” to support local responses to emergencies, and emergency response teams be professionalized (Technical Advisory Group, 2017).

The government essentially agreed with the recommendations and reform of the national emergency system began (Minister of Civil Defence, 2018). The National Emergency Management Agency, charged with supporting communities to reduce the impact of emergencies across all hazards and risks, and to better respond to, and recover from, emergencies was established in 2019 within the Department of Prime Minister and Cabinet. Also established that year was the Emergency Management Assistance Team, a group of people with a mix of the appropriate skills, experience and attributes to go wherever required, without delay, to work with and support the local incident controller as they manage emergencies. Work has also begun on overhauling the Civil Defence Emergency Management Act and its associated plan to ensure that they are fit for purpose (Department of Prime Minister and Cabinet, 2020; 2021b).

The worldwide pandemic of COVID-19 struck New Zealand early in 2020. New Zealand chose to go “hard” and “early” in its response, with one of the most stringent border closures and lockdowns internationally. During 2020, it largely succeeded in keeping cases and deaths low. However, when the Delta variant arrived in mid-2021, it proved difficult to continue this
“elimination” strategy, although a long lockdown in Auckland between August and December 2021 did keep case numbers reasonably well contained. Māori and Pacific populations were particularly affected by the 2021 Delta outbreak. Vaccination uptake has been high in New Zealand, although Māori rates in particular lagged behind those of other populations; Māori-led providers worked extremely hard to get the rates up for their populations. The Omicron variant entered the country in late December 2021. Restrictions began to be loosened in early 2022, and the number of cases and deaths has ballooned as a result, but still remains low compared to many similar countries.

The country has learned many lessons from the pandemic, and it is to be hoped that it is much more prepared for any future outbreaks, requiring a better-resourced nationwide public health response, and greater connection with community-based organizations, which are crucial in reaching key populations. Key positives arising from the pandemic may be a realization of the value of Māori and Pacific providers in working to improve the health of their communities, and of the need to take equity much more seriously than has been the case to date.

The economic cost of the outbreaks has been high, particularly for the tourism and hospitality businesses, but significant government support has meant that the economy has weathered this storm quite well. The longer-term effects, however, for those who had COVID-19 and for the economy, with significant government borrowing keeping the economy afloat, are yet to be clear.

7.5 Health system efficiency

7.5.1 Allocative efficiency

Allocative efficiency means getting the most health and independence from health and disability expenditure. It requires administrative efficiency (keeping administration costs low); no wasted spending; salaries being at reasonable levels; focusing on delivering effective services (those that generate health and independence gains); delivering services efficiently (using few resources at appropriate cost); and delivering the mix and quality of services that produces the most health and independence possible.

As noted earlier (Section 7.4.1), New Zealand’s health and disability system generates, overall, good outcomes for its level of expenditure compared with other countries. This section focuses on a range of factors that help contribute to this level of allocative efficiency, and points to areas where improvements might be made.
One major advantage of the New Zealand health and disability system is that it is a system with only one major funder – Central Government. Central Government has the ability to determine key priorities and to direct funding to the services and/or populations it feels will lead to the greatest gains in health and wellbeing. Resource allocations are not driven by market factors – such as services user ability to pay or by supplier decision-making about what services to provide – but through government decision-making. This report has pointed to the key strategies and plans that Central Government has in place to guide resource allocation. It has also pointed to some uncertainties about which of the many stated priorities are the most important, and also to the difficulties in tracking funding and achievements against key strategies and action plans.

Budget data available in New Zealand show quite broad allocations of funding (e.g. around two thirds of funding goes to DHBs, which then allocate resources themselves), alongside more narrowly defined allocations (e.g. to the COVID-19 response). This means that at times it can be difficult to identify if key shifts in the allocation of spending is really happening or not. For example, it has long been policy to shift to a greater focus on PHC service delivery, but the Health and Disability System Review reported that there was evidence of DHBs allocating an increasing proportion of their funding to hospital services (Health and Disability System Review, 2019), something that suggests that the prioritizing of PHC is not happening in practice.

Another advantage of the pivotal role of Central Government in financing the health and disability sector is that it provides a restraint on overall expenditure. This means that health and disability expenditure should not rise unexpectedly and that resource costs (e.g. salaries, buildings) are also more likely to be restrained. This, of course, can be a downside as well – for example, governments have been underpaying the nursing workforce for many years, with pay equity a major focus in recent years; and such salary restraints may make it difficult for New Zealand to compete for health and disability staff in an internationally competitive labour market.

A key question then arises as to how decisions are made in terms of allocating resources. At Central Government level, there are processes that support budget decisions at the Vote level (e.g. how much new funding does Vote Health get this year) and new programmes within each Vote. These decisions are, in part, based on assessing the gains that will be achieved from new programmes and who benefits, set within the context of the governing parties’ own priorities (under its proportional representation system of voting, New Zealand is typically governed by coalitions of parties). Previous work in New Zealand has focused on the key criteria for deciding
on resource allocations (e.g. the work of the Core Services/National Health Committee; the work of the Health Funding Authority in setting out a prioritization process), but this work is largely no longer as visible as it once was. The Choosing Wisely campaign, which involves the HQSC, is, however an example of where the New Zealand health and disability system emphasizes the importance of ensuring that the services provided are those that make a difference to people’s lives.

The major area where clearer prioritization occurs is with respect to pharmaceuticals, through the work of PHARMAC, which has been very successful in restraining overall medicines expenditure through emphasizing cost–effectiveness, working with a cap, and using monopsony power to negotiate with pharmaceutical companies supplying the New Zealand market. At DHB level, it was recognized that with a national service coverage schedule, national service and employment contracts, along with Ministerial directives, DHBs had limited ability to allocate resources to meet specific local needs. Early research on the DHB health reforms found considerable variety in how DHBs undertook their planning and priority-setting, and that their strategic and annual plans were only indirectly related to the specific resource allocation and purchasing decisions made by the DHBs (Mays, Cumming & Tenbensel, 2007). In addition, prioritization was considered realistic only for new or additional funding, with DHB board members and managers reporting that government opposition and community resistance constrained disinvestment from existing services or contracts (Tenbensel, 2007).

Another important factor in supporting overall allocative efficiency relates to how health and disability providers are paid. Since July 2003, DHBs were funded through a population-based funding formula, the aim of which is to fairly distribute available funding between DHBs according to each DHB population’s relative needs and the cost of providing health services (Ministry of Health, 2003d). The main (inpatient) funding formula adjusts for cost weights (based on historical utilization), age, gender, ethnicity and socioeconomic status, with adjusters for rurality, international visitors, and unmet need. Such a formula focused on DHBs keeping within the budget and keeping the costs of key services low, while also aiming to ensure an equitable allocation across DHBs.

Increasing deficits in recent years, have, however meant that DHB spending was not quite as capped as it might be. The new Health System Indicator Framework that began assessing the performance of the health sector from 1 July 2022 explicitly recognizes the need for the system to stay within
budget, although this was always a key aspect of accountability for DHBs for many years.

Prior to the development of the Primary Health Care Strategy in 2001, GPs were funded on a fee-for-service basis. PHOs were now funded on a capitation basis, with rates determined by the number and characteristics of a PHO’s enrolled population. This approach is infinitely more equitable in terms of funding – as government funding now flows to all those enrolled rather than just to all those who actually use services. It also supports the government’s ability to control overall expenditure and encourages cost consciousness. However, as has been noted earlier, the funding formula for PHC is widely regarded as not sufficiently weighted towards meeting the highest needs – not only is this inequitable, but it also suggests that funding is not being adequately allocated to populations with the highest needs.

7.5.2 Technical efficiency

Having a technically efficient health and disability system is important in contributing to overall allocative efficiency, ensuring that funding is generating a good level of high-quality outputs, and is not wasted.

Health sector efficiency is notoriously difficult to measure. Beyond difficulties in access to data on both inputs and outputs across all parts of the health and disability system, important changes in the quality of care are particularly difficult to assess. There have been a number of attempts in New Zealand to measure technical efficiency, usually in hospitals, but reports often conclude that the existing data are insufficient to be sure about how the sector is performing. Focus tends therefore to remain on whether or not there is an increase in the proportion of services delivered as day-patient events (to reduce admissions to hospitals), average length of stay and readmission rates (as reducing lengths of stay may lead to higher readmission rates) (Fraser & Nolan, 2017).

Hospital entities in New Zealand have often run up significant deficits, whatever their organizational form, spending more than the level of funding they receive. Significant DHB deficits were a regular occurrence in recent years – with frustration that some DHBs may not have worked as hard as others to keep their spending under control; in recent years, it certainly appears to be the case that DHBs increasingly believed that they had no incentive to avoid deficits (Health and Disability System Review, 2019). Deficits reached over $1 billion a year in recent years; for 2020/2021, the deficit across all DHBs was $711 million, reducing to $414 million net of exceptional costs (Ministry of Health, 2021al).
In PHC, the move to capitation funding in PHOs in the early 2000s, in theory, created a set of incentives that should encourage cost-consciousness within PHC. However, although the government can set the funding arrangements for PHOs, PHOs then in turn funded GPCs, which in turn paid those working within the GPC. In the early years of the PHCS, research showed that 92% of PHOs were using the MoH’s weighted capitation formula (rather than measures related to practice activity) to determine how first-level funding should be allocated to practices, but within practices, there were a variety of payment methods being used, with at least some income still being paid on a fee-for-service basis (Smith & Cumming, 2009a).

In addition, the use of capitation to support overall cost containment is undermined to some degree by the continued user charges for PHC services, which are set on a fee-for-service basis. Fee-for-service arrangements encourage a greater level of output (e.g. encouraging more patients to be seen), but this may come at a cost of poorer quality of care (e.g. short, multiple visits).

### 7.6 Transparency and accountability

There is a significant amount of information collected and reported about the New Zealand health system. For example, Cabinet papers are usually released publicly, and an Official Information Act also allows government information to be sought and released (e.g. for researchers, or by the media). At times, however, the release of such material can be slow, with key sections often redacted (blacked out).

Significant amounts of information are routinely published on health status, including differences in health status across different groups in the population, and through annual Health and Independence Reports from the MoH. However, in many datasets and reports, it can be difficult to track trends over time, often due to changing priorities and the lack of an overall consistent performance framework, and because data are only reported annually. There are, however, excellent examples of data availability through the MoH “shiny apps” being used to show, for example, fetal and infant mortality and suicide rates over time (see Annex Section 9.1). It is also difficult to link changes in health status with particular strategies, services or initiatives. More routine monitoring reports and evaluations are needed to fully understand how strategies are funded and implemented and what they achieve.

Comprehensive information used to be available on expenditure trends in New Zealand. The most recent published data covers the decade 2000–2010.
(Minister of Health, 2012). Without these data, it is difficult to track changes in the proportions of public and private expenditure, and in how resources are allocated across services.

DHB annual plans and reports were routinely available, but they were difficult to interpret. A more consistent and logical framework for these across DHBs would have been useful. With DHBs now abolished and HNZ becoming a single national entity, it is to be hoped that district data do not disappear.

The MoH now routinely undertakes surveys on key topics in health care in New Zealand, including self-reported health, diagnoses with key chronic conditions, and risk factors, along with modules on specific topics such as health services, mental health, and tobacco use. These data, from the New Zealand Health Survey, are now quite quickly made available publicly. Hospital discharge data are also routinely reported. Such data are now part of the national Stats NZ-managed Integrated Data Infrastructure, allowing researchers to link various health datasets together. This is supported by a National Health Index number that assigns people a unique number, technically enabling the system to track the range of services people use. The New Zealand Health Survey is, however, not a longitudinal dataset – hence it is difficult to track changes over time among the same population.

The HQSC releases much data and many reports on key aspects of performance of the health sector, including patient experiences, and these data fill major gaps in our understanding of issues from patient perspectives. Future improvements could usefully include work on patient-reported outcomes, as occurs in other countries.

Inevitably, there are significant gaps in our understanding of how the system performs and there can be long delays in data being reported. Despite being recognized as a problem for many years, there is still no national PHC dataset, while data for community services also remains poor. These gaps make it difficult to form a comprehensive overview of the performance of the New Zealand health system. A particular challenge for the reformed health system will be the availability of data for localities initiatives. Although the national minimum dataset should allow such analyses, New Zealand Health Survey data, which include important data on health status and unmet need, do not include enough people for each potential locality to have confidence in locality-level reporting.

The accountability arrangements within the New Zealand health system are complex. The Health and Disability System Review reported on the raft of accountability requirements for DHBs, including: an annual letter
of expectations from ministers to DHBs; enduring letters of expectations; annual plans; regional service plans; statements of intent; statements of performance expectations; Crown funding agreements; operational policy framework; service coverage schedule; annual reports; and quality accounts. These sat alongside what the Review called “an ever-expanding list of demands” (Health and Disability System Review, 2019) or priorities (e.g. reducing smoking), along with monthly financial reports; health targets; quarterly summaries; and elective/planned service patient flow indicators.

The arrangements are therefore resource intensive, with the Review commenting that stakeholders are concerned that “no common view exists about what ‘good performance’ or success for the system would look like. As a result, financial performance (with a focus on DHB deficits) became the key driver – there is no sense of seeking a balanced view across other dimensions of performance” (Health and Disability System Review, 2019). As a result, the Review recommended key changes to accountability processes, and a more streamlined approach – including the new Health System Indicators – is due to be implemented in 2022. It is interesting to reflect, however, that the routine calls for better accountability across many service areas might better consider the best ways of successfully bringing about change in what is a large and complex system.
8. Conclusions

Key findings
Overall, New Zealanders experience a high health status by international comparisons and have very good access to a wide range of health and disability support services, with virtually universal coverage. The health and disability system is well funded by international standards, although New Zealand does tend to spend less than countries such as Canada, Australia and the United Kingdom. Central Government is able to set priorities and direct resources to areas thought to offer the best opportunities for improvement in health and independence. The system is staffed by highly qualified and motivated professionals and is well supported by key infrastructure, including a range of institutional arrangements focused on improving the quality of care. In terms of overall value for money, the system performs well compared with many other countries.

The main concern is with the many inequities that have persisted over many years. Māori and Pacific populations, those living in the most socioeconomically deprived areas, and the disabled, all have significantly lower health status than other New Zealanders. Reducing these inequities is a major challenge for the New Zealand health system.

The Accident Compensation Corporation (ACC) established in 1974 provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors injured in New Zealand. The scheme continues to be strongly supported by New Zealanders. However, the inequities between access under ACC and access under the health and disability system are increasingly difficult to justify, as are inequities within ACC, including in terms of its overall coverage and the extent to which this is biased, especially towards working men.

In recent years, there has been a mix of both improvements and deteriorations in health status in New Zealand. For example, mortality from cancer and cardiovascular and cerebrovascular disease is falling; smoking rates are falling; while obesity and diabetes rates are stabilizing. On the other hand, there has been a measles outbreak and increases in rheumatic fever rates, especially among Pacific peoples; there are declining breast
and cervical cancer screening rates; and target times for elective/planned services increasingly not being met. DHBs ran deficits now over several years, and some infrastructure has not been well maintained.

Some of these developments have arisen in part from limited annual increases in health and disability expenditure during the 2010s. More recent increases in spending have been higher, but the pressures on the system from rising costs, and a growing, ageing population are not going to diminish any time soon, while the system in 2022 needs additional funding to establish new organizations and ways of working, as well as to fill key gaps in infrastructure (e.g. information technology [IT] systems, buildings) and key gaps in service delivery (e.g. in mental health, to remove the “postcode” lottery, catch up on reduced service delivery during COVID-19, reduce inequities). The recent COVID-19 pandemic has led to significant new government expenditure and borrowing. Future governments are going to find it difficult to achieve all that they wish to achieve, and a fast-growing economy will be important to bring deficits and debt down while also seeking to maintain and expand service delivery.

Since 2001, primary health care (PHC) services have been provided through primary health organizations (PHOs), funded on the basis of their enrolled populations (with most patients paying additional user charges on a fee-for-service basis). Significant additional government funding for PHC was provided during the 2000s, resulting in some short-term improvements in access. However, the user charges people pay have continued to rise, and new funding has been provided in recent years to try to keep those charges low and ensure good access to care for those on lower incomes. But overall access to and use of PHC services appears to be static, and reductions in key measures such as amenable mortality and ambulatory sensitive hospitalization (ASH) rates appear to have slowed. Service delivery improvements in PHC have not developed in the way that many would have hoped. What was probably really needed was an emphasis on widening the scope of services available within PHC, taking a more holistic approach, and focusing on improvements for those with the most complex needs. The underfunding of high-needs populations through an insufficiently weighted PHC capitation funding formula has meant not only difficulties for high-needs groups in accessing services and continued significant inequities in health, but also significant financial pressure for providers.

A major review of the health system was undertaken between 2018 and 2020. This review identified many key strengths in the health and disability system, but also pointed to major concerns, including limited attention being paid to Te Tiriti partnerships; significant inequities in access to health
services and in health status; a lack of clarity in the roles, responsibilities and accountabilities of key organizations; a continuing focus on hospital care as opposed to PHC and community services and health promotion/disease prevention; and significant variations in the delivery of services.

As a result, a new health system has been introduced, starting from 1 July 2022. This focuses the role of the Ministry of Health (MoH) on policy and a strengthened public health response through a new Public Health Agency; established a new Health New Zealand (HNZ) that has taken over the roles of the 20 DHBs and the commissioning functions of the MoH; established a new Māori Health Authority (MHA) to oversee Māori health and to commission Kaupapa Māori services; abolishes PHOs formally; and sets up a locality focus for PHC and community care. A new Ministry of Disabled People (MoDP) has been established, decoupling responsibility for disability services from the health system, although the health system will have the role of improving services for disabled people.

Lessons learnt from health system changes

New Zealand has had seven significant health system reforms since the beginning of the 1980s:

- Establishing geographically focused area health boards (AHBs) in the 1980s
- Abolishing AHBs and setting up a market system in the 1990s
- Removing the surplus requirement and encouraging collaboration among hospitals and amalgamating the four regional health authorities in the late 1990s
- Abolishing the market model and re-establishing a geographically focused DHB system with continued commissioning for primary and secondary care in the 2000s
- Implementing a Primary Health Care Strategy with new PHOs in the 2000s
- Encouraging PHO amalgamations and emphasizing integrated care and alliances in the 2010s
- Abolishing DHBs and establishing new state agencies – including HNZ, the MHA and the MoDP, in 2022.

In this section, lessons from New Zealand reforms are considered in light of the upcoming changes, and an assessment of whether or not these latest reforms are likely to succeed.

A first key lesson from New Zealand’s many reforms is that they take considerable time, effort, and money. Policy work needs to be completed,
new legislation introduced, new agencies established and staffed, new institutional policies and processes established, and new relationships built within and across organizations. This focus can divert attention from ongoing system issues. It can also mean that actual change may not occur for several years.

A second key lesson is that typically reforms do not always succeed in sustaining a focus on achieving their stated key goals. The 1990s reforms were different from others in separating purchasing and provision and emphasizing market mechanisms. But the other reforms have had almost exactly the same set of goals – being desirous of a more holistic approach, with a much greater focus on health promotion and the delivery of PHC and community care and aiming to achieve reductions in inequities in access to services and in health. Even over short periods of time, reforms can easily drift away from their starting points without a continued focus on what it is they are trying to achieve. For example, a clearer idea of how the 2000 PHCS reforms were actually going to reduce inequities, and careful attention to the governance and funding models being established, and later changed when PHOs were encouraged to merge, might have meant that more progress was made than has occurred in practice. Ministers of Health and their key advisory agencies must pay careful attention to how these latest reforms are being implemented and be ready to act early if they feel they are drifting.

A third key lesson relates to the many plans and strategies in the newly reformed model. The Pae Ora (Healthy Futures) Act includes the following:

- Three-yearly Government Policy Statement on Health that sets out government priorities and objectives and sets out the parameters for the New Zealand Health Plan. It must include a framework for monitoring of progress and reporting requirements.
- A number of health strategies – a New Zealand Health Strategy (with a 5–10-year horizon), a Hauora Māori Strategy, a Pacific Health Strategy, a Health of Disabled People Strategy, a Women’s Health Strategy, and a Rural Health Strategy. These are to be developed by the MoH, with the Hauora Māori Strategy jointly prepared by the MoH and MHA in partnership. The Health of Disabled People Strategy focuses on how the health system can improve the health of disabled people. There is no hierarchy for these strategies, but it is recognised that the Minister will need to consider consistency with existing health strategies when making new ones. All strategies are to be regularly monitored and reviewed, with assessments of performance.
- A New Zealand Health Plan, to be developed by HNZ and the MHA. This is to be a three-year costed plan, with annual reporting.
• A locality plan for each locality, and for preferences in localities to be taken into account in the New Zealand Health Plan. Locality plans are to cover 3 years and be annually reported upon.

These requirements are a significant ramping up of formal planning processes within the health system. This may be a good thing, given the lack of clarity around the overall direction of the health system over the past 15 years or so. Some of the requirements set out here deal with some of the problems that have arisen with strategies over the past 20 years – such as a lack of clarity as to how key new policies fit with key strategies and how funding is being allocated to support them, and a lack of regular reporting. There must also be a concern, however, over whether the system will become bogged down in planning and reporting processes, especially if all the key agencies need to agree on their content, direction and funding. Developing brand new strategies when key strategies already exist, and when it is so clear where the key problems lie, would be a significant waste of resources. It has been noted that, although many New Zealand strategies have been noted to be very good (Health and Disability System Review, 2019), the country does seem to focus on high-level strategies that set out the same goals and principles over and over, with far less attention paid to designing concrete action plans that move things forward. It would appear that the Government Policy Statement on Health, the New Zealand Health Plan and the Locality Plans will be more specific, but only time will tell. What is clear is that if they are to make a real difference, there must be sustained attention to their implementation, including monitoring and evaluation.

A fourth key lesson, relating to both structural reforms and to strategies, is that the complexities of the health and disability system do make setting real priorities difficult. Changes in the political landscape (e.g. changing ministers, crises, changing governments) often lead to either the ignoring of key stated priorities altogether, or the actual allocation of funding to other areas. New Zealand should be able to do better – setting a smaller set of priorities with policy and funding focused on those priorities for at least several years. Perhaps the strategy and planning processes set out above will make it clearer what the key priorities actually are and enable a more sustained approach.

A fifth key lesson from recent New Zealand reforms relates to relationships. The MoH, HNZ and the MHA will need to work closely together to make the reforms work. HNZ will dominate in terms of staffing numbers and funding. Previous reforms (especially during the 1990s) saw problems with agencies not working well together and, for example, arguing over who is responsible for what in terms of policy development. There will be a need for strong
oversight from the responsible ministers and a highly collaborative approach among agencies to make these reforms work.

A sixth key lesson is that it is important to carefully pay attention to history and how a country has the health system that it has. New Zealand’s history is that, as new technologies developed, hospital services became an important focus for governments and for funding. With GPs determined to remain independent and to be able to charge patients fees, much Central Government policy in New Zealand has focused on what it can more directly control – hospital services. Yet the burden of health conditions has changed and more service delivery through stronger PHC and community services is needed. New Zealand’s history continually informs us that successfully bringing about change – allocating resources in a different way and building new models of care – is extremely difficult to achieve. Key opportunities to bring about change need to be seized upon, and adequate resourcing is needed to support such change. Previous attempts at change (e.g. the BSMC business cases) were not always well supported either financially or with the resources required to be successful (e.g. people’s time). A stronger focus on change management processes may bring about more successful changes in the future.

The development of localities in the reformed system appears, at face value, to have learned the lessons from the PHCS, by focusing immediately on high-needs populations, and taking a more local approach (as opposed to a national approach and emphasizing the traditional GPC providers). Localities have been one of the areas where there has been a lack of clarity as to exactly how they will work and be developed. Nine locality prototype areas and leadership arrangements have now been announced: Ōtara/Papatoetoe, Hauraki, Eastern Bay of Plenty, Taupō/Tūrangi, Wairoa, Whanganui, Horowhenua, Porirua and West Coast. Localities are now defined as:

*Essentially a place-based approach to improving the health of populations, as well as a mechanism for organising health and social services to meet the needs identified by whānau, community and mana whenua.*

*There are three characteristics to a locality. First, it is a partnership with mana whenua, recognising their tino rangatiratanga. Second, the approach supports locally led solutions that take a holistic approach to wellbeing, acknowledging the range of other factors that impact on a person’s health. Third, the locality approach will join up care across communities and improve integration with different layers of the health system* (Department of Prime Minister and Cabinet, 2022, paragraphs 3 and 4).
The approach will be tested with the above nine communities and lessons used in the roll-out of the approach to the rest of the country. Accompanying information notes:

_We will see a change in traditional provider roles and service models over time, and the commissioning and development of new roles and services to meet community need...Localities are not intended to commission services directly. However, the partners within a locality will work with Health New Zealand and the Māori Health Authority to provide local insights about the needs of communities (Health New Zealand, 2022, pages 4 and 6)._

The new approach to localities is an incredibly important development in the history of the New Zealand health-care system. It potentially gives a greater role to Māori and to communities in better defining the services they would like to see delivered in their local communities to best meet their local needs. What is also excellent to see is the funding of an evaluation and the taking of a learning approach to localities, something not always seen with such reforms in New Zealand. What will also be important will be a focus on training and support for local communities to engage more in health-care decision-making.

The PHCS took a universal approach and established PHOs, many of which were built off pre-existing GPC services and hence did not always work as well as they might with local communities, especially Māori. The encouragement of amalgamation of PHOs in the late 2000s probably further undermined local community engagement with PHC. However, there are risks with the localities approach. Expectations at local community level may exceed what in practice can be achieved, and it is HNZ and the MHA that will make the final decisions on commissioning arrangements. They will need to be well resourced at a local level to work closely with local communities. Service providers will also have to work more collaboratively than they have in the past.

Recent experience is that changing models of care is extremely complex and will require strong change management skills to effectively bring about change. What is also to be hoped is that more Māori-led and Pacific-led providers and models of care can be expanded to better meet the needs of those communities. An increased focus on the determinants of health and social services is also needed to truly make a dent in existing inequities. Significant new funding is likely to be needed to make this work well.
Furthermore, one issue that has yet to be addressed in the reforms is the thorny issue of user charges in PHC. That they exist goes back to disagreements between GPs and the government in the 1930s and 1940s, with GPs not trusting governments to fund subsidies to keep up with costs and hence wanting the right to set their own user charges. Significant changes have been made with GPCs (including the shift to capitation in the 2000s and the setting up of a fees regulation process), but even with the PHCS the government had to allow the continuation of user charges to get GPCs behind the reforms. User charges in PHC continue to be a major barrier to change. As was seen in earlier chapters, levels of unmet need for PHC remain high and have not really changed over many years. New funding then to PHC is simply keeping things stable. But in addition to unmet need, the charges make it difficult to shift services out of hospitals – as such a shift would mean services that were free suddenly have a charge associated with them when delivered in PHC.

A seventh key lesson comes when considering the desire for a “truly national ... system”. Here, the reforms are signalling problems over having 20 semi-autonomous DHBs with which to negotiate and on which to rely on to deliver government objectives. National consistency for hospital and specialist services is a major focus for the reformed system, thus removing the “postcode lottery”, so that everyone gets the same level of service regardless of where they live. For a nationally funded health service, this is an important goal. However, it is not yet clear if this will be easily achieved. The experience with elective/planned services shows the many ways in which local adaptations to policy can lead to variation in service delivery at that level. Key to removing the “postcode lottery” will be ensuring that funding arrangements support the delivery of national consistency. If the government is serious, it will need to be measuring need carefully across the country and then be funding services to meet an agreed level of need. For example, in the context of the existing elective/planned services processes, this would mean ensuring that all who get so many points using clinical priority assessment criteria actually do get services delivered, and in a timely way. Funding regions and/or services through bulk grants will immediately likely undermine all attempts at removing the postcode lottery, as regions will likely have different local priorities and existing rates of service delivery that they feel they must fund. Another issue will be what levels are chosen for consistent service delivery – i.e. levelling up or levelling down – the latter meaning some will lose services they currently might be receiving. In early May 2022, it was announced that a national approach to elective/planned services will be taken, and work is under way to set out how the arrangements will work (Little, 2022).
Eighth, another issue not apparently considered in depth to date relates to research and evaluation. Typically, the health system and health services research – multidisciplinary research focused on supporting learning and decision-makers, including about the effectiveness of services – has not been well supported in New Zealand. Report after report notes how pockets of innovation spring up but are rarely well evaluated and do not spread. The MoH, HNZ and MHA must develop a research and evaluation strategy to support their decision-making. This too, will require investment in capacity and capability, in particular, of Māori and Pacific researchers, but also of provider, consumer and community researchers at a local level.

Ninth, New Zealand has not had great success with its various IT strategies over many, many years. DHB computing and information systems were old, patched together, and vary considerably across the country, and security at least in one DHB recently had a major effect on service delivery. Digital technologies are now more sophisticated, and the rising use of e-prescribing and telehealth during the COVID-19 pandemic do show what can be done. A clear plan that supports the overall direction of the system, e.g. in delivering services closer to home – along with good funding and excellent project management – is going to be needed to ensure that we make the most of new technologies in health.

Finally, a major issue relates to the workforce. New Zealand has always had workforce shortages – for specialists, GPs, nurses, and rest home-care services, the country relies heavily on migrants. There is also a woeful lack of Māori and Pacific staff. The COVID-19 pandemic has meant that the borders have been closed for two years and migrants are few and far between. There is also a concern that with the borders back open, many (especially young) New Zealanders will be heading overseas for their overseas experience (OE). There is a need for a strong workforce plan that focuses on key priority areas and carefully tracks progress if the reforms really are to work.
## 9. Appendices

### 9.1 Health and disability data in detail

#### 9.1.1 Maternal and child health data

<table>
<thead>
<tr>
<th>Table 9.1 Maternal and child health, 2000–2019</th>
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<tbody>
<tr>
<td><strong>Birth rate, women aged 15–19 years</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Abortion rate, general&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Perinatal mortality rate&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Neonatal mortality rate&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Post-neonatal mortality rate&lt;sup&gt;e&lt;/sup&gt;</td>
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<tr>
<td>Infant mortality rate&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
<tr>
<td>Under-5 mortality rate&lt;sup&gt;g&lt;/sup&gt;</td>
</tr>
<tr>
<td>Maternal mortality rate&lt;sup&gt;h&lt;/sup&gt;</td>
</tr>
<tr>
<td>Fully immunized rate for children (2 years)&lt;sup&gt;i&lt;/sup&gt;</td>
</tr>
<tr>
<td>Fully immunized rate for children (5 years)&lt;sup&gt;j&lt;/sup&gt;</td>
</tr>
<tr>
<td>Children born underweight rate&lt;sup&gt;k&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Definitions and sources: Births and abortion rates are per 1000 women; mortality rates are per 1000 live births except for maternal mortality, which is per 100 000 live births; underweight is a percentage of all births.

<sup>a</sup>Number of births per 1000 women aged 15–19 years, Source: https://www.stats.govt.nz/information-releases/births-and-deaths-year-ended-december-2021-including-abridged-period-life-table/#:~:text=The%20fertility%20rates%20for%20women,down%20to%2086.8%20from%20109.1

<sup>b</sup>Number of abortions per 1000 women aged 15–44 years, Source: stats.govt.nz/topics/abortions

<sup>c</sup>Number of perinatal deaths [sum of fetal [death prior to the complete expulsion or extraction from its mother] per total births and early neonatal death [death of a live-born infant before seven completed days after birth]] per 1000 live births, Source: minhealthnz.shinyapps.io/fetal-and-infant-deaths-web-tool/

<sup>d</sup>Number of neonatal deaths [death of a live-born infant before 28 completed days after birth] per 1000 live births, Source: minhealthnz.shinyapps.io/fetal-and-infant-deaths-web-tool/

<sup>e</sup>Number of post-neonatal deaths [death of a live-born infant after 28 completed days after birth and before the first completed year of life] per 1000 live births, Source: minhealthnz.shinyapps.io/fetal-and-infant-deaths-web-tool/
Number of infant deaths [death of a live-born infant before the first completed year of life] per 1000 live births, Source: minhealthnz.shinyapps.io/fetal-and-infant-deaths-web-tool/

Number of deaths of those aged <5 years per 1000 live births, Source: data.worldbank.org/indicator/SH.DYN.MORT?locations=NZ

Number of maternal deaths per 100 000 live births, Source: data.worldbank.org/indicator/SH.STA.MMRT?locations=NZ

Number of fully immunized (including measles, mumps, rotavirus, etc.) children aged 2 years, as % of total children, 2010 data are for year ended October, all other years are for year ended December, Source: https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data

Number of fully immunized (including measles, mumps, rotavirus, etc.) children aged 5 years, as % of total children, 2010 data are for year ended October, all other years are for year ended December, Source: https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data

Low birthweight babies as a percentage of all births [newborns weighing less than 2500 g], Source: data.worldbank.org/indicator/SH.STA.BRTW.ZS?locations=NZ

Data on baby and infant deaths show a general downward trend, but some increases in recent years (e.g. for fetal deaths)

Figure 9.1 Rate of fetal deaths by ethnic group, 2009–2018

Note: Deaths per 1000 total births
Source: Fetal and Infant Deaths web tool [Ministry of Health, 2021am]
Figure 9.2  Rate of perinatal deaths by ethnic group, 2009–2018

Note: Deaths per 1000 total births
Source: Fetal and Infant Deaths web tool (Ministry of Health, 2021am)

Figure 9.3  Rate of neonatal deaths by ethnic group, 2009–2018

Note: Deaths per 1000 live births
Source: Fetal and Infant Deaths web tool (Ministry of Health, 2021am)
Figure 9.4  Rate of post-neonatal deaths by ethnic group, 2009–2018

Note: Deaths per 1000 live births
Source: Fetal and Infant Deaths web tool (Ministry of Health, 2021am)

Figure 9.5  Rate of infant deaths by ethnic group, 2009–2018

Note: Deaths per 1000 live births
Source: Fetal and Infant Deaths web tool (Ministry of Health, 2021am)
9.1.2 Health and Independence Report data for 2019

The Health and Independence Report for 2019 (Ministry of Health, 2020a) on the health status of New Zealanders (prior to COVID-19) showed the following:

- Life expectancy for Māori and Pacific people is five to seven years lower than for non-Māori and non-Pacific people.
- The rate of premature mortality is falling, from 16,667 years of life lost per 100,000 population in 1990 to 9,122 in 2019. In 2017, the age-standardized mortality rate for Māori was almost twice as high as for non-Māori; the Māori rate declined further than the non-Māori rate between 1996 and 2017, but the declines have slowed, especially for Māori.
- The infant mortality rate overall has fallen between 1996 and 2016 (from 7.3 in 1000 live births to 4 in 1000 live births).
  - However, rates are higher for Māori and Pacific peoples (at 6.2 per 1,000 births and 5.9 per 1000 births, respectively, compared with 2.8 per 1000 births and 2.5 per 1000 births for European/Other and Asian ethnic groups, respectively).
- The majority of New Zealanders’ health loss (83.5%) is due to noncommunicable diseases, with four condition groups providing half of this health loss: cancers (18.5%), cardiovascular and cerebrovascular diseases (15.1%), mental distress (8.7%) and musculoskeletal disorders (8.6%).
  - Mortality from the first two conditions is slowly decreasing, but rates remain high for Māori and Pacific peoples; indeed, between the late 1990s and mid-2000s, gaps between Māori and non-Māori, and Pacific and European, in terms of cancer mortality did not reduce.
- The rate of non-fatal health loss did not change much since 1990. Mental disorders are the largest group of contributing conditions, accounting for 17.2% of non-fatal health loss. Musculoskeletal disorders (16.4%) and unintentional injuries (13.3%) follow.
- Most adults (86.2%) report their health as good, very good or excellent; but this is slowly trending down, from 89.3% in 2011/2012. The proportion of adults rating their health as only fair or poor is slowly increasing, rising from 10.7% in 2011/2012 to 13.8% in 2018/2019.
  - Māori and Pacific adults report lower levels of self-rated health, and these have worsened over time: for Māori reducing from 83.6% in 2011/2012 to 77.3% in 2018/2019, and for Pacific reducing from 87.2% in 2011/2012 to 78.7% in 2018/2019. Māori and Pacific...
adults rating of their health as fair or poor has increased over time: for Māori from 16.4% in 2011/2012 to 22.7% in 2018/2019, and for Pacific adults rising from 12.8% to 21.3% between 2011/2012 and 2018/2019.

- Adults living in the most deprived areas are less likely to report their health as good, very good or excellent (79.4%) compared with adults living in the least deprived areas (91.0%).
- Almost all parents (98.2%) rate their child’s health as good, very good or excellent, a rate that has not changed since 2011/2012. There are no differences by ethnic group or socioeconomic status.

• Diabetes prevalence increased between 2010 and 2015, with rates stabilizing more recently.
• About one in twelve adults experience high levels of psychological distress, and this rate has increased since 2006/2007.
• Communicable diseases remain an issue, with a large measles outbreak, especially among Pacific children, in 2019, and rheumatic fever rates (especially among Pacific peoples) increasing again since 2015.

In terms of risk factors, the Report showed the following:

• The top five risk factors for health loss in New Zealand are smoking, high body mass index, high systolic blood pressure, dietary risks and high fasting plasma glucose. The report pointed to the falling contribution of smoking, high systolic blood pressure and dietary risks to health loss over time, but with the rate of improvement slowing over the past decade. The other two key risk factors (i.e. high body mass index, high fasting plasma glucose) are making a larger contribution to health loss, and although obesity rates appeared to be stabilizing, they remain high, especially among older adults.

### 9.1.3 New Zealand Health Survey data for 2019/2020

New Zealand Health Survey data also show trends and inequities in relation to a range of health measures. These are set out in Table 9.4 below. Data from 2019/2020 (Ministry of Health, 2022b) show the following:

- Smoking rates are falling over time, but there are high rates for Māori and Pacific peoples, those in quintile 5 and the disabled.
- There are higher rates of hazardous drinking among Māori in particular.
- Overweight or obesity rates are stabilizing, but there are much higher rates for Māori, Pacific and those in quintile 5, for both adults and children, and higher rates among the disabled.
• In terms of key conditions, there are:
  o higher rates of asthma, gout and diabetes among Māori adults, and higher rates of childhood eczema for Māori children, along with higher rates of food running out sometimes or using food grants;
  o higher rates of diabetes among Pacific adults and higher rates of childhood eczema among Pacific peoples, along with higher rates of food running out sometimes or using food grants;
  o high rates of asthma among those living in the most deprived areas, and higher rates of food running out sometimes or using food grants.

• In terms of mental health:
  o Overall, the most common serious mental health disorders were mood and/or anxiety disorder (20.1%), mood disorder (depression and/or bipolar) (16.4%) and depression (16.4%).
  o Compared to rates in 2011/2012, the greatest rise has been in psychological distress, which affected 4.6% of respondents in 2011/2012, rising to 7.5% in 2019/2020. The next highest was diagnosed anxiety, which affected 6.1% of respondents in 2012, and 11.3% in 2019/2020.
  o Māori rates are similar to those for European/Other groups, except for high or very high psychological distress where the Māori rate (13.4%) was much higher than for European/Other (7.5%), for moderate distress where the Māori rate (18.7%) was also higher than the European/Other rate (14.1%), and for bipolar disorder (1.7% for Māori and 1% for European/Other).
  o Pacific rates are generally lower than for European/Other, the one exception being moderate psychological distress, where the Pacific rate for moderate distress (21.7%) was much higher than the European/Other rate (14.1%).
### 9.1.4 Immunization data

Data on immunization are set out in the tables below (see also Figure 1.2, 1.3, 1.4 and 1.5 in Chapter 1).

#### Table 9.2 Child immunization rates (%) at 2 years by ethnicity and level of deprivation, 2010–2021

<table>
<thead>
<tr>
<th></th>
<th>NZ European</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Quintile 1</th>
<th>Quintile 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>87</td>
<td>84</td>
<td>90</td>
<td>93</td>
<td>90</td>
<td>86</td>
</tr>
<tr>
<td>2011</td>
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<td>2016</td>
<td>93.3</td>
<td>92.0</td>
<td>95.9</td>
<td>95.7</td>
<td>92.7</td>
<td>92.4</td>
</tr>
<tr>
<td>2017</td>
<td>93.4</td>
<td>90.6</td>
<td>94.6</td>
<td>95.8</td>
<td>93.0</td>
<td>91.1</td>
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<tr>
<td>2018</td>
<td>92.3</td>
<td>87.8</td>
<td>93.6</td>
<td>95.5</td>
<td>91.9</td>
<td>89.3</td>
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<tr>
<td>2019</td>
<td>92.6</td>
<td>86.6</td>
<td>92.4</td>
<td>95.9</td>
<td>92.3</td>
<td>88.3</td>
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<tr>
<td>2020</td>
<td>92.5</td>
<td>84.7</td>
<td>92.8</td>
<td>95.9</td>
<td>92.7</td>
<td>87.7</td>
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<tr>
<td>2021</td>
<td>88.1</td>
<td>72.9</td>
<td>83.0</td>
<td>95.4</td>
<td>85.2</td>
<td>83.9</td>
</tr>
</tbody>
</table>

Number of fully immunized children aged 2 years, as a % of all children.

Source: Immunization coverage at milestone age (24 months of age), National Immunisation Register (Ministry of Health, 2021an)

#### Table 9.3 Child immunization rates (%) at 5 years by ethnicity and level of deprivation, 2010–2021

<table>
<thead>
<tr>
<th></th>
<th>NZ European</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Quintile 1</th>
<th>Quintile 5</th>
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<tbody>
<tr>
<td>2010</td>
<td>77</td>
<td>68</td>
<td>73</td>
<td>76</td>
<td>75</td>
<td>69</td>
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<td>2011</td>
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<td>2012</td>
<td>86</td>
<td>78</td>
<td>80</td>
<td>81</td>
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<td>2013</td>
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<td>74</td>
<td>77</td>
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<td>2014</td>
<td>85</td>
<td>78</td>
<td>78</td>
<td>82</td>
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<td>2015</td>
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<td>80.7</td>
<td>79.4</td>
<td>84.4</td>
<td>85.9</td>
<td>79.4</td>
</tr>
<tr>
<td>2016</td>
<td>90.3</td>
<td>84.7</td>
<td>86.8</td>
<td>88.9</td>
<td>89.5</td>
<td>84.1</td>
</tr>
<tr>
<td>2017</td>
<td>91.2</td>
<td>86.2</td>
<td>89.4</td>
<td>90.7</td>
<td>90.0</td>
<td>86.4</td>
</tr>
<tr>
<td>2018</td>
<td>90.9</td>
<td>85.5</td>
<td>88.8</td>
<td>90.5</td>
<td>89.5</td>
<td>85.9</td>
</tr>
<tr>
<td>2019</td>
<td>91.0</td>
<td>84.6</td>
<td>88.7</td>
<td>91.1</td>
<td>89.9</td>
<td>86.0</td>
</tr>
<tr>
<td>2020</td>
<td>91.5</td>
<td>84.5</td>
<td>89.6</td>
<td>91.4</td>
<td>91.3</td>
<td>85.6</td>
</tr>
<tr>
<td>2021</td>
<td>87.1</td>
<td>76.2</td>
<td>84.0</td>
<td>90.4</td>
<td>84.4</td>
<td>82.7</td>
</tr>
</tbody>
</table>

Number of fully immunized (including measles, mumps, rotavirus, etc.) children aged 5 years, as % of total children.

Source: Immunization coverage at milestone age (5 years of age), National Immunisation Register (Ministry of Health, 2021an)
9.1.5 Suicide data

Data on suicide are set out in the graphs below.

Figure 9.6 Number of suicide deaths for Māori, Pacific, Asian, Other ethnic groups, 2009–2020

Source: Suicide web tool [Ministry of Health, 2021ao]

Figure 9.7 Rate of deaths by suicide per 100 000 for Māori, Pacific, Asian, Other ethnic groups, 2009–2020

Source: Suicide web tool [Ministry of Health, 2021ao]
In terms of specific components of the health system, OECD (2021) data show that New Zealand has:

- close to the OECD on average health spending per capita, with New Zealand spending US$ 4212 and the average OECD countries’ spending being US$ 4087;
- close to the OECD countries’ average for the number of doctors and nurses: 3.4 per 1000 people for doctors and 10.2 for nurses in New Zealand compared with the OECD average of 3.6 per 1000 people for doctors and 8.8 for nurses.

New Zealand does less well than the OECD countries’ average with respect to:

- cancer incidence – which is the second worst in the OECD, with Australia the worst, and cancer mortality; infant mortality;
- death by suicide;
- alcohol consumption (only just over the OECD countries’ average);
- physical activity by adults; overweight adults (with rates steady between 2009 and 2019);
- number of in-person doctor consultations (3.8 in New Zealand in 2019 compared with 6.8 across the OECD countries);
- number of hospital beds per 1000 population (2.5 in New Zealand compared with 4.4 across the OECD countries);
- adult intensive care beds (3 per 100 000 population in New Zealand compared with 14.1 across the OECD countries);
- CT scanners, MRI units and positron emission tomography (PET) scanners;
- admissions for asthma and chronic obstructive pulmonary disease among adults; including with respect to effective PHC relating to avoidable admissions for chronic obstructive pulmonary disease, with 298 per 100 000 people compared with an OECD average of 171 per 100 000 people;
- hospital admissions for diabetes among adults;
- share of inpatient and community mental health service users who were treated with courtesy and respect by care providers;
- hospital discharge rates;
- hip and knee replacements; waiting times for hip replacements (from assessment to treatment);
- obstetric trauma;
- excess mortality from bipolar disorder and schizophrenia;
- oesophageal cancer five-year net survival;
- medical and nursing graduates;
• share of foreign-trained doctors and nurses – New Zealand has the second highest rate for doctors (42.6% compared with an OECD average of 17.9%) and the highest rate for nurses (26.6% compared with an OECD average of 6.1%);
• practising pharmacists per 100 000 population.

New Zealand has a better rate than the OECD average (i.e. it is in the top 10 countries; in the top five countries if not all countries included; or close to the best-performing country) in the following areas:

• premature deaths attributable to ambient particulate matter pollution;
• adults rating their own health as bad or very bad (New Zealand is second lowest on 2.6%);
• adults rating their own health as good or very good (and the difference between higher- and lower-income earners is one of the least among the OECD countries);
• adults aged 65 years and over rating their own health as fair, poor or very poor (where New Zealand has the lowest percentage);
• daily vegetable consumption among the population aged 15 years and over;
• prevalence of anxiety or symptoms of anxiety;
• out-of-pocket spending as share of final household consumption;
• proportion of primary care physician offices using electronic medical records (New Zealand on 95%; top-performing countries on 100%);
• percentage of children at 1 year vaccinated for diphtheria, tetanus and pertussis, measles and hepatitis B;
• mammography screening (close to the OECD average);
• people with diabetes prescribed recommended antihypertensive medication in the past year in primary care (New Zealand on 89% compared with an OECD average of 83%);
• share of generics in the total pharmaceutical market;
• share of cataract surgeries carried out as ambulatory cases (97.6%);
• effective secondary care relating to 30-day acute myocardial mortality, with 4.3 cases per 100 000 people compared with an OECD average of 6.6 per 100 000 people;
• waiting times for cataract surgery from assessment to treatment (New Zealand had the lowest waiting times for cataract surgery and knee and hip operations in 2020 among seven countries);
• melanoma five-year net survival;
• long-term care workers per 100 people aged 65 years and over;
• long-term care beds in institutions and hospitals per 1000 population 65 years and over (although these have fallen between 2009 and 2019 to a greater extent than in other OECD countries, by 8.1%).
9.1.7 Patient experience surveys

Health Quality and Safety Commission Hospital Survey – November 2021
(Health Quality and Safety Commission, 2022d)

Care from health-care team

- Doctors (91.8%), other staff members (90.7%) and nurses (89.5%) treating them with respect.
- Cultural needs being met (90.4%); Māori rates were statistically significantly lower; Pacific rates were lower but not statistically significant.
- Names being pronounced properly by those providing care (88.4% responded yes, always); Māori rates were statistically significantly a little lower.
- Doctors (89.4%), nurses (87.6%) and other staff (88.9%) treating people with kindness and understanding; with rates for the last of these higher for Pacific peoples but not statistically significant.
- People feeling comfortable to ask any questions (85.8%); Pacific rates were lower but not statistically significant.
- Doctors (85.6%), nurses (82.5%) and other staff listening to views and concerns (82.5%).
- People having trust and confidence in the doctors (85.4%), nurses (83.9%) and other members of the team (84.0%); Māori rates were statistically significantly a little lower for nurses; Asian rates were statistically significantly higher for doctors.
- Spiritual needs being met (82.2%); Māori rates were statistically significantly lower.
- Explanations being given about what was going on in a way people could understand (81.1%); Māori rates were a little higher, as were rates for Pacific peoples (but not statistically significant).

The lowest scores have been for:

- staff, including family/whānau in discussions about care (68.4%);
- people being kept informed about treatment and care (76.9%); Pacific rates were higher but not statistically significant;
- people being given conflicting information by those involved in care (77.1% responded “no”); Pacific rates were lower but statistically significant;
- people being involved in decisions about treatment and care (76.9%);
- people being asked how to say their name if staff was unsure (79%); Māori rates were statistically significantly a little higher; Pacific rates were lower but not statistically significantly so;
- individual needs being met (79.5%).
Hospital environment

- Scores were generally very high when people answered “no” about whether they were being treated unfairly, although Māori and Pacific peoples were more likely not to say “no” to these questions.
- Scores overall for cleanliness, privacy, staff helping people use bathroom or bedpan as soon as they wanted, all had scores just over 80% on average, or below.

Surgery

- Scores were a bit lower in relation to whether staff helped people understand how their operations went [79.9% overall].

Discharge

A number of discharge-related scores were much lower than responses to other questions:

- People being told about possible side-effects of medicines they left hospital with [62.7%]
- There having been a discussion about help needed after discharge [66.5%]; Pacific rates were statistically significantly different.
- People having enough information to manage their condition or recovery after discharge [68.5%]; Māori and Pacific rates were higher, statistically significantly so for Pacific peoples.
- People being kept informed about what would happen and what to expect before discharge [72.8%]; Pacific rates were statistically significantly higher than European/Others.
- People being told what the medicine they left hospital with was for [86.3%].

Health Quality and Safety Commission Primary Health Care Survey – November 2019 (Health Quality and Safety Commission, 2022d)

This shows the highest scores (answering, “Yes, always”) for:

- people following instructions when they took medication [93/100];
- their GP or nurse treating people with kindness and understanding [93/100] and respect [95/100].

The HQSC reported that there was no variation across DHBs at that point in time, and little change overall since February 2018.
The lowest scores are in relation to:

- being told what to do if people experience side-effects (55/100);
- a specialist doctor asking what is important to you (52/100);
- people being contacted after a treatment or care plan was made (40/100).

Th HQSC reported that there was no variation across DHBs at that point in time, and some small improvements over time since February 2018.

For Māori:

There are some overall lower scores in some DHB districts, in particular, in relation to:

- meeting physical and emotional needs, with six DHBs scoring below average for Māori and three above average;
- Coordination scores, with scores in six DHBs scoring below average, two being the same DHB locations as with the physical and emotional needs scores.
- Communication scores, which are similar for Māori as the national average, with two DHB areas scoring below average (one of which also scored below average on coordination) and three above average (two of which scored above on physical and emotional needs as well).
- Partnership scores, which are also similar for Māori as the national average, with two DHB areas below average – with one having both lower-than-average communication scores and coordination scores, and one also scoring low on communication).
- One DHB scoring below average for Māori on three of the four scores (Nelson Marlborough), while two DHBs scoring above average on two scores (Auckland and Waitematā).

For Pacific peoples:

- Two DHB areas had lower-than-average scores on physical and emotional needs, and one DHB area has higher than average scores.
- One DHB area had a lower-than-average coordination score, and one DHB area has an above-average score).
- Two DHBs were below average for communication, and two are above average.
- Two DHB areas were above average for partnership scores for Pacific peoples. (Note that small numbers mean that not all DHB areas have scores reported.)
One DHB had above-average scores for three topics (Nelson Marlborough) and one has above average scores for three topics (Canterbury).

The HQSC work in the area of patient experience has provided significant new information about aspects of the performance of the New Zealand health system. There is, however, especially for the PHC data, a need for clearer reporting on a wider range of data, and increased access to the dataset. It is also important that the qualitative survey findings be analysed in depth to explain the quantitative scores, and further work be done to link initiatives with outcomes in terms of patient experience.

New Zealand Health Survey – 2019/2020 (Ministry of Health, 2022b)

The most recent New Zealand Health Survey (2019/2020) showed high levels of satisfaction with aspects of PHC services [see Table 9.4]. For example:

- 82.4% of adult respondents said they definitely had trust and confidence in their GP. This was lower for Asian people (78.5%) and for Māori (78.9%) compared with non-Māori (82.9%); those living in the most deprived areas (79.4% compared with 84.8%).
- 91.6% said their GP was very good or good at explaining health conditions and treatments in a way that could be understood. This was lower for Māori (87.2% compared with 91.5% for non-Māori) and lower for the disabled (86.9% versus 92.3%).
- 89.7% said their GP was very good or good at involving them in decisions about their care. This was a bit lower for Māori (86.2% compared with 89.1% for non-Māori) and for the disabled (86.4% versus 90.2%).
<table>
<thead>
<tr>
<th>Year</th>
<th>2011/2012</th>
<th>2019/20</th>
</tr>
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<tbody>
<tr>
<td>Self-rated health - adult - E, VG, G</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Male | 87.0 | 87.6 | 91.9
| Female | 87.3 | 97.4 | 91.8
| Total population | 87.2 | 87.8 | 91.8
| Māori | 87.0 | 87.3 | 91.8
| Pacific | 87.6 | 97.4 | 91.8
| Asian | 87.8 | 97.3 | 91.8
| European/Other | 87.1 | 97.4 | 91.8
| Parent-rated health - child - Ex, VG, G | | |
| Male | 97.8 | 97.3 | 97.8
| Female | 97.3 | 96.3 | 97.3
| Total population | 97.6 | 96.5 | 97.6
| Māori | 97.8 | 96.3 | 97.8
| Pacific | 97.3 | 96.3 | 97.3
| Asian | 97.0 | 96.0 | 97.0
| European/Other | 97.1 | 96.1 | 97.1
| Current smokers - A - monthly | | |
| Male | 18.4 | 16.5 | 15.0
| Female | 18.3 | 16.5 | 15.0
| Total population | 18.5 | 16.6 | 15.1
| Māori | 18.6 | 16.7 | 15.1
| Pacific | 18.2 | 16.4 | 14.9
| Asian | 18.0 | 16.3 | 14.8
| European/Other | 17.9 | 16.2 | 14.7
| Parent-rated health - child - Ex, VG, G | | |
| Male | 14.1 | 12.9 | 12.4
| Female | 13.9 | 12.7 | 12.2
| Total population | 14.0 | 12.8 | 12.3
| Māori | 14.2 | 13.0 | 12.5
| Pacific | 13.9 | 12.7 | 12.2
| Asian | 13.8 | 12.6 | 12.1
| European/Other | 13.7 | 12.5 | 12.0
| Alcohol use - A - hazardous | | |
| Male | 1.3 | 1.1 | 1.0
| Female | 1.1 | 0.9 | 0.8
| Total population | 1.2 | 1.0 | 0.9
| Māori | 1.3 | 1.1 | 1.0
| Pacific | 1.2 | 1.0 | 0.9
| Asian | 1.1 | 0.9 | 0.8
| European/Other | 1.0 | 0.8 | 0.7
| Overweight or obese - A | | |
| Male | 64.0 | 66.6 | 69.0
| Female | 66.4 | 69.0 | 69.4
| Total population | 65.2 | 68.3 | 69.2
| Māori | 64.4 | 66.6 | 68.6
| Pacific | 66.4 | 69.0 | 69.4
| Asian | 65.0 | 68.1 | 69.1
| European/Other | 65.6 | 68.3 | 69.3
| Parent-rated health - child - Ex, VG, G | | |
| Male | 97.1 | 97.0 | 96.9
| Female | 97.0 | 96.8 | 96.8
| Total population | 97.1 | 96.9 | 96.8
| Māori | 97.1 | 96.9 | 96.9
| Pacific | 97.0 | 96.8 | 96.8
| Asian | 97.0 | 96.8 | 96.8
| European/Other | 97.1 | 96.9 | 96.9
| Parent-rated health - child - Ex, VG, G | | |
| Male | 97.6 | 97.4 | 97.4
| Female | 97.4 | 97.3 | 97.3
| Total population | 97.5 | 97.4 | 97.4
| Māori | 97.6 | 97.4 | 97.4
| Pacific | 97.5 | 97.4 | 97.4
| Asian | 97.5 | 97.4 | 97.4
| European/Other | 97.5 | 97.4 | 97.4
| Use food grants often/sometimes | | |
| Male | NA | NA | NA
| Female | NA | NA | NA
| Total population | NA | NA | NA
| Māori | NA | NA | NA
| Pacific | NA | NA | NA
| Asian | NA | NA | NA
| European/Other | NA | NA | NA
| Diagnosis of diabetes - A | | |
| Male | 5.5 | 5.6 | 5.6
| Female | 5.6 | 5.7 | 5.7
| Total population | 5.5 | 5.6 | 5.6
| Māori | 5.5 | 5.6 | 5.6
| Pacific | 5.6 | 5.7 | 5.7
| Asian | 5.5 | 5.6 | 5.6
| European/Other | 5.6 | 5.7 | 5.7
| Diagnosis of asthma - A | | |
| Male | 11.0 | 11.9 | 11.9
| Female | 11.9 | 12.8 | 12.8
| Total population | 11.9 | 12.8 | 12.8
| Māori | 11.0 | 11.9 | 11.9
| Pacific | 11.9 | 12.8 | 12.8
| Asian | 11.9 | 12.8 | 12.8
| European/Other | 11.9 | 12.8 | 12.8
| Diagnosis of chronic pain - A | | |
| Male | 10.2 | 10.4 | 10.5
| Female | 10.4 | 10.5 | 10.6
| Total population | 10.3 | 10.5 | 10.6
| Māori | 10.2 | 10.4 | 10.5
| Pacific | 10.4 | 10.5 | 10.6
| Asian | 10.4 | 10.5 | 10.6
| European/Other | 10.5 | 10.6 | 10.7
| Food runs out often/sometimes - A | | |
| Male | 20.7 | 27.0 | 28.5
| Female | 23.0 | 30.3 | 31.9
| Total population | 21.9 | 28.4 | 30.0
| Māori | 20.7 | 27.0 | 28.5
| Pacific | 23.0 | 30.3 | 31.9
| Asian | 21.9 | 28.4 | 30.0
| European/Other | 21.9 | 28.4 | 30.0

Table 9.4: Indicators of health and access, 2011/2012 and 2019/2020
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<tr>
<th>Population group</th>
<th>Total population</th>
<th>Male</th>
<th>Female</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>European/Other</th>
<th>Quintile 1</th>
<th>Quintile 5</th>
<th>Disabled</th>
<th>Non-disabled</th>
</tr>
</thead>
</table>
| Year                             | 2011/2012        | 2019/20
| Indicator                        | % of total population |
| Oral health – Ex/VG/G - A        | NA               | 79.7  | 77.3   | 82.0  | 67.4    | 76.8  | 85.7          | 80.3       | 87.6       | 71.5     | 65.7         | 80.8        |
| Oral health – Ex/VG/G - Ch       | NA               | 93.0  | 91.9   | 94.2  | 91.4    | 92.4  | 92.7          | 93.1       | 94.7       | 90.5     | NA           | NA          |
| Tooth removed last 12 months – A | 7.6              | 6.9   | 7.0    | 6.9   | 10.3    | 12.1  | 6.6           | 6.2        | 4.5        | 8.6      | 11.2         | 6.6         |
| Tooth removed last 12 months – Ch| 3.9              | 3.5   | 4.0    | 3.0   | 3.8     | 4.9   | 4.5           | 2.4        | 2.3        | 5.6      | NA           | NA          |
| Tooth removed lifetime – A       | NA               | 45.1  | 45.3   | 44.9  | 52.2    | 52.0  | 29.9          | 45.7       | 38.4       | 53.4     | 66.9         | 44.3        |
| Tooth removed lifetime – Ch      | NA               | 11.3  | 11.9   | 10.6  | 13.8    | 14.2  | 9.8           | 9.3        | 8.3        | 15.2     | NA           | NA          |
| Unmet need for PHC – A          | 26.6             | 31.0  | 24.9   | 36.9  | 42.6    | 35.2  | 24.4          | 31.3       | 26.6       | 38.3     | 47.5         | 29.5        |
| Unmet need for PHC – Ch         | 19.7             | 20.2  | 21.4   | 18.9  | 23.9    | 27.0  | 16.8          | 19.8       | 17.0       | 23.3     | NA           | NA          |
| Unable to get appointment – A    | 26.6             | 31.0  | 24.9   | 36.9  | 42.6    | 35.2  | 24.4          | 31.3       | 26.6       | 38.3     | 47.5         | 29.5        |
| Unable to get appointment – Ch   | 13.5             | 17.2  | 18.2   | 16.1  | 20.6    | 22.2  | 14.0          | 17.0       | 14.2       | 17.7     | NA           | NA          |
| Unmet need for GP due to cost – A| 13.6             | 13.5  | 10.8   | 16.1  | 20.5    | 16.1  | 11.2          | 13.3       | 10.6       | 17.7     | 21.8         | 12.8        |
| Unmet need for GP due to cost – Ch| 4.8              | 1.6   | 1.7    | 1.5   | 1.2     | 2.2   | 2.1           | 1.4        | 1.5        | 3.2      | NA           | NA          |
| Unmet need for a/h due to cost – A| 6.8              | 6.2   | 4.3    | 8.1   | 12.6    | 10.4  | 4.0           | 5.9        | 3.9        | 10.4     | 12.2         | 5.7         |
| Unmet need for a/h due to cost – Ch| 4.5              | 1.6   | 1.5    | 1.8   | 1.9     | 4.2   | 1.9           | 1.2        | 0.3        | 2.8      | NA           | NA          |
| Unfilled prescription due to cost – A| 7.3              | 5.2   | 3.6    | 6.9   | 12.6    | 13.6  | 2.8           | 4.2        | 2.2        | 12.2     | 13.3         | 4.6         |
| Unfilled prescription due to cost – Ch| 6.6              | 1.9   | 1.4    | 2.4   | 3.3     | 4.4   | 1.9           | 1.2        | 1.4        | 4.1      | NA           | NA          |
| Unmet need dental care due to cost – A| NA               | 42.3  | 37.8   | 46.6  | 53.7    | 51.8  | 42.2          | 40.5       | 33.2       | 51.0     | 54.7         | 41.3        |
| Unmet need dental care due to cost – Ch| NA               | 2.6   | 2.8    | 2.4   | 2.2     | 1.8   | 1.8           | 2.8        | 2.5        | 2.1      | NA           | NA          |
| GP visit – A                     | 78.3             | 78.9  | 73.9   | 83.7  | 79.2    | 75.5  | 69.3          | 81.0       | 77.5       | 77.4     | 93.4         | 77.6        |
| GP visit – Ch                    | 73.9             | 74.5  | 74.7   | 74.3  | 73.7    | 79.4  | 75.9          | 74.0       | 76.4       | 74.3     | NA           | NA          |
| Year       | Practice nurse visit – A | Practice nurse visit – Ch | Mean no. GP visits – A | Mean no. GP visits – Ch | Mean no. PN visits – A | Mean no. PN visits – Ch | Saw a dental worker – A | Saw a dental worker – Ch | Unmet need for dental care – A | Unmet need for dental care – Ch | Unmet need for GP due to COVID-19 | Definite confidence and trust in GP – A | GP good at explaining | GP good at involving patient in decisions – A |
|------------|--------------------------|---------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|------------------------|--------------------------------|--------------------------------|--------------------------------──|--------------------------------|------------------|--------------------------------|
| 2011/2012  | 30.5                     | 32.4                      | 7.9                    | 7.6                    | 0.6                    | 0.5                    | 48.2                   | 79.8                   | NA                             | NA                             | NA                      | Not app                      | 84.2             | 93.0                             |
| 2019/2020  | 29.9                     | 29.4                      | 7.2                    | 7.0                    | 0.5                    | 0.5                    | 46.6                   | 79.6                   | 31.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| Total %   | 30.5                     | 32.4                      | 7.9                    | 7.6                    | 0.6                    | 0.5                    | 48.2                   | 79.8                   | 31.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| Male      | 26.4                     | 26.7                      | 7.2                    | 7.0                    | 0.5                    | 0.5                    | 46.6                   | 79.6                   | 31.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| Female    | 31.0                     | 33.0                      | 8.2                    | 7.8                    | 0.6                    | 0.6                    | 51.3                   | 80.0                   | 33.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| Non-disabled | 29.9                          | 29.4                          | 7.2                    | 7.0                    | 0.5                    | 0.5                    | 46.6                   | 79.6                   | 31.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| Disabled | 26.4                     | 26.7                      | 7.2                    | 7.0                    | 0.5                    | 0.5                    | 46.6                   | 79.6                   | 31.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| European/Pacific | 29.9                          | 29.4                          | 7.2                    | 7.0                    | 0.5                    | 0.5                    | 46.6                   | 79.6                   | 31.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| Asian | 26.4                     | 26.7                      | 7.2                    | 7.0                    | 0.5                    | 0.5                    | 46.6                   | 79.6                   | 31.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |
| Other | 31.0                     | 33.0                      | 8.2                    | 7.8                    | 0.6                    | 0.6                    | 51.3                   | 80.0                   | 33.7                           | 33.9                           | 35.3                   | 3.7                           | 88.0             | 90.0                             |

**Source:** (Ministry of Health, 2022b)

**Table 9.4 Indicators of health and access, 2011/2012 and 2019/2020 (contd)**

A=Adults; C=Children; E/VG/G = Excellent/Very Good/Good; F/P=Fair/Poor

NA=Not available, Not app=Not applicable

**Note:** This table continues with additional indicators and data for the year 2019/2020.
### 9.1.9 District health board performance against targets

#### Table 9.5 District health board performance against targets (percentage of target achieved), 2010-2020

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</thead>
<tbody>
<tr>
<td>Shorter stays in emergency departments</td>
<td>88</td>
<td>92</td>
<td>93</td>
<td>94</td>
<td>94</td>
<td>94</td>
<td>94</td>
<td>90</td>
<td>86</td>
<td>85</td>
<td></td>
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<tr>
<td>Improved access to elective surgery</td>
<td></td>
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<tr>
<td>Faster cancer treatment</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>66</td>
<td>75</td>
<td>82</td>
<td>93</td>
<td>90</td>
<td>89</td>
<td>89</td>
</tr>
<tr>
<td>Better help for smokers to quit</td>
<td>70</td>
<td>89</td>
<td>95</td>
<td>66</td>
<td>89</td>
<td>85</td>
<td>86</td>
<td>88</td>
<td>87</td>
<td>82</td>
<td>78</td>
</tr>
<tr>
<td>More heart and diabetes checks</td>
<td>73</td>
<td>74</td>
<td>55</td>
<td>73</td>
<td>87</td>
<td>90</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
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<tr>
<td>Raising healthy kids</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
<td>Not app</td>
<td>72</td>
<td>98</td>
<td>97</td>
<td>97</td>
<td>93</td>
</tr>
</tbody>
</table>

Not app = Not applicable

Definitions: As at September–December 2009 for all but the last target; changes over time noted within each definition.

- **Shorter stays in emergency departments:** 95% of patients will be admitted, discharged or transferred from an Emergency Department within 6 hours. The target measures the efficiency of flow of acutely ill patients through hospitals.

- **Improved access to elective surgery:** an increase in the volume of elective surgery of an average 4000 discharges per year.

- **Faster cancer treatment:** shorter waits for cancer treatment radiotherapy, with everyone needing radiation treatment having it within 6 weeks of their first specialist assessment by the end of July 2010 and within four weeks by December 2010 (January 2011 for the 2010/2011 year). Changes to include chemotherapy for 2012/2013. Changes in 2014/2015 to 85% of patients receiving first treatment or other management with 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016, increasing to 90% by June 2017.

- **Better help for smokers to quit:** 80% of hospitalized smokers are provided with advice and help to quit by July 2010; 90% by July 2011; and 95% by July 2012. Changes in 2012/2013 to include 90% of patients who smoke and are seen by a PHC practitioner. Target only applies to PHC from 2015/2016.

- **Better diabetes and cardiovascular services:** average progress made against 3 indicators: (i) an increased % of the eligible adult population having had their risk assessment in the past 5 years; changes to 90% for September–December 2012; (ii) an increased % of people with diabetes attending free annual diabetes check-ups; and (iii) an increased % of people with diabetes having satisfactory or better diabetes management. Changes in 2012/2013 to (i) only, in stages to 90% by July 2014.

- **Raising healthy kids:** by December 2017, 95% of obese children identified in the Before School Check programme are offered a referral for assessment.

*Source:* (Ministry of Health, 2022u)
Figure 9.8  Shorter stays in Emergency Departments, 2010-2020

Source: How is my DHB performing? [Ministry of Health, 2022u]

Figure 9.9  Improved access to elective surgery, 2010-2017

Source: How is my DHB performing? [Ministry of Health, 2022u]
Figure 9.10  Faster cancer treatment, 2010-2020

Source: How is my DHB performing? (Ministry of Health, 2022u)

Figure 9.11  Better help for smokers to quit, 2010-2020

Source: How is my DHB performing? (Ministry of Health, 2022u)
Figure 9.12  More heart and diabetes checks, 2010-2015

Source: How is my DHB performing? [Ministry of Health, 2022u]

Figure 9.13  Raising healthy kids, 2016-2020

Source: How is my DHB performing? [Ministry of Health, 2022u]
9.2 References


Department of Prime Minister and Cabinet (2021a). Our health and disability system. Wellington: Department of Prime Minister and Cabinet.


Figure NZ (2022). Total government income from excise duty on alcohol in New Zealand. In: FigureNZ [website] (https://figure.nz/chart/P5rszR8R3CbU4kEl-dxppbpD0pvAfu3I7, accessed 13 January 2022).


9.3 Further reading

**Government review documents on the New Zealand health system**

**Additional reading**
• Morgan G, Simmons G (2009). Health cheque: the truth we should all know about New Zealand’s public health system. Wellington: Morgan Family Charitable Trust.

9.4 Useful websites
See Chapter 2.


Te Aka Whai Ora / Māori Health Authority website: https://www.teakawhaiora.nz/

Te Whatu Ora / Health New Zealand website: https://www.tewhatuora.govt.nz/

WhaiKaha / Ministry of Disabled People website: https://www.whaiKaha.govt.nz/

9.5 Health Systems in Transition methodology and production process
Health Systems in Transition (HiT) reports are produced by country experts in collaboration with an external editor and the Secretariat of the Asia Pacific Observatory based in the WHO Regional Office for the Western Pacific in Manila, the Philippines, or the European Observatory based in Brussels, Belgium (depending upon the country/region). HiTs are based on a template developed by the European Observatory on Health Systems and Policies that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context.

The most recent template is available online at: https://apps.who.int/iris/handle/10665/208276
Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Data are drawn from information collected by national statistical bureaus and health ministries. Furthermore, international data sources may be incorporated, such as the World Development Indicators of The World Bank.

In addition to the information and data provided by country experts, WHO supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the Western Pacific country health information profiles (CHIPs) and the WHO Statistical Information System (WHOSIS). HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are subject to wide consultation throughout the writing and editing process, which involves multiple iterations.

They are then subject to the following:

- A rigorous review process consisting of three stages. Initially, the text of the HiT is checked, reviewed and approved by the Observatory Secretariat. It is then sent for review to at least two independent experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant Ministry of Health, or appropriate authority, and policy-makers within those bodies to check for factual errors within the HiT.
- There are further efforts to ensure quality while the report is finalized, which focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and, in close consultation with the authors, ensures that all stages of the process are taken forward as effectively as possible.
9.6 About the author

Dr Jacqueline Cumming is an independent health services research and policy consultant in New Zealand. She has extensive experience in public and health policy, having previously worked in a range of policy roles, including in the Department/Ministry of Health. Most recently, she worked as a researcher and Director of Te Hikuwai Rangahau Hauora/Health Services Research Centre, and as a Professor of Health Policy and Management at Victoria University of Wellington. She has 30 years’ experience as a health services researcher and evaluator, analysing major reforms of the New Zealand health system. She has coordinated Health Policy and Monitoring and Evaluation courses for postgraduate, post-experience students and has supervised many PhD students examining aspects of the New Zealand health system. She is the co-editor of the *Journal of Health Services Research & Policy*, an international academic journal focusing on health policy issues and analysis.
Asia Pacific Observatory on Health Systems and Policies (APO) publications to date

**Health Systems in Transition (HiT) review (20 countries)**
- The Fiji Islands (2011)
- The Philippines (2011 & 2018)
- Mongolia (2013)
- Malaysia (2013)
- New Zealand (2014)
- Lao People's Democratic Republic (2014)
- The Republic of the Union of Myanmar (2014)
- Solomon Islands (2015)
- The Kingdom of Cambodia (2015)
- Bangladesh (2015)
- Republic of Korea (2015)
- The Kingdom of Thailand (2015)
- The Kingdom of Tonga (2015)
- People's Republic of China (2015)
- The Republic of Indonesia (2017)
- The Kingdom of Bhutan (2017)
- Japan (2018)
- Sri Lanka (2021)
- India (2022)

**Policy brief (16 series)**
- The Kingdom of Thailand (2016)
  Health system review: achievements and challenges
- Bangladesh (2017)
  Improving the quality of care in the public health system in Bangladesh: building on new evidence and current policy levers

**HiT policy notes (four countries)**
- The Republic of the Union of Myanmar (2015)
  #1. What are the challenges facing Myanmar in progressing towards Universal Health Coverage?
  #2. How can health equity be improved in Myanmar?
  #3. How can the township health system be strengthened in Myanmar?
  #4. How can financial risk protection be expanded in Myanmar?
- The Kingdom of Cambodia (2016)
  Increasing equity in health service access and financing: health strategy, policy achievements and new challenges

**Comparative country studies (seven series)**
- Public hospital governance in Asia and the Pacific (2015)
- Case-based payment systems for hospital funding in Asia: an investigation of current status and future directions (2015)
- Strategic purchasing in China, Indonesia and the Philippines (2016)
- Health system responses to population ageing and noncommunicable diseases in Asia (2016)
- Resilient and people-centred health systems: progress, challenges and future directions in Asia (2018)
- Integrated care for chronic diseases in Asia Pacific Countries (2021)

The APO publications are available at https://apo.who.int
The Asia Pacific Observatory on Health Systems and Policies [the APO] is a collaborative partnership of interested governments, international agencies, foundations, and researchers that promotes evidence-informed health systems policy regionally and in all countries in the Asia Pacific region. The APO collaboratively identifies priority health system issues across the Asia Pacific region; develops and synthesizes relevant research to support and inform countries’ evidence-based policy development; and builds country and regional health systems research and evidence-informed policy capacity.