New Zealand embraces a parallel private system — and a growing gap between rich and poor

Heather Kent

New Zealand, the scenic island nation that once embraced a cradle-to-grave welfare-state philosophy, has undergone a cultural and economic revolution since the mid-1980s. And no area has been affected more than health care.

Visiting my native country this spring for the first time in 8 years was a striking experience. Gas cost 80 cents a litre, double the Vancouver price, and the Canadian dollar actually provided a 15% bonus.

Some things hadn't changed. The English-style villages and wooden bungalows were still there, and the lush vegetation still flourished in subtropical Auckland, which is home to about a third of the country's 3.8 million people.

But many other things were different, and the changes were hard to miss. Thanks to taxation reform, New Zealanders now enjoy a maximum tax rate of 33%. However, the once-cherished ideal of egalitarianism has been replaced by a harsher economic reality, and the gap between rich and poor has widened dramatically. This has created a new underclass that now appears to be firmly entrenched in New Zealand society. And no one knows this better than the country's doctors.

Dr. Janet Frater has practised family medicine in Auckland's low-income area of Mount Roskill for 18 years. About half of her patients receive social assistance, and helping them pay for their health care has become her number one priority. "We are constantly having to spend time in our consultations thinking about costs and how to get the system to work best for our patients. In the old days, we could spend time on patient education. There is so much that we have to fit into a consultation now. The other thing we struggle with is finding the cheapest drugs. A lot of the medications are not fully subsidized, and it changes every month. It's very difficult to keep up with it all."

$39 office fee

Although New Zealand doctors have charged patients directly for office visits for decades, fees in the 1990s are out of reach for many poorer patients. Frater frequently reduces or waives her $39 fee ($24 for those on social assistance). There is no fee for children under age 6; they are subsidized by the government. But a dispensing fee of $15 for adult prescription drugs and $10 for children's medications, as well as a separate $3 charge per prescription, adds to the financial burden. Frater often tries to help her patients by providing drug samples from her office cupboard.

Heather Kent

Dr. Janet Frater: "Profits have become much more important than people"

Faced with these kinds of costs, patients frequently delay office visits, and eventually arrive with long lists of problems. While patients are still well-served by public hospitals for emergency surgery, Frater says, delays arise when people need investigation at outpatient clinics. "It's the ones who need a barium enema or colonoscopy [who have problems]. . . . You have to work out whether they are going to get into the surgical outpatient clinic quicker than the barium enema clinic; it may be quicker to send them to the gastroenterology clinic. This kind of juggling takes extra time and energy."

The waiting time for a barium enema in a public clinic is up to 3 months, compared with 3 days in a private clinic; a surgical outpatient appointment may take 5 months.

Whither the social conscience?

Has New Zealand lost its social conscience? Frater is unequivocal: "The government puts far too much emphasis on user-pay and does not really realize how difficult it is for people on low incomes. Profits have become much more important than people. Before, we thought totally about the best thing for the patient. I'm finding it very difficult."

Frater says things are worse for general practitioners than before the reforms (see sidebar). "When I talk to my colleagues, they also say the rapidity of the change has led to a huge increase in the amount of paperwork and a lot of extra stress. A lot of us really enjoy general practice, but morale has gone down."

The Royal New Zealand College of General Practitioners recently produced a "self-care" package for stressed doctors, and peer groups in independent practitioners associations (IPAs) offer psychological support, she says. Frater joined her IPA (see sidebar) 4 years ago and is happy to let it negotiate with government on her behalf. She also appreciates the benefits of office computerization, monthly meetings and guidelines for cheaper drug prescribing. And she no longer does on-call work; her group practice has paid an urgent medical service to cover emergencies for the last 15 years.

The incomes of New Zealand's family doctors have declined over the last 10 years, but Frater doesn't want to increase her fees because of the impact on patients. Instead, she would like to see more taxation directed to health care; with a national election slated for November, she is hoping that the political pendulum will swing closer to Canadian-style medicine.

$3600 for full coverage

Across town, in Auckland's affluent St. Heliers Bay, Dr. Graeme Washer is more optimistic about the new directions family medicine is taking. "I'm cautiously happy about where we are going. I think we are going through a very immature phase of what is ultimately a correct direction." Washer, a family doctor and general surgeon, divides his time equally between his family practice and performing surgery in private hospitals.

New Zealand's private hospitals perform only elective surgery, although they will soon treat patients sent by the Accident Compensation Commission as well. At least 80% of Washer's patients carry private insurance. "There needs to be a financial incentive for the patient to value the service," says Washer, who admits that "it is going to take a while for the population to get on board."

About half of New Zealanders were covered by private insurance 10 years ago, but that has dropped to about 30% now. "As the government moves further away from the provision of health care generally, which it clearly is doing, insurance companies have been caught and have responded by raising premiums," explains Washer.

Many seniors, whose rates typically double or triple when they reach age 60, have dropped their coverage. Some younger people prefer to hedge their bets when weighing the insurance costs against their perceived risk of needing hospitalization. Annual premiums for a family of 4 range from about $800 annually for elective surgery insurance to $3600 for a full range of coverage that includes diagnostic tests, specialist appointments, prescriptions, paramedical care, hospitalization and visits to the family doctor.

Despite the rising costs and diminishing clientele, Washer says private "surgical throughput has clearly increased, particularly in areas like orthopedics. Elective orthopedics is one of the major areas where the public system is failing, certainly in Auckland."

Heather Kent

Dr. John Arcus, shown here at a Maori *marae* (meeting place) near his practice in Auckland: "disgraceful" waiting lists

Charging by the minute

The number of day-stay clinics for outpatient surgery is growing, and a luxurious new private facility — the Ascot Hospital — opened in March. It charges for surgery by the minute, and already has a $1-million contract with the government to treat some of the patients on the waiting list for hip and knee-joint surgery. The wait for these procedures at public hospitals can be up to 5 years.

Dr. John Arcus operates in medicine's middle ground. He runs his own family practice in a "very mixed" socioeconomic area in the north shore Auckland suburb of Beachhaven. His patients range from Maoris — New Zealand's native people — and Polynesians at the lower economic end of the economic scale to people living in $500 000 clifftop homes.

Arcus, who chairs his local IPA, feels that things are worse now for family medicine than before the raft of reforms. He says the patient is no longer "central" in the business of arranging care. "There are still huge barriers to secondary care," he says, calling waiting lists at public hospitals "disgraceful."

He cites a number of threats to family medicine, including the growth of walk-in clinics — there are now 20 in Auckland alone — which he says are "skimming the cream" and leaving difficult cases for others. Obstetrics, which Arcus has given up, is no longer economical for family doctors; he estimates that fewer than than 10% of Auckland's general practitioners still deliver babies. In New Zealand, midwives are heavily involved in hospital births.

Arcus says FPs have had to change their focus to providing more community-based preventive care. He and other family doctors are now actively building relationships with community agencies. For example, they have been cam-

paigning at food outlets in the local shopping mall to reduce fat used in food preparation. There is also a move to "enrol" people who have no family doctor — about 10% of the population on the north shore — with a primary health care provider.

The recent introduction of Maori health providers has been "a real success story," he says. Only about 5% of New Zealand's family physicians are Maori, but with preferential entry rules boosting the number of Maori students at the University of Auckland's medical school to 15% of the total, this could soon change.

"Profits have become more important than people."

Despite his unhappiness with the changes in family medicine, Arcus says he enjoys a "lot better" quality of life today: there are no obstetrics cases, and his nightly on-call work has been reduced to once every 2 months. He says medicine "remains a respected profession, although less so than 15 years ago."

Are there too many doctors in the country? Arcus says there is probably an oversupply of family physicians in the cities, but a severe shortage exists in some rural areas.

That shortage of doctors is just one of many problems that sets rural family medicine apart from its urban counterpart. Ron Dunham is the chief executive of Pacific Health, which manages health care for the 180 000 people in the east coast's Bay of Plenty area. Access to care is a major problem in "economically extremely depressed" areas, where significant numbers of patients can't reach a hospital because they don't own a car. The "one-size-fits-all" purchasing approach introduced by the Health Funding Authority doesn't work for these areas, he says.

For example, a district nurse's visit costs $40, but in remote areas of the East Coast the nurse may have to travel by 4-wheel drive or even horseback to reach patients who live 4 hours from the nearest hospital. As well, cultural barriers sometimes hamper care for Maoris. "We inherited a British colonial health system that doesn't fit Maori culture," Dunham says. Like Arcus, he welcomes growing Maori participation in health care.

"The rural population isn't large," says Dunham. "Health inequities cost us all money. I frequently see costs incurred that could have been prevented quite easily."

He says New Zealand could learn a lot from its south Pacific neighbour, Australia, where physicians in remote locations receive much stronger support.

Heather Kent is a Vancouver journalist.

Political winds of change blast through New Zealand

New Zealand's major health care reforms followed a 1991 government report recommending a competitive ethic among hospitals and family practitioners. This was the start of a fundamental cultural shift in New Zealand medical practice, away from conventional collaborative practice and toward competitive practice.

In 1992, 4 regional health authorities (RHAs) were formed: 3 in the country's more populous North Island and 1 in the South Island. Hospitals were grouped into "Crown health enterprises" and told to compete with one another for patients.

Also in 1992, the government and the New Zealand Medical Association published a report, *Independent Practitioner Associations in New Zealand - Policy Issues,* which recommended that family doctors form geographically based associations, called IPAs (independent practitioners associations).

The IPAs were to manage resources for drugs and laboratory procedures through "budget holding." With the cost of prescriptions rising at an annual rate of 10%, the government was anxious to reduce costs. Physicians were enticed to join by the promise that any savings gained would be shared between themselves and the government. These savings, averaging 10%, are used for continuing medical education, office computerization and staff training after IPA operating expenses have been covered. The first IPAs were formed in 1992; there are now 50 throughout the country, representing about 85% of New Zealand's family doctors. Their membership ranges from 8 to 330 physicians. Members may become shareholders within their IPA; IPA contracts with the government are open-ended and can be renegotiated at any time.

In 1997, recognizing the failure of the RHAs to generate competition, as well as disparities in health care delivery around the country, the government replaced them with a central agency — the Health Funding Authority — that is based in Wellington, the country's capital. While still maintaining the previous split between the funders and providers of health care, this move changed the style from a competitive to a collaborative approach.

Starting this July, the Accident Compensation Commission, a Crown corporation that covers health care costs for accidents from any cause, began contracting out hospital services for workplace accident patients to the private sector. These patients will be treated in private hospitals, reducing their waiting times for surgery and potentially speeding up their return to the workforce.