The New Zealand health system after 75 years: let’s stop and smell the roses

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As Professor Robin Gauld discusses in an article in this edition of the NZMJ, this year is the 75th anniversary of the 1938 Social Security Act, which laid the foundations for the New Zealand public health system as it is today. Birthdays are usually a time for celebration, as well as a time to reflect on both the past and the future. So what do we have to celebrate?

According to the Minister of Health: “The New Zealand health system is performing well…Almost 90% of New Zealanders report that they are in good health…Life expectancy continues to rise. In 2010, life expectancy at birth in New Zealand stood at 81.0 years, more than 1 year higher than the OECD average of 79.8 years.”

Other indicators of improving health status include: infant mortality has fallen to a record low (at 4.2 deaths per 1000 live births), 93% of children under 2 years of age are now fully vaccinated, and smoking rates continue to decline, especially amongst youth.

Of course, many other factors have contributed to these improvements in health status other than the health system. So what other indicators do we have of the performance of the health system? Three domains that are commonly used to assess health system performance are access (including timeliness), quality, and cost (or value for money).

Universal access to free, high quality care in public hospitals for everyone with an urgent or essential need is certainly a cause for celebration. Timely access to non-urgent care is also rapidly improving, with the Minister of Health’s target for elective surgical procedures increasing the numbers of operations being performed in public hospitals and reducing surgical waiting times.

Between November 2008 and April 2012, an additional 1078 full-time equivalent (FTE) doctors and 2445 more nursing FTEs were employed in the public health system, bringing the number of FTE doctors in New Zealand public hospitals to 7008 and nurses to 20,781, and thus facilitating further expansion of services provided by the district health boards (DHBs).

Gauld discusses some problems of access to primary medical care, especially in relation to copayments for general practitioner (GP) services. Yet timeliness and physical access to primary health services are generally very good, with 84% of people reporting that they are able to see a GP within 24 hours.

Unlike many countries, almost all practices have a practice nurse which reduces the pressure on GPs, expands the scope of services provided, and keeps the costs down for some patients.
Access to after-hours care has also improved significantly in recent years. In a 2012 survey, only 72 (6%) of 1152 patients attending a GP considered that the opening hours were too restricted while 75% knew how to get after-hours access if required.\(^6\)

With regard to quality, one legacy of the series of health reforms that have been implemented in New Zealand over the past two decades has been the emergence of a culture of quality throughout the system. Many agencies and organisations have contributed to this shift including DHBs (many of which have developed strong quality improvement programmes), the Office of the Health and Disability Commissioner, Independent Practitioner Associations (IPAs), Primary Health Organisations (PHOs), and most recently, the Health Quality and Safety Commission. Resultant improvements in the quality of our health services are too numerous to mention here but, to the extent that they have improved the experiences of patients, are surely worthy of celebration.

As far as cost is concerned, New Zealand spends an average of US$3182 per person per year compared with US$3800 in Australia and US$3322 for the OECD average.\(^7\) While our lower expenditure largely reflects the fact that NZ’s GDP is lower than many OECD countries, the coverage and quality of our health system is comparable to that of many wealthier countries suggesting that we get pretty good value for money.

Here it is opportune to acknowledge the sterling work done by New Zealand’s Pharmaceutical Management Agency (Pharmac) in keeping the prices of pharmaceuticals down over the past 20 years. Analysis by the Commonwealth Fund indicated that, in 2006/07, the prices in New Zealand of 30 commonly prescribed drugs were around two-thirds of the average price of 9 other countries, and one-third of the average price paid in the United States.\(^8\) In 2011, annual expenditure per capita on pharmaceuticals in New Zealand was just US$298 compared with the OECD average of US$495.50.\(^6\)

Another cause for celebration is that, unlike many other OECD countries, New Zealand governments have continued to invest tax funds into the health system. The public share of total expenditure has been slowly increasing in recent years and now accounts for about 83% of total expenditure compared with the an average of 77% across all OECD countries.\(^6\) This has resulted in a concomitant fall in the share of health expenditure that is accounted for by out-of-pocket payments from 17% of total health expenditure in 2001 to 10.9% in 2011. This is the fourth lowest in the OECD, with only the United Kingdom, France and the Netherlands reporting lower shares of expenditure paid out-of-pocket.

Perhaps the greatest cause for celebration is the mere fact that a collectively-funded, universal public health system exists in New Zealand, and is likely to continue to do so for many years into the future. Clearly there is still room for improvement in some areas—and Gauld discusses a number of these. There will also be ongoing challenges, especially in terms of how to manage the burgeoning cost of long-term chronic conditions such as diabetes and dementia and the need to continue reducing ethnic inequalities.
But we can be grateful that we have in place a health system that is well-placed to plan services and develop processes for managing these challenges. On behalf of all New Zealanders, thank you Michael Joseph Savage!

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