

**A CURRENT TALE OF TWO COUNTRIES:
HEALTH CARE REFORM
IN NEW ZEALAND AND IN THE UNITED STATES**

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In National Health Systems Of The World, Milton Roemer provided us with a scheme for national health systems based on economic level and degree of market intervention policies. The only country in the Industrialized and Entrepreneurial category is the United States, my country. This uniqueness I suppose can be traced all the way back to our American Revolution. We have maintained an avoidance of a strong central government. New Zealand on the other hand is listed with Great Britain and Norway in the Industrialized and Comprehensive, Universal category. I was interested in examining New Zealand's health policies because it has a history of progressive social legislation. It was the first country to grant women the right to vote, and the first country, with a free-market economy, to cover its entire population via taxes with a social security system that included medical, hospital and related social benefits.

The United States is a federated nation, highly decentralized in policy development and implementation. The US has a Constitution-based separation of powers separating the activities of the executive, legislative and judicial branches of government. Additionally, there is a well-financed collection of special interest lobbies that have access to elected officials. This intricate, complex, pluralistic system of checks and balances discourages rapid change in policy and encourages bargaining and compromise. It is easy to defeat change, particularly comprehensive legislation, and to maintain the status quo. Thus, legislation that is passed by Congress or state legislatures and eventually implemented through executive bureaucratic regulation and contested in various levels of courtrooms very often is weak and incremental.

In contrast, New Zealand has a democratic parliamentary system of government with a unicameral House of Representatives. This system concentrates authority in a central government. Thus, the majority party is much more able to bring about quick changes and sweeping changes. (Blank, 1994) As has been mentioned, New Zealand has had a long history of supporting social services and a long tradition of public hospitals providing high quality care. However, in 1983 New Zealanders found themselves shaken by a set of sweeping health reforms that would cause them to begin questioning their leaders.

During the 1980s, the United States and New Zealand, like other affluent industrialized countries, experienced high inflationary economies, fueled in part by escalating health care costs, changing and difficult to predict disease patterns, continuing costs of new health-related technology, an aging population who spoke of their growing expectations of the marvels of modern medicine.

With a cry for accountable government, hard questions were asked. “In regard to health care, what should be the role of government versus the private market?” “Should more control be given to the central government or should control be decentralized?” “ To what degree should patients participate in decisions about their health and public expenditures?”

In response, the New Zealand Parliament passed legislation that introduced a population-based funding formula for setting a global, national budget and regionally allocating resources. Literature suggests that this supply-side intervention is among the most effective means to contain costs. (Saltman & Figueras, 1998)

This was a radical change to the open ended practice of supplying health care that had been in effect since 1938. These new capped budgets were allocated not to the central Department of Health but to regional agencies. In addition, 27 local hospital boards were replaced by 14 new but still elected Area Health Boards. However, further legislation restructured the purchasing of care so that the purchaser and provider roles of the Area Health Boards were separated creating a quasi open market approach for purchasing services. Now purchasing would be managed by four Regional Health Authorities (RHA), each similar to a large Health Maintenance Organization. Their responsibilities were to analyze the needs of the people of the regional, to set the regional health policy and to purchase the services. The RHAs were given authority to purchase not only hospital services but also primary care, another move to remove this control function from the central Department of Health.

By 1993 Area Health Boards were abolished and replaced with 23 appointed Crown Health Enterprises which were to compete with private healthcare providers to win contracts for particular services funded by the RHAs. For profit insurance companies domestic and foreign are seeing this period of change in New Zealand's history as a window of opportunity. They are setting up new hospitals and have created a duplication of services in some areas. Aggressively the private companies now compete with public servants for contracts. This new, competitive market has expanded the private insurance market and the use of private hospitals and has spawned a diversity of purchasing arrangements. A managed care type of system has been created.

“Managed care has been defined as applying one or more of the following elements: limited choice of providers, selective contracting, financial incentives for providers, gatekeeping, physician profiling, utilization review, and organizational culture.” (Saltman & Figueras, 1998)

The RHAs decide the mix of services and types of contracts. So, the array of services vary from region to region. People grumble that if you are ill, you may or may not get treated depending on whether your region still has money for your procedure. However, there are efforts to establish a “core” set of health services that all regions will provide, defined as those services everyone should be able to afford and to access without waiting. Though some pharmaceutical companies no longer see some regions as viable markets and will not introduce new drugs there. Of course, if health care consumers do not like the benefits arranged by the RHA they may complement with private health insurance. However, some analysts worry about a widening gap between those able to purchase private insurance and those without the private purchasing power. They worry that a two tiered health care delivery system that runs counter the value of equality which undergirds New Zealand’s social compact will emerge. A lower tier for the poor that depends on a state funded minimum set of core services. While those wealthy enough for membership in the higher tier enjoy the latest high-tech procedures via private insurance.

Government officials counter that industrialized countries have always rationed their resources including health care. The new system, they reply, sheds more light on rationing decisions. In the past, general practitioners had the discretion to make implicit rationing decisions based on professional opinion. If the GPs were poor gatekeepers, the

government just increased the health care budget. However, with the current government's attempt to balance the health budget with others like education, income support and debt repayment, a new, explicit conversation about health care expenditures is taking place. An open conversation that government officials proclaim as fairer. If service levels are being altered or reduced in some regions which have been over-serviced in the past and levels of service are being increased for some consumer groups which have historically been under-served, then the reforms are working. What is needed is more "evidence-based guidelines and needs assessment procedures to verify rationing decisions, and officials say that they are under development.

New Zealand moved quickly with their overhaul. Some suggest that maybe it would have been better to have a more incremental set of changes. As one consumer told me, "They tore up the old system which wasn't perfect, but they tore it up without an understanding of what it takes to set up a new system."

During this same time period, during 1994, President Clinton offered a sweeping restructuring of America's health care system. Two of the most controversial parts of the proposal also were to establish a national health care budget and a set of federal quality standards. While misinterpreted by many, the Clinton plan supported competition within a private marketplace for various healthcare plans, a version of managed care. As an aside, managed care in the United States is really a misnomer. What is being managed is usually not care but costs. Managed care most often means laying new financial techniques on existing organizations. Little attention, to date, has been given to reorganizing delivery systems so that

services can be integrated and performance optimized. (Brown, 1997)
Virtually all health care reform today is driven by cost.

For a variety of reasons which I will not go into today, the Clinton plan got terribly distorted, lost it's focus. People feared a big government take over. Bill and Hillary's plan was lobbied out of consideration by the Congress. Let me give you two examples of the impact of money from lobbies in the United States. According to the Center for Public Integrity, when the Clinton healthcare reform legislation was being developed, \$100 million was spent by over 100 public relations firms and lobbies. \$25 million went to candidates seeking Federal election. Second, this year we have seen patient bill of rights legislation proposed in Congress. Insurers and their allies have fought hard against this legislation. So far an average \$112,000 per lawmaker has been spent to lobby Congress in the first half of 1999. (Salant, 1999)

Clinton's core assumption in his reform plan was that the Federal government would be required to make health care markets actually work. (Zelman, 1996) Lower prices would come with increased competition. As you know his legislation did not pass. Thus, without central government direction, the US has moved to a loosely unregulated managed care system.

Today about 92% of American physicians participate in some form of managed care. (Reno, 1999) According to the Institute for the Future, employers are increasingly shifting more health care costs to employees and employees are reacting by purchasing the lowest cost, managed care

plans. There will be 120 million people in HMOs by 2010. That is a 70% increase from the 70 million enrolled today.

Two countries, New Zealand and the United States, coming from very different histories of social policies are using market competition to address their health care economies. What have been the results of these decisions?

In New Zealand analysts report that the public is better informed and included in the hard decisions. The single purchaser has reduced the dominance of the acute care public hospital and now more money is going into areas such as mental health, child health, and environmental health expenditures. They believe that there have been efficiency gains but not necessarily cost effectiveness. (Frey, 1995)

Physicians have complained that there has not been enough physician input into policy decisions and more physicians are joining large multi-specialty groups. These responses are seen as political moves that are necessary to successfully compete and win contracts. Furthermore, many physicians do not like the concept of core services. They feel their latitude to make professional judgements is being eroded and that local boards only provide “lip service” to their complaints about stringent parameters of care. There are physicians who see these policy changes as just another set of changes that will not last, and with the huge increase in paperwork, they hope they will not last. But there is also a subset of physicians who are predicting that the new policies will lead to better quality of outcomes through opportunities to measure in new ways the quality of services by utilization review, monitored clinical indicators and education.

As I mentioned, the unique place of the hospital in the health care system has been challenged. Comprehensive services are being transformed into more specialized care institutions such as trauma care centers, but some report that an “emergency room” syndrome is emerging where patients wait for a health crisis to occur and then present themselves at emergency rooms for long overdue care.

Also, New Zealanders have emotional attachments to their public hospitals and are worried about these secondary care services. For example they fear that RHAs will fund private hospitals and eliminate the smaller local hospitals. Employees of public hospitals report a growing sense of insecurity and uncertainty. Sliding fee scales are replacing universal entitlements and the average citizen is distrustful about long queues and rationing decisions.

Anecdotal horror accounts are regular fodder for the popular press and are also seen as contributing to rising anxieties. Historically, New Zealanders have not fought the concept of waiting their turn for services. They believed that the most seriously affected patients should be treated first and are willing to wait their turn in line. This has been an issue of social justice. However, observers report a falling off of volunteerism within the system, and as waiting lines have grown longer, patients are becoming “consumers” not sure that their tolerance is contributing to the communal good.

In the United States, managed care has been cited as an economic success story. It is generally believed that managed care is responsible for slowing down soaring health care costs. During the 60s, 70s, 80s and the first part of the 90s, annual growth in health care averaged 11%. In the past five years, the average increase has been 6.75%. (Russell, 1999) There are opponents to managed care who dispute the success story by claiming that perverse consequences have been part of the managed care story such as: under treatment of patients, gag rules on physicians, restrictions on a patient's choice of providers and outlandish administrative overhead costs, costs that are often in the form of corporate salaries and proprietary company profits. Investigators suggest that in large managed care companies, 25 cents of every premium dollar are needed to cover management expenses. While in the government run program, Medicare, only about 5 cents of each dollar is needed to run the services. (Light, 1994)

Perhaps most troubling for the U.S. health care system is that in the last 10 years, the number of uninsured has increased by 40%. Today 43.4 million Americans are without health insurance. The Congressional Budget Office projects that that number will increase another 5 million in the next three years. (Wielawski, 1999) In California, my own home state, 7 million people lack health insurance and 50,000 people each month lose coverage. (Russell, 1999)

What can we predict for the future?

It appears that New Zealand has made a definite change in course. The country has said, There are limited resources and those free health care

resources that do exist should go to those most in need equally regardless of geography. Their priorities seem to have shifted to the health of the collective nation rather than the individual in the queue. A lack of advocacy for the individual patient is lamented.

In bringing about these changes, the central government also has shifted the public's call for accountability to the Health Funding Authority, the single purchaser, and away from itself. Whether elected officials can escape the wrath of the citizen remains to be seen.

While the stated vision of the new policies is to increase the emphasis on primary care and preventive care, the government has tried to contain any new expenditures to the budget. Pragmatically, they have tried to encourage the private insurance market while also trying to provide resources to those well managed public hospital enterprises. Particularly distressed by the "just purchase private insurance" option are the elderly who often retired have fixed incomes and have not saved money for healthcare needs. (They never believed that they would be expected to pay for health care.) Surveys indicate that the average citizen is unhappy with the way things are going and fear the further privatization of health services.

Finally, New Zealand has embarked on a major task, developing standards of consultation with service providers. These national standards across the health and disability sector are to reduce the inconsistencies in the quality of care. It is expected that all providers will be required to meet these national standards by 2002.

In the United States, major reform is not likely in the immediate future. Due to a good economy, the Medicare Trust Fund is not in crisis and the 2000 Presidential and Congressional campaigns will prevent risky legislation from passing. However, currently some work is underway to redesign Medicare from a defined benefit plan to a defined contribution plan where citizens would buy private insurance with help from government funds rather than the government purchasing care for citizens. This type of proposal certainly is in keeping with traditional US values. The US has a fascination with individual responsibility and individual preference, but the legislation is controversial.

Within the decade though, we could see a rise in consumer political activity about health issues. The large, post war, “baby boom” cohort will be nearing retirement age. This vocal cohort will have money and will demand more benefits, security, flexibility and coverage in their plans. I predict that they will get what they want due to their sizable potential political clout.

In the future, the US and other countries must address the issue of rising pharmaceutical costs. Currently, Medicare does not cover the costs of prescription drugs. So 19 million elderly have little or no drug coverage. Millions of other Americans also do not have drug purchasing plans and resort to many, dubious solutions. (Lagnado, 1999) When examining the 1999 first quarter profits of Aetna, one learns that it stopped routinely covering some of the most popular medicines for many of its members. HMO executives say they have no option but to pass on the soaring drug costs to their customers. (Galewitz, 1999)

The United States is still left with the hard questions. Who will control the costs of this potentially insatiable social function? The government? The insurer? The physician? In an affluent society like the United States, no administrative system is likely to survive if it severely restricts the freedom of patients to seek any physician they want to seek or gags a physician pledged to treat his/her patient. I believe that it will be increasingly clear that physicians should be the managers of health care treatment and not second-guessed by bureaucrats. In the future, their practices will be guided by evidence-based data, and they will accept the responsibility to manage our limited resources. This can be possible with properly designed information systems that disperse current clinical research to physicians, patients and payers. It is just a matter of time until these technological solutions are in place in the affluent nations. For example, the Kaiser Foundation Health Plan and the Kaiser Foundation Hospitals recently announced that they intended to spend up to \$1.5 billion to set up a high-tech clinical information system that doctors can consult to compare practice techniques with colleagues. (Staff, 1999) This kind of advancement will bring true efficiencies, reduced costs and will improve the quality of care.

In conclusion, I have discussed two different industrialized, affluent countries. Historically, they have approached the provision of health care for their citizens in very different ways. However, both are now moving toward more free market solutions in reaction to epidemiological, demographic and economic dynamics, and both governments are feeling the backlash of public dissatisfaction.

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