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**The New Zealand Policies  
to Reduce Inequalities of Access to Healthcare**

A thesis presented in partial fulfillment of the requirement for the degree of  
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## Abstract

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This research aims to provide an insight into different policies and strategies in addressing issue of inequality of access to healthcare in New Zealand's health system. Inequalities in health exist between ethnic and socioeconomic groups, people living in different geographic areas, people belonging to different generations, and between males and females. In New Zealand, as in most countries, socially disadvantaged and marginalized groups have poorer health, greater exposure to health risks, and lesser access to high-quality health services. The research attempts to pinpoint policies based on equity to promote equal access to healthcare in order to reduce inequality in health.

The research design is a qualitative research and utilized system theory and policy analysis approach. The researcher derived information from primary and secondary data, and analyzed the issue of equal access to healthcare from Social Democracy, Neo-Liberal and Third Way perspectives. The main difference in the abovementioned perspectives is the perceived role and responsibility of the State in promoting equality of access to healthcare. The focus of the research is equity policy for Māori and Pacific people to access healthcare at primary care level.

The findings discover that New Zealand has shifted from mainly universalism approach to a mix of universalism and targeted benefits approach; it also shifted from mostly State sector provision to a mix of public and private sector provision, and partnership with non-profit sector. Māori and Pacific health providers are also encouraged. The key lever of the equity policy is the Primary Health Care Strategy.

The thesis concluded that, being so used to swinging between different ideologies and reforming the health system accordingly, New Zealand government should make use of experiences from a readily available and proven established strategy rather than engage in further radical reform. Additionally, the government needs to find balance between universalism and targeted benefits.

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I have come to believe that the whole world is an enigma -  
a harmless enigma that is made terrible by our own mad attempt to interpret it,  
as though it had an underlying truth.

**Umberto Eco - Foucault's Pendulum**

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## CHAPTER 1 Introduction

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Progress in health status such as life expectancy and infant mortality rate at aggregate data is usually accompanied by substantial variation within and across countries. Wade (2001, pp. 23-27) suggested that inequality has increased rapidly in recent decades amid the acceleration of globalization. He (Wade, 2001, p. 27) argued that economic development often brings about the improvements in infrastructure and living conditions, but it could also widen income inequality and decrease the care of basic human needs.

Consequently, governments in industrialized societies have begun to focus on inequalities in both the rates and risks of poor health between population subgroups. In several countries, the goals of public health policy have been widened from concern with improving population health to a broader commitment to promoting both health and health equality. Health impacts of inequality, poverty, economic deprivation and weak social cohesion no longer could be ignored (Wilensky, 2002, p. 626). In the new policy agenda, the goals of promoting health and reducing health inequalities are often brought together through an overarching commitment to tackle determinants.

Health policy is comprised of courses of action that affect the set of institutions, organizations, services and funding arrangement of the health system (Buse, Mays, & Walt, 2005, p. 6). The content of a policy is usually the strategy to achieve set goals. Health policy making involves the dynamic interaction between who makes and/or influences policy making, how they exercise that influence and under what condition (Buse et al., 2005, p. 6). Thus, policy could not be separated from the values and ideologies of the policymakers; these values and ideologies are fundamental to the policy process and usually refer to an underlying philosophical commitment. Different values and ideologies may lead to different policies.

Irrespective to differences in values and ideologies, health systems of any given country at any given time should aim to enhance the health of individuals and communities. Efficiency, effectiveness and equity assessment usually provide intermediate evaluative indicators of the health system (Aday, Begley, Lairson, & Slater, 1998, p. 11). Most importantly, inequitable access to healthcare by income can contribute to and exacerbate disparities in health and quality of life. Conversely, policies that seek to promote equity in access for lower income individuals offer the potential of moderating underlying health differences and, over the longer term, providing more equal opportunities for health and productivity.

Consistently, the New Zealand health strategy (King, 2000, p. 3) explicitly aims for:

- A health system that all New Zealanders can trust.
- A health system that is there when people need it, regardless of ability to pay.
- A health system that makes a real contribution to reducing inequalities between the health status of Māori and Pacific people, and other New Zealanders.

This research aims to demonstrate whether the New Zealand government lay down policies accordingly to meet the health strategy that contribute to reducing inequalities between the health status of Māori and Pacific people, and other New Zealanders.

## ***1.1 Literature Review***

First of all, we need to clarify the concept of equity. Although some people use the term “equity” and “equality” interchangeably, they actually mean a different thing. An author illustrated this as a case of dividing a loaf of bread to a group of people (Barker, 2000, p. 117). If we were going to distribute the bread according to the principle of ‘equality’, we would slice and distribute the bread equally, giving each the same amount of bread. On the contrary, if we were going to distribute the bread based on the principal of ‘equity’, we would define some criterion to decide who gets the most of the bread, possibly based on inequality in hunger, nutritional status or wealth between these people.

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Accordingly, equity has two aspects: horizontal and vertical. Horizontal equity refers to similar treatment of those in similar circumstances, while vertical equity refers to different treatment of different people in order to reduce the consequences of innate differences (Poutasi, 2000, p. 137).

Evaluating how health systems perform means looking at what they *achieve* and at what they *do* i.e. how they carry out certain *functions* in order to achieve anything (Blank & Burau, 2004, pp. 19-21). A good health system, above all, contributes to good health. However, it is not satisfactory to protect or improve the average health of the population if at the same time inequality worsens or remains high because the gain accrues disproportionately to those already enjoying better health. Thus, the health system also has the responsibility to try to reduce inequalities by preferentially improving the health of the worse-off, wherever these inequalities are caused by conditions amenable to intervention.

The objective of good health is in fact twofold: the best attainable average level (*goodness*) and the smallest feasible differences among individuals and groups (*fairness*)(Healy & McKee, 2004, p. 2). A gain in either one of these, with no change in the other, constitutes an improvement, but the two may be in conflict. It is desirable to raise the average level, or to reduce inequality, or both, and sometimes to judge the relative values of one and the other goal.

“Goodness” means the system responds well on average to what people expect of it, with respect to its non-health aspects (Healy & McKee, 2004, p. 2). While “fairness” means that it responds equally well to everyone, without discrimination or differences in how people are treated (Healy & McKee, 2004, p. 2). The distribution of responsiveness matters, just as the distribution of health does, as either one is valuable by itself.

We need to point out that the health system differs from other social systems as well as most consumer goods and services. Healthcare can be catastrophically costly. Much of the need for care is unpredictable, so it is vital for people to be protected from having to choose between financial catastrophe and loss of health. This is the

very reason why fair financing is an important issue. Arguably, there is no overall notion of 'goodness' related to financing. There are good and bad ways to raise the resources for a health system, but they refer to how fairly the financial burden is shared. In contrast, fair financing is concerned only with distribution. It is not related either to the total resource bill or to how the funds are used. Hence, it is not always better to spend more on health; because, at high levels of expenditure there may be little additional health gain from more resources.

Having said that, how the system treats people's health needs and how it raises revenues from them, including how much protection it offers them from financial risk, carries some weight. Current health systems are modeled to varying degrees on one or more of a few basic designs that emerged and have been refined since the late 19th century. One of these models is to cover all or most citizens through mandated employer and employee payments to insurance or sickness funds, while providing care through both public and private providers (Bodenheimer & Grumbach, 2002, p. 7). The earliest such social insurance systems usually evolved from small, initially voluntary, associations, while later versions have sometimes been created by public action. Another model centralizes planning and financing, relying primarily on tax revenues and on public provision (Bodenheimer & Grumbach, 2002, p. 10). Resources are traditionally distributed by budgets, sometimes on the basis of fixed ratios between populations and health workers or facilities. In another model, state involvement is more limited but still substantial, sometimes providing coverage only for certain population groups and giving way for the rest of the populace to largely private finance, provision and ownership of facilities (Bodenheimer & Grumbach, 2002, p. 5). There had been a lot of debates on whether one way of organizing a health system is better than another, but what matters about a system's overall structure is how well it facilitates the performance of its key functions.

Health system comprises three sub-systems, namely funding/financing, provision and governance (Blank & Burau, 2004, p. 59). The purpose of healthcare financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal healthcare (OECD, 1992, p. 19). This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a

result of trying to do so. In other words, healthcare financing should reduce financial barriers to access healthcare.

To ensure that individuals have access to health services, three interrelated functions of health system financing are crucial: revenue collection, pooling of resources, and purchasing of interventions (Blank & Burau, 2004, p. 59). The main challenges are to put in place the necessary technical, organizational and institutional arrangements so that such interactions will protect people financially in the fairest way possible, and to set incentives for providers that will motivate them to increase health while improving the responsiveness of the system.

Countries might vary widely in the extent to which public financing of healthcare and rules governing insurance markets seek to promote equal access and healthcare experiences across income classes and population groups. Even countries with universal coverage also differ in benefit design, patient-cost-sharing, and the role of private insurance. Furthermore, non-financial barriers, such as waiting lists or queues, cultures, infrastructures, as well as financial barriers may contribute to inequalities of access to healthcare.

Since the 1980s economic and political factors have put a lot of pressure to constrain social spending and call of the need for greater efficiency and effectiveness. To many, it also raised a question of government's role and responsibility. The unfortunate result appears to be a shift in social values away from ensuring the good of all towards increasing immediate economic opportunities for some. Another way to put it was that it is not the State's job to provide an easy life, but rather to foster economic growth so that people could choose and purchase their own services such as health (Shannon, 1991, p. 48). The hope is that by placing first priority on efficiency and overall economic growth, societies can break out of the vicious cycle of poverty and underdevelopment, and then the benefit will trickle down to all.

Studies have shown strong correlation between the size of income gaps in some countries and states within countries and the health of their populations that are not explained by the absolute level of income (for instance see Kennedy, Kawachi, & Prothrow-Stith, 1996; Lahelma, 1994; Wilkinson, 1992). A lesson drawn from

evidences in Asia, Africa, Europe and the America is that economic growth does not automatically lead to equity (World Health Organization, 1996, p. 26). It might create an opportunity to achieve more equity, but only when there is strong commitment and sustained series of actions toward equity goals.

Inequalities in access to and decisions over healthcare resources are among the primary causes of health inequalities. Differential access to health services and in the quality of care provided to patients also contributes to unequal health outcomes. In this light, we understand that pursuing equality in health and pursuing equity in healthcare means a different thing. Pursuing equality in health means that there is high standard of real access, quality, and acceptability of health services for all. While equity in healthcare means that healthcare resources and health services are allocated according to need, while the payment for the services is made according to ability to pay (World Health Organization, 1996, p. 21).

It is clear that real access to healthcare is not merely about the ability to pay for it. It also about the availability of health services facilities that are close to where people live, accessible by transportation, culturally acceptable, and capable of providing appropriate care in timely manner and in a language spoken by those who need assistance (Bodenheimer & Grumbach, 2002, p. 25-26). These factors comprise the non financial barriers to healthcare.

Concurrently, a health system also should take account of increasingly diverse population, particularly since this diversity is growing with greater movements of people between countries in an increasingly global world. There are several reasons why a health system should do this. Firstly, governments have committed to doing so. There are several legal and morally authoritative frameworks for this notion, for example (Healy & McKee, 2004, p. 8):

- The *Universal Declaration of Human Rights* 1948 had recognized the right to health and the right to non-discrimination
- The United Nations *International Covenant on Economic, Social and Cultural Rights* 1966 required governments to identify any groups within their populations whose health situation is significantly worse than that of the

majority and whether policies and measures have been taken to improve this situation

- The *Health 21: Health For All in the 21<sup>st</sup> Century* stated that equity underpins the concept of health for all and calls for the removal of unfair and unjustified differences between individuals and groups.

Secondly, there is ‘the inverse care law’ which signaled that those whose health needs are greatest and who are often to be found among marginalized groups in society often have the worst access to care (Healy & McKee, 2004, p. 11), while those with least need will use the services more (Broom et al., 2007, p. 12). Thirdly, international agencies have recognized equitable and affordable healthcare policy as one of the key elements in an integrated anti-poverty strategy (Healy & McKee, 2004, p. 10). Fourthly, there is a trend toward poly-ethnic society. Countries such as United States, Canada, Australia and New Zealand have become multi-ethnic societies specifically as European settlers have displaced the indigenous population, along with the number of new immigrants and refugees (Healy & McKee, 2004, p. 12). For instance, the population of Auckland, the largest city in New Zealand, comprises of European descendants and 11.1% Māori, 14.4% Pacific people, and 18.9% Asian people (Auckland Regional Council, 2007).

In New Zealand, as elsewhere, inequalities in health exist between ethnic and socioeconomic groups, people living in different geographic areas, people belonging to different generations, and between males and females. These inequalities are not random. Studies demonstrated that socially disadvantaged and marginalized groups have poorer health, greater exposure to health risks, and lesser access to high-quality health services (for instance see Dahlgren & Whitehead, 1991; Gwatkin, 2000; Lahelma, 1994; Nazroo & Smith, 2001; Roberts, Hsiao, Berman, & Reich, 2004; World Health Organization, 1996). Furthermore, WHO study found that indigenous people tend to have poorer health (World Health Organization, 1996).

In New Zealand, these socially disadvantaged and marginalized groups include, but are not limited to: Māori, Pacific people, people with disability and people with language barriers such as new migrants, refugees and political asylum seekers.

Barriers to accessing healthcare for these groups might include language and communication difficulties, lack of access to appropriate information, lack of culturally sensitive services in relation to religious and cultural needs, institutional racism, different health belief systems and procedures, negative previous experiences of the health and social services, attitudes of some health staff, fears about entitlement to healthcare and so on and so forth (Kai, 2003, p. 93). However, to limit the scope of the research, this thesis will only address the issue of inequality relating to those of Māori and Pacific people.

The regulated economy of the late 1970s and early 1980s featured subsidies to control price and wage fluctuations, state housing and mortgage subsidies for low-income people, and low unemployment rate. However, starting apace from 1984 to at least 1993, successive governments implemented major reforms to the relationship of the state with the public by deregulating the financial sector, reorganizing the state sector, and ending state support for industry (for instance see Belich, 2001; Dalziel, 1999). Some results of these reforms included a substantially flattened tax system, fully targeted income support, a regressive consumption tax (GST), privatized major utilities, user charges for health, education and other government services, and a restructured labor market designed to facilitate 'flexibility' (Dew & Kirkman, 2007a, p. 249). These changes resulted in substantially widened income inequalities in New Zealand. Some even argued that benefit cuts in 1990 resulted in the mean equivalent disposable income of households with a beneficiary dropping significantly (for instance see Dalziel, 1999; Mowbray, 2001).

The social and macroeconomic changes did not impact equally on Māori and non-Māori. Māori leaders had warned that such economic reforms would make Māori the 'shock absorbers in the economy' (Watene-Haydon et al., 1995, p. 149). Indeed, studies by Howden-Chapman and Tobias (2000) demonstrated that inequalities between Māori and non-Māori widened in employment status, education, income, and housing, all of which are key social determinants of health. Other studies indicated that unemployment rates for Māori rose from levels similar to those of non-Māori in the early 1980s to three times those of non-Māori in the late 1980s, while real incomes of Māori households dropped during this period and did not recover to the level they had reached in the early 1980s (Blakely et al., 2005, p. 2245).

Throughout the period of 1980s to 1990s, Māori experienced higher mortality rates than non- Māori within all income groups; while for people aged 25–59 years, the mortality rates for Māori with high incomes were similar to, or higher than, mortality rates for non- Māori in the low-income group (Ministry of Health and University of Otago, 2006, p. 17). The gap between life expectancy of Māori and non-Māori had narrowed over the years, but the rate of improvement for Māori appears to have slowed (Davis & Ashton, 2000, p. 8).

Meanwhile, the situation for Pacific people is similarly disadvantaged. The population of Pacific people living in New Zealand is made up of seven main ethnic groups: Cook Island Māori, Fijian, Niuean, Samoan, Tokelauan, Tongan and Tuvaluan (Statistic New Zealand, 2007b). The unemployment rate of Pacific peoples rose between 1986-1991 from 6.6% to 28% but then started to decline in 1992 to as low as 7.4% in 2004, lower than that of Māori (Ministry of Social Development, 2005, p. 48). However, while other ethnic groups had improvement in economic family units between 2001-2004, there was none for Pacific peoples (Ministry of Social Development, 2005, p. 65). The economic condition for Pacific people have stabilized and new opportunities have emerged, but never to pre-1992 level when the unemployment rate for Pacific people started to fall (Public Health Advisory Committee, 2004, p. 33). Census also indicated that the Pacific peoples are over-represented in lower paid employment (Southwick, 2005, p. 105).

Pacific people health status is similar to Māori in some areas and lower in others. For instance, the rate of ambulatory-sensitive hospitalization for Pacific people is generally lower than that of Māori, which indicated that Pacific people utilized more of the primary care (Southwick, 2005, p. 107). On the other hand, in the case of preventable hospitalization, the rate for Pacific people is generally higher than that of Māori, which indicated that they had not been reached extensively by population-based interventions (Southwick, 2005, p. 107). The proportion of Māori and Pacific people affected by the income–mortality relationship is greater than for non-Māori non-Pacific because Māori and Pacific people population is distributed more towards lower income levels (Ministry Of Health, 2000, p. 4).

The situation easily pointed toward the concept of “*social determinants of health*”, a concept that directs attention to the social factors shaping people’s health. The concept originated in a series of influential critiques published in the 1970s and early 1980s, which highlighted the limitations of perspectives and interventions targeted at individuals at risk of disease and that understanding and enhancing health required a population focus, with research and policy directed at the societies to which individuals belonged. It was the dichotomy of ‘high-risk approach’ and ‘population-based approach’ (Crampton, Salmond, Blakely, & Howden-Chapman, 2000, p. 96). The trend was “refocusing upstream” from the individual risk factors for disease to the social determinants of health (McKinlay, 1975, p. 7). It referred to economic and social conditions that influence the health of individuals, communities and a nation as a whole (Raphael, 2004, p. 1).

The concept was quickly adapted in the public health sphere and stimulated the World Health Organization (WHO) strategy of *Health for All* in 2000 (World Health Organization, 1988). Since then, the social determinants of health approach gained widespread acceptance as the appropriate framework for developing and delivering public health policy. In New Zealand, for instance, the National Health Committee report on the determinants of health argues for “acting on the determinants of health in order to improve population health and reduce health inequalities” (National Health Committee, 1989, p. 8). The second wave came with the Ottawa Charter which put social structure and policy as key determinants in health (Bonita & Beaglehole, 2004, pp. 255-256).

In a comparable way, the report on inequalities in health commissioned by the New Zealand government uses a model of the social determinants of health to identify “major components of social inequalities as they relate to health” (Ministry Of Health, 2000, p. 3). Health system might not be able to intervene in other sectors to ensure that all social determinants of health would contribute to equal health status, but it could ensure to endorse equity policies to promote equal access to healthcare and minimize the inequalities of health status.

A principle of equal access to healthcare denotes that every person who shares the same type and degree of health need be given an equally effective chance of receiving

appropriate treatment of equal quality and that the treatment is available to anyone (Gutmann, 1983, p. 44). This principle implies that equal *access* does not guarantee equal *result*. However, equal access principles honor the values of equal opportunity, equal relief from pain and equal respect (Gutmann, 1983, p. 51). Principle of equal access is highly significant in public policy sphere as policymakers could do more in promoting equal access to healthcare rather than guaranteeing equality in health. Notably, success in realizing equality of access partly depends on the way policymakers allocate and distribute resources (Andrain, 1998, p. 225).

## **1.2 Research question and purpose of research**

There has been a major and rapid structural change in New Zealand society during the last 20 years that has adversely impacted on Māori and Pacific people. As socioeconomic factors are known to be the major determinant of health, it is highly plausible that the widening social inequalities between ethnic groups have in turn led to widening health inequalities. Differential access to the political, social, environmental, economic and behavioral determinants of health resulted in differential incidence of disease (Whitehead, Diderichsen, & Burstrom, 2000, p. 208). Differential incidence is then compounded by differential access to healthcare and differential quality of care leading to differential mortality and life expectancy (Whitehead et al., 2000, p. 208). As inequality of health has become one of the major issues in today's health policy discussion, it is very relevant to us to question whether New Zealand's health system has identified the need to address this issue with suitable policies. Public policy could influence the characteristics of the health delivery system and the population to be served by it, and it is a highly relevant issue to New Zealand as the social wellbeing for both Māori and Pacific people is still worse than that of other New Zealanders (Ministry of Social Development, 2005, pp. 132-133).

Considering that New Zealand had undergone several reforms in its health system, it is even more significant to look at policy differences resulting from these reforms. The Social Democracy, the Neo-Liberal and the Third Way perspectives heavily influenced these reforms. This research compares different equity policies undertaken

by New Zealand government to address the inequality of access to healthcare under different health systems since 1980s.

The research question is to what extent did the policy initiatives taken in those different systems recognize the inequality of access to healthcare problems and how did they intend to find the solution to them. The research will analyze general issues relating to inequalities in New Zealand and appropriation of the strategies to address them. Subsequently, it will try to anticipate the impact of these strategies on promoting equal access to healthcare, in particular for Māori and Pacific people. It will also evaluate the likelihood of success of these strategies.

The delimitations of the research are as follows:

- By ‘inequality of access to healthcare’, the researcher refers to inability of people to access healthcare due to financial barriers.
- By ‘equity policy’, the researcher focuses on the availability of subsidies, benefits, and other provisions that were designed based on the equity principle to enable people from lower socioeconomic status, especially Māori and Pacific people, to access healthcare.
- By ‘equity’, the researcher refers to different treatment of different people in order to reduce the consequences of innate differences.
- By ‘access’, the researcher refers to *opportunity to seek access*, and thus avoiding the issue of *real* access. In this sense, equal opportunity refers to a particular obstacle that the opportunity in question removes (Westen, 2001, pp. 287-288). When it is appropriate, a proxy indicator for the so-called ‘opportunity’ will be used, for instance utilization rate of services, enrolment status, and card uptake, depending on the context of discussion.
- By ‘healthcare’, the researcher limits herself to primary healthcare, in particular the general practitioner (GP), and thus excluding secondary and tertiary care. The reason being that primary healthcare is an entry level to health services, and studies have revealed that the financing, organizing and delivery of primary healthcare has an important impact on population health (for instance see Macinko, Starfield, & Shi, 2003)

- By ‘health status’, the researcher limits herself to the avoidable mortality rate, as it is the most basic indicator of health outcomes. The researcher acknowledges the fact that there is no separate health outcome target for Māori and Pacific people, meaning that the total New Zealand target applies to them as well (Ministry of Health, 1998, p. 5).

This research is a new tangent to the existing discussion of inequalities in health in New Zealand. However, it will not try to demonstrate which policies are better or worse nor try to prescribe the best policy to tackle inequality in health. Instead, it will link particular policies to the respective political economy framework so that each policy is seen within its context.

### **1.3 Theoretical Framework**

There are many reasons why healthcare could be observed from the political economy framework. Hall and Viney (2000, p. 39) stated at least three reasons. First of all, governments play some kind of role in financing, regulating and providing healthcare, although the degree might vary depending on several factors. Second of all, healthcare expenditure comprises a substantial proportion of the gross domestic product (GDP). Also, the health industry consists of many suppliers of specialized and non-specialized goods and services as well as health professionals and related professionals. Naturally, healthcare is a part of the political-economy agenda as much as it is a social and ethical issue. Understandably, the broader ideas and ideologies in political economy influence the direction of healthcare reforms and policies.

Traditionally, healthcare, as well as education, has been one of the primary pillars of the Welfare State. As Wilensky suggested, the root cause of Welfare State was economic growth mediated by demographic change, which resulted in rising life expectancy and population aging (Wilensky, 1975, p. 47). Perhaps the most persuasive evidence that politics and political institutions matter for welfare states, came from Esping-Andersen’s highly influential *The Three Worlds of Welfare*

*Capitalism* book (Esping-Andersen, 1990). Esping-Andersen demonstrated that they could be distinguished not only in terms of relative generosity and spending but, more fundamentally, by their institutional logic for assigning welfare functions to the state, the market, and the family.

### **1.3.1 Social Democracy**

Social democratic parties around the world began to experience office at national level during the prolonged period of economic volatility opened by World War I. New Zealand social democratic governments, for instance, came into office during the upswing of the economic cycle in the 1930s and were able to make real reforms in social policy.

Equality is a key theme in social democracy and given priority due to its nature as natural right (Cheyne, O'Brien, & Belgrave, 2005, p. 72). Thus, social democrat government believes in ensuring equal opportunity through state provision (Cheyne et al., 2005, p. 73). Evidently, social democrat governments in particular are concerned with the provision of public goods, namely education and healthcare, usually based on progressive taxation. Esping-Andersen (1990, pp. 27, 28) stated that social democratic welfare states represent a model of society characterized by extensive social rights and a marginal role for private welfare provision.

However, no government had any real idea about how money should be spent for maximum impact or, indeed, how much money needed to be spent (Kindleberger, 1973, pp. p. 116-127). The relatively small proportionate scale of government activity in the economy in the 1930s and the government's relative ignorance of how the economy worked in the absence of the necessary theoretical and statistical knowledge might be the reason why most governments ignored policies that might have successfully pulled the country out of depression, as in the case for British government (McKibbin, 1990, pp. 197-227). McKibbin also showed that domestic political forces were stacked against radical policy; expert opinion favored deflation and 'the economically and politically preponderant classes showed no signs of wanting to make any sacrifice at all' (McKibbin, 1990, p. 207).

It was the long post-war boom which sustained the conviction of how the welfare state was affordable and the Right's commitment to the welfare state, though any serious history of the welfare state must record the fact that even in the boom years it came under frequent attack and generated sessions of panic about uncontrollable spending (Timmins, 1995, p. 206). The commitment to full employment and expanding social services was maintained because of the long period of sustained economic growth and full employment experienced in this era.

Then the Bretton Woods system collapsed in 1973. It can be used as a convenient marker to denote the beginning of a period of growing financial volatility, slower rates of economic growth, higher rates of inflation, and growing unemployment. All West European countries were adversely affected, though the impact varied, as did the policy response. The prevailing economic circumstances threatened worsening budget deficits and maintained pressure for continuing budgetary austerity.

### **1.3.2 Neo-Liberal**

There is common agreement that the welfare state was challenged fundamentally in the late 1970s and 1980s. This questioning of the welfare state arose in a particular context, characterized by slowing of economic growth and fiscal strain. The stability of the post-war economic order was challenged by decline in stable exchange rates, slow growth, unemployment, the rise of newly industrialized countries, changes in financial institutions, the impact of new technologies, and de-industrialization and post-industrialization (Willis, 2005, pp. 46-60). The result was a tax-welfare backlash.

Crosland (1962) had predicted a fiscal austerity with the argument that national governments had to balance their budgets, reduced their public sector borrowing requirements, and decreased taxation on companies and on high earners as well as on the majorities which elect them. Such fiscal austerity required constraints on public spending and thus had direct impact on the shape and size of welfare states. As a

result, the old tax-and-spend policies, Keynesian demand-side economic and the argument that the public sector could be expanded were discredited.

Neo-liberalism is most often used as a shorthand term to refer to the political preference for market mechanisms as a means of ensuring economic and social wellbeing. (Cheyne et al., 2005, p. 84). Neo-liberalism demands the ascendancy of markets as society's prime distributional tool controlling the allocation of resources on the basis of competition and placing responsibility for well-being on the shoulders of the individual (Navarro, 2002, p. 81; Navarro & Shi, 2002, p. 416). The consequences of this commitment to neo-liberalism have been: a winding back of Keynesian-welfare state institutions; opposing distributive justice, emphasizing private rather than public provision, development of contractual relationship between the state and the providers and establishment of 'quasi-market' (Cheyne et al., 2005, p. 81).

Thus, citizens are constituted primarily as individual market actors. There is a reluctance to replace market relations with social rights, and citizens are encouraged to seek their welfare in the market, for example, through subsidies for private welfare benefits, while basic security schemes are more likely to be means-tested and social insurance benefits modest (Esping-Andersen, 1990, pp. 41-44).

Neo-liberal turned to civil society and voluntary organization and private charity to look after welfare (Cheyne et al., 2005, p. 82) while the state would only provide a modest safety net for those unable to meet their own needs. Thus, contrary to the previous setting, those who can make greater provision for their own should be encouraged to do so, while those who have genuine need would have adequate access to government assistance (Esping-Andersen, 1990, pp. 23-26). For instance, the New Zealand National government in 1990s stressed policies toward self-reliance, i.e. increasing the ability and incentives to individuals to take care of themselves, and toward efficiency, i.e. the highest possible value from each tax dollar spent (Bolger, 1990, pp. 11-12).

It would seem that the move to neo-liberal regimes was motivated by the increased cost of provision and the increased unwillingness to pay more tax. In addition, the

concept of 'welfare dependency' gained a hold, claiming that the culture and values of ordinary people are different from those who become long-term recipients of welfare (Godin, 1998, p. 127).

### **1.3.3 The Third Way**

There was then a move to find a Third Way (Giddens, 1998) between the Social Democracy and Neo-Liberalism, a way to converge Old Left and New Right. The common theme of this approach is community, responsibility, accountability and equal opportunity (Powell & Hewitt, 2002, p. 67). The policy paradigm associated with this Third Way includes decentralization, local variation, more discretion to bend rules at local level, joined up solutions, sharing of information and responsibility at local level, and better informed governance (Giddens, 1998, p. 100). The Third Way approach of Clinton and Blair for instance, targeted programs toward the socially excluded and tailored social policies to the interests of the contented majority (Eichbaum, 1999, p. 52).

Third Way focuses on responsibility. The fundamental principle is that there are no rights without duties (Giddens, 2000, p. 52). This old principle has been adapted from the welfare state era but modified so that the focus was on a balance of rights and obligations at the level of the individual, rather than risks being shared and collective responsibility accepted. The main stress was on getting the poor and those receiving public services to change their behavior and act more responsibly by joining the workforce (Giddens, 1998, p. 110).

The essence of the Third Way was increasing intervention in the lives of the poor and the unemployed, and utilizing joined-up approaches to increase impact (Driver, 2004, p. 32). With an assumption that social problems are restricted to small groups whose behavior has a large impact on the rest of society, most of the policies were targeted at these relatively small groups (Goes, 2004, pp. 116 - 117). Embedded in this view is the emphasis on the strong and vibrant civil society to achieve social capital and that

the voluntary sector can be an agent of efficient and effective service delivery (Anheier, 2004, pp. 116-118).

## **1.4 Summary**

Almost all countries have undergone some type of healthcare reform in the last 20 years, mostly directed at conserving money or cutting costs. Existing international comparisons have provided descriptive data on some important aspects of these health systems, but have lacked information on socioeconomic characteristics and specific strategies and/or policies that could be related to differences in population health levels.

New Zealand has undergone major transformation of its healthcare system since the 1930s. The reforms were driven both by internal pressure and international trend. At the same time, New Zealand also became a poly-ethnic society. Some of the social and economic policies have resulted in redistribution of resources and along with it unequal income. As a Welfare State, New Zealand put a lot of attention on developing its health sector. However differential socioeconomic status affected the ability to access healthcare and, consequently, producing differential in health outcomes.

The purpose of this research is to provide an insight into New Zealand's health system in relation to different policies and strategies addressing the inequality of access to healthcare for Māori and Pacific people. In investigating this issue, the research compares the Social Democracy, the Neo-Liberal and the Third Way perspectives of the role and responsibility of the State. The research will be elaborated in the next four chapters. Chapter 2 describes the method and methodology utilized to arrive at the research findings and conclusions. Chapter 3 describes a series of reforms in New Zealand health system since 1984. Chapter 4 discusses the research findings on how the New Zealand government endorsed equity policies to promote equal access to healthcare for Māori and Pacific people and what were the impact of each policy. Chapter 5 gives summary of findings and conclusions as well as suggests further research.

## CHAPTER 2 Method and Methodology

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This chapter discusses the methodological approach and method in investigating the subject of this research. It starts with a description of the research methodology that governed the whole research process. Then it will move on to the data collection process, and the data analysis and interpretation process.

### **2.1 Methodology**

Research design is a constructed plan and strategy to seek answers to a research question. It guides the way the observation is made, the way to categorize variables, and the way to conduct an appropriate analysis to draw conclusions on (Trumbull, 2005, p. 105). This research is a qualitative research design. Sarantakos (1993, p. 6) defined qualitative research as a type of research that employs methods of data collection and analysis that are non-quantitative and seeks to describe reality as experienced or as interpreted. It is usually multi-method and inductive, attempting to make sense of reality. For the purpose of this research, policy analysis and system theory are used to answer the research questions.

#### **2.2.1. Policy Analysis**

The term “policy analysis” and “policy studies” are sometimes used interchangeably. However, there is a distinction between the two approaches, and sometimes a policy analyst is unaware that s/he is moving from one to the other.

Hogwood and Gunn suggested a classification as follows (Hogwood & Gunn, 1984, pp. 25-28):

1) Policy studies

- i) Studies of policy content: explore the origins, intentions and operation of specific policies
- ii) Studies of policy process: explore how policies are made in terms of the actions taken by various policy actors at any given stages
- iii) Studies of policy outputs: establish the determinants of the patterns of indicators of policy outputs
- iv) Evaluation studies: assess specific policies in terms of the extent to which their outcomes have achieved the objectives of the policy

2) Policy analysis

- i) Information for policy making: collection and analysis of data with specific purpose of aiding a policy decision or advising the implication of alternative policies.
- ii) Process advocacy: involve putting high value on approaches, procedures and techniques of how policies ought to be made
- iii) Policy advocacy: use of analysis in making argument for a particular policy

Hogwood and Gunn (1984, pp. 28-29) further argued that there is also difference in the roles of analysis, as “policy studies” usually indicates a descriptive or explanatory set of concerns, while “policy analysis” usually indicates a prescriptive concern. Hogwood and Gunn suggested (1984, p. 27) that evaluation studies is somewhat in between policy studies and policy analysis, a mix between knowledge of the policy and knowledge in the policy process.

There are three approaches to evaluation, namely pseudo-evaluation, formal evaluation and decision-theoretic evaluation. Pseudo-evaluation refers to the use of a variety of methods to explain variations in policy outcomes in terms of policy input and process variables, while the policy outcome is taken for granted as an appropriate objective (Dunn, 2004, pp. 359-360). Formal evaluation uses legislation, program

documents, and interview with policy makers and administrators to identify, define and specify formal goals and objectives (Dunn, 2004, p. 360).

Three types of formal policy evaluation are (Duignan, 2003, p. 84):

- Formative evaluation: designed to improve the design, development, formation and implementation of a policy.
- Process evaluation: described and documented the process of what actually happened in the context or course of a policy.
- Summative evaluation: assessed the impact and outcome of a policy (although it could also be an intermediate outcome evaluation).

Decision theoretic evaluation attempts to ascend and unconceal the latent as well as manifest goals and objectives of stakeholders, and thus link information about policy outcomes with the values of multiple stakeholders (Dunn, 2004, pp. 363-364).

The aim of conducting evaluation studies is to provide reliable and valid information about policy performance, for instance the extent to which particular goals and objectives are attained (Dunn, 2004, p. 357). Another important function is to provide clarification and critique of values that lie beneath the chosen goals and objectives (Dunn, 2004, p. 357). Finally, evaluation also enables problem restructuring and providing recommendations (Dunn, 2004, p. 358).

Summative evaluation is suitable for this research as it particularly contributes to assess the overall effectiveness of a policy and the extent to which it is worthwhile in comparison to other similar policies. However, in regards to the actual impact of effecting changes to policy, this research takes on the notion of policy learning, that evaluation is conceived as an iterative process of active learning about the nature of policy problems and solutions (Howlett & Ramesh, 2003, p. 220). Thus it moves away from technical evaluation towards lesson-drawing (Howlett & Ramesh, 2003, p. 222).

As the policy studies suggested, policies are products of a large number of determinants. To analyze policy, one must take into account the broader context of

health system and the political context beyond that. Thus, it is helpful to conceptualize policy as a system model of organizational relationship and influences.

### **2.2.2. System approach**

Originally, system approach is a quantitative technique. Regarded as precise, logical and scientific method in an engineering curriculum, system analysis is increasingly evident among course offerings in the soft sciences such as politics, sociology, public health and others. For the purpose of this research, system is defined as “an aggregate of objects united by some form of regular interaction and interdependence, a group of diverse units so combined by nature or art as to form an integral whole and to function, operate or move in unison and often in obedience to some form of control; an organic or organized whole” (Hoos, 1972, p. 16).

A system is perceived to be complex, comprises a hierarchy of levels of organization or sub-systems. There are three different approaches to system analysis. According to Kuhn (1974, p. 12), when one examines a system as a functioning unit, it is a holist analysis; when one looks downward from that system to the sub-system that composed it, it is a reductionist analysis, and when one look upward from a system to the larger system (super-system) to examine the role it play in the larger system, it is a functionalist analysis.

Kuhn (1974, p. 28) also recognized closed system as a system in which interactions occur only among components of the system, as opposed to an open system that receives inputs from or releases outputs to its environment. Notably, almost every system is presumably open at some times, in some respects or to some degree. A system is not isolated from its environment. In other words, there is flow across the boundary between system and environment, and the environment affects and limits the way in which the system operates. This notion was elaborated further later on by Checkland (1993, pp. 149-161) as soft system theory.

As methodology, soft system will not *solve* problems, rather it has potential to *improve* the problem situation (Checkland, 1993, pp. 237-240). Thus, it serves as a

guidance mechanism, not as a definitive tool. Soft system methodology is an aid to the researcher in making sense of situations that are inevitably complex, by taking an overview of situations especially in addressing matters that are difficult to quantify or to define (Patching, 1990, pp. 33-34).

System approach as methodology suggested a holistic view, and thus is not bound to a single discipline or a limited number of them. The distinctive feature of the system approach is its flexibility in forming a more or less arbitrary system for specific purposes without losing sight of the super-system or environment in which the system is embedded (Mattessich, 1978, p. 300). Furthermore, the design of the system is closely connected with a goal-directed process of reasoning. Mattessich (1978, p. 317) referred to this as instrumental reasoning i.e. a process of reasoning which includes deductive and inductive logic as well as preference criteria and the explication and reduction of value judgments, the “rational” pursuit of goals and the adaptation of models or system to the goal attainment as far as environmental or other constraints permit.

As already mentioned above, the systems approach in general asserts that no problem can be understood or solved in isolation from its greater environment. Such a holistic approach was desirable for a research of this nature as it guided the search for how factors in both the internal and external environments of New Zealand health sector interacted to determine its performance, which eventually affected its ability to pursue its national objectives. The research thus took a systemic view of the subject of investigation because of the realization that Ministry of Health as an institution, and New Zealand as a government was likely to face constraints from both the internal and external environments, as it is part of the wider system in which activities of conflicting interests took place.

Finally, it is important to mention that the use of systems methodology under the qualitative research tradition steered the research towards the desired direction. The unique feature of this research was its attempt to understand the broader reality of what was emerging out of the interaction of the external and internal constraints. Through its emphasis on the principle of wholeness, the systems theory facilitated movement towards this goal.

In summary, for the purpose of this research, “policy analysis” would refer to summative evaluation studies. The evaluation analysis aims to draw a conclusion of a particular policy that was adopted from information on goals, policies, and relations and relation between them, and thus be a retrospective outcome evaluation in nature. System theory would be useful to define the area in which action is possible and clarify the sources of influences, inputs and interferences that must be avoided or tolerated.

## **2.2 Method**

### **2.2.1 Data Collection and Data Analysis Process**

The techniques in qualitative research in terms of fieldwork activities usually fall into either experiencing, enquiring or examining (I. Hall & Hall, 2004, p. 103). Experiencing usually involves observation, while enquiring usually involves survey, interview and focus group discussion (I. Hall & Hall, 2004, pp. 104-122). This research employs the third technique, which is examining, or as Wolcott put it, an archival research (Wolcott, 1999, p. 46).

Two main methods of data collection were used, namely: primary and secondary data. Primary data in this case is defined as the written records of actual participants or witnesses, for instance constitutions, charters, official minutes or records, periodicals, contracts, and the like (Rubinson & Neutens, 1987, p. 197). Secondary data analysis is a method of data collection that involves further analysis of an existing data-set to come up with interpretations, conclusions, or knowledge that is additional or different from those that were presented in the primary data (Kelsey, 2003, p. 340). The use of two different methods of data collection promoted the principle of triangulation, which is defined as the combination of different methods of data collection in studying the same social issue (Sarantakos, 1998, p. 168). The use of different methods in this research was preferred in order to obtain a variety of information on the subject and to allow the strengths of each method of data collection to overcome the deficiencies of the other methods.

In this research, primary and secondary data analysis involved collecting and analyzing key documents and other documents that outlined New Zealand health strategies related to inequality of access to healthcare. The documents derived from socially produced material, such as books, journal publications, statistic reports, research reports, and government department documents. Documents were checked for their authenticity, completeness, representativeness, and terminology/classification schemes used in their compilation (Mason, 1996, p. 75). Each data was recorded according to events, themes and categories.

The major sources of primary and secondary data for this research were Massey University library collection, Auckland City library collection, websites of government departments, and other websites that collected statistical data and issued reports on health issues for various purposes. It was relatively easy to find out what material was available on these websites and determine its relevance to this study, as information on these websites is usually available for public consumption. Another important source of data was population data that represent demographic and deprivation.

One of the limitations that this method of data collection had in this research was that some of the reports that were consulted presented the views of their authors or the organizations to which the authors of such reports were affiliated (Shaw, 2005, p. 164). Furthermore, since only data that was available for public consumption was collected and analyzed, the research might have fallen short of input from some official sources of information that were designated as not available for public consumption.

Triangulation of data was treated carefully, especially because data were derived from different sources. To achieve rigor, the researcher tried to adhere to the following criteria: credibility, fittingness, auditability and confirmability (Walton, 1994, p. 285). As Walton stated (1994, pp. 285-286), credibility refers to recognition of descriptions and interpretations both by the study participants and by others who might read the resulting report; fittingness is when the findings are meaningful and when the

explanations reached 'fit' the data from which they were derived; auditability refers to the ability of another researcher to do the same research and likely to come up with similar and non-contradicting findings or interpretations; while, confirmability refers to neutrality of the findings.

Historical nature of the analysis was essential to provide insights into the context and interrelation between events. The researcher compiled and interpreted relevant information from official documents and literatures in order to chronicle events. Meta-analysis (Crano & Brewer, 2002, p. 333) was used to re-examine the existing data in order to draw new conclusions and make alternative interpretations relevant to a new set of research questions. The researcher compared and crosschecked the consistency of information derived from different studies at different times.

Throughout the data collection process, the researcher maintained a research journal and field notes where the researcher recorded her reactions to the data collection process, her reactions to the ideas that the researcher read in the primary and secondary material (Rubinson & Neutens, 1987, p. 141). All these activities formed critical components of the data analysis and interpretation process, as the ideas generated through these activities eventually found their way into this report in one way or another.

The next step is data analysis and interpretation. There are several approaches to analyzing qualitative data, namely ethnographic, grounded theory/thematic, narrative, content analysis (including discourse analysis), and framework approach (Donovan & Sanders, 2005, pp. 518-522). In analyzing the qualitative data, the researcher followed framework approach, using the steps as pointed by Rubinson and Neutens (1987, pp. 146-150) and summarized as follow:

Step 1: The researcher read the research diary and fieldnote, primary and secondary material in order to identify emerging themes.

Step 2: The major themes of the research provided a framework for analyzing and interpreting the data. All the major themes of this research were given separate color codes.

Step 3: The researcher re-read the research diary and fieldnote, primary and secondary material and highlighted materials that corresponded to the related theme according to these color codes. All material relating to a particular theme was grouped together by cutting and pasting it under a heading corresponding to that particular theme.

Putting related material from different sources under one heading and highlighting related material from different sources using the same color enabled the researcher to make cross comparisons of the views that different authorities had on particular issues. The thesis writing process became describing and discussing the findings of the study under headings that corresponded to the themes that were already identified during the data collection and processing phases.

### **2.2.2 Limitation of research**

Unfortunately, there is a difficulty in examining ethnic inequalities prior to the 1990s. The reason being that until the mid 1990s the concept of ethnicity used in New Zealand's official statistics was biological race (Ministry of Health, 2001, p. 4). For example, the mode of measurement of ethnicity in the 1966 Census required respondents to calculate fractions of racial origin. The first major change to the Census question came in 1976 for enumeration of all those with Māori ancestry no matter how remote; this was a response to a legislative requirement, i.e. Māori Affairs Amendment Act 1974 (Ministry of Health, 2001, p. 4). It was changed again in 1981 Census when biological/racial concept reemerged (Ministry of Health, 2001, p. 4). The societal concepts of ethnicity changed again, and in the 1986 Census respondents were simply asked to indicate their ethnic origin with no indication of relative magnitude (Ministry of Health, 2001, p. 5). At last in the 1991 Census the biological or racial concept of ethnic *origin* was explicitly replaced by the sociocultural concept of ethnic *group*, and it was measured by self-identification (Ministry of Health, 2001, p. 6). All these changes contributed to the possibility of undercounting the Māori people prior to 1996 Census. To maintain the consistency of data collection, the Ministry of Health issued a protocol for ethnicity data collection based on Ethnicity-Standard Classification 1996 and used a similar form of question as in 2001 Census (Ministry of Health, 2004a, pp. 3,5,6).

The way Statistics New Zealand viewed the concept of ethnicity also had an impact on undercounting the Pacific people. For instance, Tobias (2001, p. 15) found that some people who were identified as 'Māori and Pacific' were excluded from 'Pacific people' but included in 'Māori'. Furthermore, registry staff might find it uncomfortable to inquire about ethnicity and thus leaving the ethnic question blank or guessing the ethnicity.

### **2.3 Summary**

This thesis is a qualitative research design. It utilizes a system theory approach to conduct a summative policy evaluation, based on primary and secondary data collection method. The findings and discussion will be presented as a descriptive study using framework approach. The biggest challenge in this research is ethnicity measurement in statistical data that limited the ability to conduct a cross-ethnic analysis prior to 1990s. The next chapter will describe the New Zealand health system in chronological order to provide a historical perspective of each relevant reform that had took place since 1984.

## CHAPTER 3 The Health System

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This chapter elaborates the health system in New Zealand, as well as reforms that has taken place throughout different periods. This chapter will look at how the health system is organized, structured and paid for.

### ***3.1. The development of health system in New Zealand***

In the early European settlement days in New Zealand, a mix of providers offered healthcare services: the government, mostly voluntary and private sectors. The healthcare system was based upon the English model familiar to the settlers which is Poor Laws that mandated local responsibility for the poor (Rose, 1971), and hospitals were regarded to be the place to be avoided (Cheyne et al., 2005, p. 212). Medical practitioners worked independently and were paid directly by their patients and public hospitals were established to treat those who could not afford medical and nursing care in private hospitals or their own homes or who had no homes (Gauld, 2001, pp. 8-9). As hospital treatment became more effective, the middle classes increasingly paid for care and utilized it even more (Cheyne et al., 2005, p. 212). While some towns and districts financed their hospitals, as did some voluntary organizations, others found it impossible to maintain sufficient public support, and by the 1880s the government funded all hospitals (Royal Commission on Social Policy, 1988, p. 43). Government funding gradually increased while patient fees made up an increasingly smaller share of revenue (Royal Commission on Social Policy, 1988, p. 45).

The Public Health Act 1900 created a Department of Public Health headed by a Chief Health Officer while 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, p. 44). New Zealand thus set up a national department of health to oversee the health of the population. The

Department of Public Health gradually took on broader functions, merging with the Department of Hospitals and Charitable Aid (Dow, 1999, p. 92).

As the theoretical framework suggested, basically there are two extreme views regarding health sector. The Social Democratic views the financing, organization and delivery of healthcare as oriented to the collective good, in which government's role is to provide public system and ensure the achievement of social objectives. The Neo-Liberal views health as commodity, just like everything else. Individuals have rights to choose for themselves and therefore those who are able and willing to pay more should be able to purchase what they want. Government's role is to look after those disadvantaged who could be excluded from healthcare. The Third Way stance is somewhere in between. The next section depicts a series of health system reforms in New Zealand based on the above ideologies.

### **3.1.1 National Healthcare System during 1935- 1984**

It could be suggested that the welfare provisions in New Zealand were driven mostly as response to economic depression. The first Labour government of New Zealand (1935–1949) substantially shaped the healthcare system of today, setting up a welfare state in the years following the 1930s World Depression. By 1938, two-thirds of total government expenditure was spent on health, education, social security and defense, but mostly on health (French, 1977, p. 396).

The Social Security Act 1938 marked the introduction of a comprehensive health system that mandated the provision of free care for all (Department of Health, 1974, p. 43). The welfare state regime was adopted first and foremost by New Zealand during this period, and the expectations were that the state should ensure that all citizens have access to good education and health facilities regardless of their capacity to pay, by providing heavily subsidized or free services. This was an application of a fundamental social democracy principle in which the State is seen as the instrument to achieve greater socialism and reduce inequalities (Cheyne et al., 2005, p. 73). Consequently, the State was committed to ensure that all citizens have equal opportunity.

By 1947, New Zealand had set up a predominantly tax-funded healthcare system that made most services available free to the user at the point of delivery with mixed public and private provision. By 1960s, New Zealand spent \$148 million on health, or 3.9% of GNP, while it's increased to \$489.4 million in 1970s, or 5.2% of GNP (French, 1977, p. 407). It was clearly agreed that State-monopoly systems ensured equal access, economic use of resources and maintained level of quality. A comprehensive system of government-provided benefits and services was later on codified by the 1972 Royal Commission on Social Security (Barretta-Herman, 1994, p. 5).

However, it was realized by then that healthcare could not be free. It was free for the patients, but it was not free to society as a whole. Historically, New Zealand had a strong agriculture-based economy during the 1950s and the 1960s, but in the late 1960s it faced a growing balance of payments problems (Roper, 1997, p. 9). The government tried to solve this problem by expanding overseas borrowing and conducted protective economic policies, yet the problem continued on during the 1970s and 1980s (Roper, 1997, p. 9)

High levels of protection of domestic industry undermined competitiveness and the economy's ability to adapt to the changing world environment. The combination of expansionary macro policies and industrial assistance led to macroeconomic imbalances, structural adjustment problems and a rapid rise in government indebtedness (Treasury, 1984, pp. 107-115).

There are two ways government could response to the ever-increasing health budget. One is to limit how much it will subsidize services and determine who will get access to these subsidies; and, second, reorganize how the services are provided. This chapter focuses on the latter strategy, while the next chapter will discuss the former strategy.

In the mid 1970s, attention shifted to ways of organizing the services. This was a result of a government review entitled *A Health Service for New Zealand* (Department of Health, 1974) that noted that health services had developed in a fragmented way

and could not be described as a comprehensive national healthcare system. In the late 1970s, the Minister set up a Special Advisory Committee on Health Services Organization to advise on ways to integrate the array of health services. Their recommendations resulted in the Area Health Boards Act 1983, which provided the basis for establishing local boards, initially elected and later composed of both elected members and those appointed by the Minister of Health, to plan and manage the delivery of health services for their area (Royal Commission on Social Policy, 1988, p. 46).

Thus, from the centrally funded and managed model of the 1940s, New Zealand's health system gradually changed to a more devolved structure in the 1970s and 1980s with Hospital Boards having greater autonomy, and later to Area Health Boards who appointed their own chief executives.

In addition to that, more confidence is placed in greater efficacy of prevention rather than later cure. The agreed principles of funding and service delivery were that increased emphasis would be placed on health education, promotion and prevention of disease and accidents, on the development of public health services; and, that policy would move towards community-based services away from hospital-based services (New Zealand Planning Council, 1979, p. 33).

### **3.1.2 National Healthcare System during 1984 - 1993**

After the election of the fourth Labour government in 1984, the direction of economic policy in New Zealand turned toward Neo-Liberalism marked by the elimination of many forms of government assistance (Rudd, 1997, p. 248). The ideas behind the restructuring of the health system at that time were to restrict public health spending and increase the level of private involvement in the health sector. The argument for Neo-Liberalism was that the State had used its resources to build the welfare state, and created a non-market sector, i.e. a sector where the economy was based around public service and not creating wealth (Cheyne et al., 2005, p. 80).

Contrary to an endorsement by The Royal Commission on Social Policy 1986 to expand state-funding health, the Treasury briefing paper in 1987 focused on overall restructuring of the State and especially reducing its role in the provision of social welfare (Treasury, 1987). Shipley (1991, p. 1) stated that the idea was that welfare function of the state acted only as safety-net, while the responsibility was transferred to citizen as individuals. In other words, the policies were aimed at spreading the burden of care and responsibility more widely within society.

As it was not possible to expand health budget due to low economy growth, the options available were to rationalize health care and to shift cost to users. Consequently, in 1983 population-based funding was introduced to put a cap on major part of the budget and in turn forced hospital to rationalize services; at the same time a variety of user charges in hospitals was introduced, as well as reducing subsidies for general practitioners as part of demand-side cost containment strategy (Blank, 1994, pp. 140-141).

As a result, the percentage of public expenditure on total health expenditure fell from 88% in 1980 to 81.7% in 1989 (Muthumala & McKendry, 1991, p. 11). In addition to that, in 1991 the government introduced a NZ\$31 charge for hospital outpatient services to reduce utilization and increase competition among service providers (Hindle & Perkins, 2000, p. 94). The Gibbs report introduced a managed competition concept, that is a competition for contracts among providers in hoped for efficiency, and a competition among funding organization to offer best value bundle of services to clients (Gibbs, 1988, p. 27). Managed competition seemed to be a way out for governments aiming for retrenchment, as it allowed government to step aside and let competitors do the work.

It seemed that the government became more conscious of the cost of social policy, especially of what part of the standard living is to be provided by public expenditure or what size and form it will take. Reason for this was that increased public expenditure does not necessarily produce better results proportionately. Money does not equate to welfare. Welfare programs were regarded as disruptive as they did not encourage responsibility (Schmidtz, 1998, p. 17).

Fees and user-charges were considered to be a mean of improving distribution of benefits and burdens among the population, as described above. However, several studies demonstrated that at higher level income level healthcare is fairly price-inelastic but at lower level it is increasingly price-elastic (for instance see Getler & Van de Gaag, 1990; Waddington & Enyimayew, 1989; Yoder, 1989). In other words, the consequence was that demand for healthcare from poor people might drop as user-charges were introduced.

Another argument for Neo-Liberalism was that individuals should have freedom and choice, and therefore Neo-Liberalism economy relied on market forces and competition to provide quality of goods and services for consumers to choose from (Cheyne et al., 2005, pp. 80-81). Further, Neo-Liberals did not acknowledge any claim to public services but rather promoted individualism (Cheyne et al., 2005, p. 84). In fact, Neo-Liberals perceived state provision as a violation of individual freedom (Cheyne et al., 2005, p. 78). The principle of individual responsibility suggested that the government only subsidize people who do not have ability to pay for themselves (Ashton, 2000, p. 111).

The swing to a market-model approach in healthcare reflected the predominant mode of economic and political thinking, rather than systemic analysis of the system (Ashton, 2000, p. 107). Simply put, as the market-model seemed to work in other sectors, it was assumed that it would work as well in health sector. In the New Zealand health system, the market-model approach took form mostly in the establishment of supply side competition (providers), the commercialization of public providers, the implementation of demand-side strategy of separating the purchaser, the introduction of user-charges, and contracting out non clinical services to the private sector (Ashton, 2000, pp. 113-115).

Critiques suggested that the changes in values orientation of the political and their advisers had been fundamental. The Minister of Social Welfare made a bold statement in 1991 that they are going to challenge most New Zealanders beliefs and attitudes to the welfare state; indeed, New Zealanders at that time were expected to become true believers in the values of competition, self-reliance, freedom, individualism, choice and market signals (St John, 1994, p. 94).

A note should be taken into account in this matter. If the purpose of private sector expansion is to *supplement* the resources already available, then the private sector must attract those who can afford to pay by offering them a higher standard of care, but this would suggest that wealthier people will have access to better care than the poor. On the other hand, if private sector expansion is used to *replace* government financing, then many poor people who cannot afford to pay for private sector may be denied access to healthcare.

Therefore, the equity affect of user-charges and promotion of private sector depend critically on the government's commitment to redirecting the revenue gained or the resources saved to the poorest group in society. Lessons from other countries showed that there was a danger in that, which was the creation of two-tier system where the poor get the poor services (for instance see Chandra & Kakabadse, 1985; Klein, 1982). To anticipate this, in 1992 the government introduced a targeted benefit scheme, Community Service Card (CSC) which gave people with annual income lower than NZ\$35,000 access to health service at reduced prices (Hindle & Perkins, 2000, p. 94).

In summary, during 1984-1993 there was a prominent shift from welfare state model of social-democracy to neo-liberal approach, which Tenbensen and Gauld (2000, pp. 35-36) summarized as:

- Advocate economic policies towards competitive and free market, as well as maximize utilization
- Demand for small government and limited public expenditure
- Primacy of the individual and freedom of choice
- Key focus on objective (and profit) based service delivery

From organizing point of view, there was also an alarming issue. According to Duncan and Bollard (1992, p. 169) during the 1980s, the 14 Area Health Boards paid and provided the health services in New Zealand through 155 public hospitals. This move to decentralized services was complicated for two reasons. Firstly, as the previous section described, New Zealand has a historical dependency on the state for

social provision as a comprehensive welfare state where centralization and universality were emphasized while the needs of individuals, families and households are defined for them by government. Secondly, effective decentralization and devolution is dependent on the strong local government infrastructure to promote community development and services. These were not evident in New Zealand during that period.

### **3.1.3 National Healthcare System during 1993-1997**

The so-called “Green and White Paper” *Your Health and the Public Health*, stated that the Government primary objective is to “improve access for all New Zealanders to a health system that is effective, fair and affordable” and to “widen consumer choices of services” (Upton, 1991, p. 3). As costs had continued to increase in the health sector, the new elected government indicated a wish to achieve greater allocative efficiency (i.e. rationing resources efficiently) and technical efficiency (i.e. producing services at minimum cost) (Palmer & Short, 2000, p. 38).

The series of structural changes to the New Zealand healthcare system were also driven by the pressures evident in many OECD countries: rising costs, rising demand, higher consumer expectations, and political ideology (Somjen, 2000, p. 67). New Zealand was unusual, however, in implementing quite major reforms in a short time. A convergence of conditions in the early 1990s produced a climate for change: economic stress; the perceived failure of government; a new political government; and a new set of economic concepts (Poutasi, 2000, p. 134).

There was expectation that the centre-right government would perform a rather incrementalist approach in restructuring the welfare state. Despite that expectation, National government embarked on major transformation. National government intensified expenditure cuts, and major changes were made to most areas of social policy, for instance accident compensation, education, and healthcare (St John, 1994, pp. 89-93). These changes were designed to shift to an even more targeted social assistance, to reduce the real value of most welfare benefits, and separate the state’s

roles as funder, purchaser and provider (Boston, Martin, Pallot, & Walsh, 1996, pp. 6-7).

This was one of the indications of supply-side economic strategy that put great emphasis on contracting, quasi-marketization, and separation of purchaser-provider function (Whyman, 2006, p. 129). The overall New Zealand public sector was in fact radically transformed, with buzzwords such as 'public choice theory', 'agency theory' and 'transaction cost economics', 'new institutional economics' and 'new public management' (Cheyne et al., 2005, pp. 81-82; Tenbenschel & Gauld, 2000, pp. 36-38). The application of these theories in the public sector was recorded extensively (for instance see Boston et al., 1996, pp. 16-40). It created a market model for public services in order to improve the government role in policy process by separating itself from the service delivery process, dubbed as provider capture (Gregory, 2004, p.155). A similar notion was enacted to health sector in 1993 through the Health and Disability Services Act 1993 (Boston et al., 1996, p. 174).

There are several reasons for separating the purchaser and provider. Firstly, a separation of purchaser and provider offers an opportunity to introduce population-based budgeting instead of allocating resources to different type of healthcare institutions (OECD, 1996, p. 40). Secondly, this separation defines different roles for different actors: the purchaser's role is to allocate the resource to achieve the objectives, while the provider's role is to provide the demanded services efficiently using the available resource (OECD, 1996, p. 40). Thirdly, the separation also enables better accountability (OECD, 1996, p. 41). Lastly, separation of purchaser and provider may introduce internal markets (OECD, 1996, p. 41). Internal market, or quasi market, aims to use the advantages of the market mechanism to optimize the operation of a public service by creating competition, efficiency and flexibility to adapt changes in the market (Malin, Wilmot, & Manthorpe, 2002, pp. 74-75).

Two years after Area Health Boards were disbanded in 1991, the Crown established four regional health authorities (RHA) to cover North region, Central region, Midland region, and South region (Ashton, 1999, p. 135). The government also tried to introduce competition for purchaser through Healthcare Plan (HCP) as an alternative (Gauld, 2001, p. 84). HCP would be a privately managed health plan, with a partial

insurance premium paid by government-supplied voucher, something that might appeal to trade unions, Māori and rural communities (Upton, 1991, pp. 67-71). HCP would have enabled opting out from public sector to private sector, however, the government decided that they would not proceed with HCP due to insufficient support (Finlayson, 2000, pp. 166-168). HCP also failed because Treasury was unable to decide how to calculate the payments to be made to individuals (Green, 1996, p. 162).

The separate funding streams for general practitioner services and for hospitals and other services were merged, and each RHA was given a budget to purchase personal health and disability services for their regional populations from both public and private providers (Gauld, 2001, p. 113) The Minister of Health (1993, p. 2) indicated that there were two major purposes of this integration, i.e. to reduce cost shifting between agencies and services and to make it easier to redirect resources as appropriate from (1) institutional to community care, (2) secondary to primary care, and (3) treatment/curative to health promotion. The government increased the RHAs funding to allow sustainable payment levels for secondary and tertiary services as well as growth in population, as the funding followed a population-based formula which weighted certain demographical and geographical factor (Shiple, 1995, pp. 44-46).

Funding for public health services was assigned to a new body, the Public Health Commission. This Commission was responsible for coordinating and contracting for the provision of public health services, monitoring the public health, and identifying areas of need in order to advise the Minister of Health ("Health and Disabilities Services Act," 1993s28). The 14 area health boards were converted into 23 Crown Health Enterprises (CHEs), which were to run hospitals, community and public health services (Gauld, 2001, p. 84).

Duncan and Bollard (1992, p. 170) stated that 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, thus they had to deliver the most cost-effective and viable health services as they were competing with community trust and private organizations. In reality, there was a peculiarity on the New Zealand internal market model. It is actually a model where few suppliers submit

tenders to provide goods or services stipulated by RHA, rather than a model where paying consumer can choose from among a range of suppliers.

Market mechanism in health sector is potentially problematic due to the nature of health sector. Firstly, the mechanism neglect the fact that in health sector the providers determine the supply; secondly, the consumers usually lack expert of knowledge and weak bargainers in the marketplace; thirdly, health needs are not elective or rarely subject to choice (Hancock, 1999, p. 61). Thus, free-market and competition in health sector usually leads to market failure. More importantly, it contradicted the argument for individual choice and consumer sovereignty.

The public and private systems in New Zealand were more complementary rather than competitive, as Scott stated (1993, p. 20). Competition among providers, was in fact, minimal (Ashton, 2000, p. 116), thus fiscal savings in health were not realized through this competition strategy. Fougere (1994, pp. 114-115) warned that, given the nature of New Zealand's quasi-market, the providers had a considerable bargaining power, and this might lead to their skimping quality and offering services at a higher cost. Most importantly, Mooney (1996, p. 22) argued that internal market mechanism was highly unlikely to create greater equity in healthcare.

At the end of 1994, the government performed a review of the health system and found that the RHAs should reduce in numbers so as to decrease purchasing and contracting cost as well as simplify the structure (Gauld, 2001, p. 122). The review also noted that the lengthy accountability chain in the Public Health Committee resulted in high transaction cost and added unnecessary complexity to the public health structure (Gauld, 2001, p. 122-125).

#### **3.1.4 National Healthcare System post 1997**

The National/New Zealand First coalition government decided that the 1993 reforms had not achieved all that was expected of them, CHEs deficit were escalating as well as real public health expenditure and waiting list (Boston et al., 1996). The coalition wanted to reduce administrative costs and eliminate geographic inequalities,

acknowledging that strict competition was not viable in the health sector (Ashton, 1999, p. 145). The 1996 coalition document *Policy Area: Health*, described a health system in which “principles of public service replace commercial profit objectives” with cooperation and collaboration rather than competition between services, and thus the government shifted back to universal provision and applied a modest market-model, abandoning competition in favor of collaboration (Somjen, 2000, p. 65).

The four Regional Health Authorities were abolished on 30 June 1997. Their functions transferred to a single health funding body: the Transitional Health Authority (renamed the Health Funding Authority on the 1 January 1998), which as a purchasing authority continued the split between purchase and provision (Ashton, 1999, p. 139). The Health Funding Authority (HFA) contracted with a range of providers for the provision of medical, hospital, public health, disability and other health services, and also was responsible for purchasing postgraduate clinical training; it also monitored the need for health services and to monitor the performance of providers (Gauld, 2003b, p. 309).

A review suggested that although there was progress promoting transparent and consistent decisions for Māori health funding, HFA fund allocation practices were not always consistent with Māori needs (Monitoring and Evaluation Branch, 2000, p. 10). It is not surprising that out of 16 targets related specifically to Māori, only 19% were achieved (Ashton, 1999, p. 149).

At the same time the Crown Health Enterprises were converted into 23 companies called Hospital and Health Services (HHS), which were relieved of the requirement to make a profit (Bloom, 2000, p. 37). Still, they continued to run hospitals and related services, community and public health services, and contracted for their funds with the HFA (P. Barnett & Barnett, 2005, p. 183). HHS continued as by far the largest healthcare providers, receiving about half of the government health budget (Vote: Health) each year (Poutasi, 2000, p. 141). Other providers included community trusts (including Māori health providers), voluntary sector providers (such as church-sponsored services), private “for-profit” providers such as dentists, and independent general practitioners (Poutasi, 2000, p. 141).

As Somjen described (2000, pp. 64, 65), at the end of 1999, the Labour/Alliance coalition government was elected on a platform that included the following: cutting waiting times for elective surgery; ensuring access to a comprehensive range of services; improving the overall health status of New Zealanders; and making hospitals non-commercial and more community oriented. It seemed that the public sector market-oriented reforms of the 1990s in New Zealand were regarded as having failed to achieve their promises. While they had some success in constraining health costs, no real competition had emerged within regional quasi markets, and at the same time the private sector had not been stimulated to expand the range of services. Consequently, greater consumer choice had not emerged, and there had been little change in the distribution of healthcare providers and services.

The objectives of the Labour/Alliance coalition government formed in 1999 do not differ significantly from the 1993 reform, but the new government had set in place very different means to achieve these goals, as we will explore later on. The policies leaned even more to the Third Way-ism as an answer to avoid welfare pathology while at the same time increase social capital by means of providing incentive for individuals to attach themselves to the labor market.

The Third Way was perceived as a way to promote social connectedness and reduce social exclusion and inequality, that were resulted from previous hardcore Neo-Liberalism approach, without creating bureaucracy as the Social Democracy did (Strathdel, 2005, p. 78). In addition, it is focusing upon the goals of equality, producing better health outcomes, and offering incentives for professionals to improve their practice. It distinct itself from neo-liberalism by promoting equal opportunity rather than equal outcome and redistribution (Whyman, 2006, p. 141). It rejected the assumption that the achievement of social justice equates with higher level of public expenditure by refurbishment of civil society and by replacing the notion of 'rights' with responsibility and mutual obligation (Eichbaum, 1999, p. 53).

The principles of the Third Way are accountability, community, responsibility and equal opportunity (Cheyne et al., 2005, p. 75). The New Zealand health system applied these principles in many ways. In 1999, HFA proposed a funding initiative, namely integration, by focusing on service coordination, risk-sharing between

provider-purchaser through budget holding mechanism, and devolved purchasing to budget-holding organization which receive per capita payment for a range of services (Health Funding Authority, 1999). Poutasi (2000, pp. 138-139) argued that as the split of purchaser-provider focused on the effectiveness and the efficiency of the health system, it strengthened the accountability of such system; and consequently, assisted the government for better allocation of funding. Furthermore, it also allowed the shift of government role to stewardship (Poutasi, 2000, pp. 143-145).

Gauld (2003a) further described another radical reorganization by The New Zealand Public Health and Disability Act 2000. Regional governance was re-established by way of 21 District Health Boards (DHBs) to replace the HHS, and the Health Funding Authority was disestablished, its role being split between the new DHBs and an expanded Ministry of Health. The legislation allowed a phasing-in period whereby the Ministry of Health took responsibility for existing service contracts until the new District Health Boards were set up and functioning.

DHBs could be seen as another evidence of the Third Way principle, specifically in regard to its emphasis on community participation, as the boards of DHBs were required to have a strong collaboration and consultation with community groups (Dew & Kirkman, 2007a, p. 253). DHBs also ended the strict purchaser/provider split, as they hold their own budgets for the services they provide, but will continue to purchase a proportion of their services from other agencies (Gauld, 2003a, p. 19). This shift reflected what Duncan and Chapman said about “abandonment of a ‘slavish’ adherence to the purchaser-provider split” (2005, p. 10). Consequently, CCMAU ceased to monitor health ownership with this function being transferred to the Ministry of Health (Gauld, 2001, p. 181).

Meanwhile, the government also issuing toolkits and provide evidence and best-practice for achieving health outcomes for different population groups (Gauld, 2005, p. 209). The new population-based funding formula was introduced in 2003, aimed for a more evenly equitable distributed funding. The formula calculated district funding based on demographics, disease profile, ethnic composition and health service utilization rates, and is more rigid than the previous population-based funding formula (Devlin & O’Dea, 1998, p. 4). The areas with high Māori, Pacific people and

low socioeconomic population that suffer from poorer health status were tend to have been previously under-funded, and thus benefited from the new population-based-funding. (Gauld, 2005, p. 213).

As mentioned in Chapter 1, the health system comprises of three different functions, namely financing/funding, provision and governance. The previous section in this chapter had elaborated the governance function in a sense of how a health system is constructed and organized. The next section will depict how a healthcare is provided at primary care level, which is the entry level to health services.

### ***3.2 Healthcare Provision: Primary Care Level***

General practitioners (GPs) provide most primary medical care from their own private practices. About 27% of general practitioners work in sole private practices, two thirds in group private practices and the remainder (about 6%) in other organizations such as universities (Ministry of Health, 1999a). Over 80% of the population visited a general practitioner at least once in the preceding year, making GP the most visited primary healthcare services (Ministry of Health, 1999c). GPs perform a gate-keeping role since an individual cannot access public secondary and tertiary services unless they are referred by their GPs except for accident and emergency services, and yet there is evidence of under-use of general practitioners by lower socioeconomic groups (Ministry of Health, 1999c).

Patients are free to choose or change their general practitioner (Crampton, 2000, p. 206).. They are charged a fee for each visit at a level set by the doctor while almost 70% of consultations are subsidized in part or whole by the government, as we will see later in the next chapter.

General practice in New Zealand has undergone considerable change since 1993. In response to the 1993 Health and Disability Services Act, GPs organized themselves into Independent Practitioner Associations (IPAs), usually within defined geographic areas, applied to manage budgets for pharmaceuticals and diagnostic testing, and used the savings to fund other local health initiatives (Love, 2003, pp. 69-70). A study

suggested that GPs was one of the areas that flourished under a contracting system (Brown & Crampton, 1998).

In the recently released *Primary Healthcare Strategy*, the Minister of Health, Annette King, announced the creation of Primary Health Organizations (PHOs) (2001, p. 5). These not-for-profit bodies managed capitation funds for enrolled patients with funds allocated by the local district health board. People were encouraged to join a Primary Healthcare Organization, usually by enrolling with a general practitioner who will become responsible for managing their care while the practice would be paid a capitation fee per enrolled patient (Gauld, 2005, p. 214). This research will elaborate further in the next chapter how PHOs plays a major role in tackling inequalities issue.

There are some other issues in the healthcare system that directly related to the issue of equality of access to healthcare. One of them is the proportion of health expenditure. The importance of health expenditure analysis is that health economist would be able to measure the equity of funding with various quantitative tools (for instance see EQUITAP, 2007; The World Bank, 2007). In this regard, the equity concern is “who pays what for whom and how much” as much as “who benefits most”. Although these measurements are not covered in this research, a brief description of health expenditure would give a hint of government’ commitment as to how much they invested in health. The next section will briefly describe who is paying for healthcare in New Zealand.

### ***3.3 Health Expenditure***

Historically New Zealand had established a health system under the welfare state model which meant universal entitlement to tax-financed (merely from general revenue) and comprehensive healthcare, i.e. free hospital treatment and free medicines; although some services, such as dental care and optometry, were still paid for privately (McGuigan, 1975, pp. 43-44). The New Zealand healthcare system is financed predominantly through general taxation. This remains the preferred method of raising revenue so that financing questions revolve around how much should be

spent on healthcare and whether complementary sources of revenue should be expanded (Poutasi, 2000, p. 137).

New Zealand has kept a relatively stable proportion of GDP for healthcare (Feldbaum, 1996, p. 99). New Zealand citizens contribute to healthcare revenue through general taxation based mainly upon Pay as You Earn (PAYE) income tax and Goods and Services Tax (a form of value-added tax). A part of general taxation is allocated to the government health system budget each year (Vote: Health). Naturally, Ministry of Health has to compete with other ministries and government agencies to secure a budget that will cover healthcare. As healthcare expenditure continually growing, the government has three choices: raise taxes, increase private spending, or curtail public expenditure (Feldbaum, 1996, p. 99). Raising taxes is an unpopular political decisions, thus government usually turns to the other two options, namely increasing proportion of private spending and containing cost.

The main components of private sector funding are consumer out-of-pocket expenditure, health insurance, and funding from charitable not-for-profit organizations. Nearly 23% of the country's total health revenue in 1998/99 came from private sources, consisted of out-of-pocket payments for around 16.1%, private health insurance for around 5.7% and the third sector for around 0.3% (Gauld, 2005, p. 212). The effectiveness of government's effort over the last two decades to contain public spending was evidenced in the decreasing share of public expenditure of total health expenditure from 88% in 1980 (Ministry of Health, 2004b, p. 12) to around 77.9% in 2002 (Ministry of Health, 2004b, p. 41) and thereafter has remained fairly stable. Thus, although the real per capita expenditure seemed to be increasing for the period of 1986 to 1997, the public spending was steadily decreasing while private spending was continually increasing (Ashton, 1999, p. 141). For example, Feldbaum (1996, p. 99) calculated that the real public expenditure rose only by \$50 per capita while private spending increased by \$227 per capita.

For instance, out-of-pocket payments by consumers rose from 10% of health revenue in 1980 to 15.6% in 1999 (Ministry of Health, 2004b, p. 50). Most out-of-pocket payments are co-payments i.e. the patient pays part of the cost of a service with a third-party payer, such as government, covering the balance. Although under many

policies private insurance companies would reimburse for most of the costs, a proportion was still contributed by the patient (Blumberg, 2006, p. 1). As public hospital accident and emergency, medical, and surgical services were provided free of charge, primary care was the major setting for out-of-pocket payments. However, co-payment mechanism was regarded as an unpopular decision in New Zealand. It created confusion, non-compliance and hostility from the population as it betrayed the tradition of free health services and was suspiciously regarded as 'privatization' (Blank, 1994, p.128).

Health insurance companies insure people against "gap" and "supplementary" costs rather than providing comprehensive health cover (Blumberg, 2006, p. 2). In other words, 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. These insurance usually reimburse consumers for surgery and other treatment by private hospitals and private specialists (Ministry of Health, 1999a, p. 47). Private health insurance expenditure had increased from 1.1% of total health expenditure in 1979/80 to 6.8% in 1996/7 (Davis & Ashton, 2000, p. 10). Interestingly, the private insurance coverage had declined from 40% of the population in the 1980s to under 25% of the population in 1998 (Hindle & Perkins, 2000, p. 93).

The other option is cost containment. Cost containment strategy usually consists of reducing demand through co-payment mechanism and gatekeeper mechanism, reducing cost through competition and price control, and regulating the market, or the combination of the above (Feldbaum, 1996, pp. 117-121). The previous section had illustrated how the government organized the healthcare system in accordance to these strategies.

### **3.4 Summary**

This chapter reviews a series of health system reforms in New Zealand. It illustrates the changing ideologies behind these reforms. Social democrat government prior to 1984 viewed health as a collective responsibility and acknowledge structural

socioeconomic inequality as the root cause of unequal health outcomes. Thus, the state is accountable to provide equitable and universal access to healthcare, a more encompassing strategy is adopted by the government to provide better housing, better nutrition and greater equality of income. This period was also marked by high level of public spending on health by means of various benefits and subsidies.

In contrast to this view, the Neo-Liberal government in mid 1980s put more emphasis on individual responsibility for its own health. Hence, more policies were developed to promote changes of individual behavior, such as smoking, alcohol consumption, lack of physical exercise, etc. The State has a low level of commitment to provide equal access to healthcare, and rather transfer that responsibility to individual, family and private providers. This was done through marketization and managerialism of healthcare that promoted competition.

In the late 1990s, there was another shift toward a more modest market model with the rhetoric of 'partnership', a shift away from hospital care to community and primary healthcare and reallocating resources to the needs of different population by means of more targeted benefits. This transformation towards a new social democracy, better known as the Third Way, recognized economic constraint as well as a reinterpretation of 'universal provision'.

The health system itself has undergone several reforms. These reforms reflected the underpinning political economic ideology of the respective government. In early days when economic prosperity was in fashion, government was able to tackle broad and ambitious programs, hence increased government expenditure on health sector and universal coverage. However, the health status did not reflect significant improvement regardless of health spending. Economic rationalism became the phenomenon of the 1980s, and along with it reforms.

In the first phase, from 1983 to 1992, the reform introduced structural changes to the public sector. Notably, healthcare funding and service management was decentralized in the hands of 14 Area Health Boards. It was believed that a deregulated market is the most efficient means of resource allocation. A Labour government (1984–1990)

introduced wide-ranging public sector reforms, such as more autonomy for managers and purchase-of-service contracting.

The second phase from 1993–1996 was implemented under the 1993 Health and Disability Services Act. One aim was to introduce market model principles and practices into the public sector such as competition; another was to improve the allocation of finances within the healthcare system. The mechanisms included the following: Firstly, purchaser and provider roles were split in order to avoid bias in resource allocation; secondly, purchasers were encouraged to buy services from best-value providers; thirdly, budgets were integrated for primary and secondary services under one purchaser; and finally, decision-making was decentralized within broad national priorities. It was in line with the notion that the government's role is to foster competitive markets and becoming more of a purchaser rather than a provider.

In the third phase from 1996–1999, the National/New Zealand First Coalition government re-branded the Crown Health Enterprises as Hospital and Health Services. The notion of hospitals as businesses had been very unpopular among the public and health professionals. This change relieved hospitals of the requirement to make a profit, but expected them to function in a commercially responsible manner.

The fourth phase began from late 1999 under a Labour/Alliance coalition government. The government reversed some changes made by its predecessors, particularly some market model methods. For example, it has combined funding with some aspects of service delivery in the new District Health Boards. The New Zealand Health and Disability Act 2000 disestablishing the Health Funding Authority, ending the purchase/provider split. Independent Practitioner Associations, Māori groups and community trusts have become more numerous and more involved locally through budget holding and joint ventures. The extension of such initiatives in local communities is intended to increase responsiveness, innovation, quality and value for money.

Health services can be categorized into four groups: primary healthcare services; public health services; hospital and specialist medical and surgical services; and

disability support services. This research focuses on the primary healthcare services. Primary healthcare is usually the first level of contact that people have with the health system. General practitioners mainly provide medical primary care. The provision of healthcare services is funded through taxation revenue and private expenditure. Out of pocket expenditure is the main source of private expenditure. The next chapter will analyze findings of equity policy in New Zealand health system to reduce inequality of access to healthcare.

## CHAPTER 4 New Zealand Policies to Reduce Inequalities of Access to Healthcare

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This chapter analyzes and discusses how the New Zealand's health system approaches the issue of inequality of access to healthcare. In particular it will answer the questions of to what extent did the policies initiatives taken in different systems recognized the inequality of access problems and what are the strategies to solve them. This chapter analyzes the appropriateness of the strategies in the sense that it will try to anticipate the impact of these strategies on promoting equal access to healthcare, in particular for Māori and Pacific people. It will also envisage the likelihood of success of these strategies.

### ***4.1 Identified inequality***

First of all we need to discuss how the government acknowledges the issue of inequality in health. The Ministry of Health defines inequality in health as “differences in health that are unnecessary, avoidable, and unjust” (Ministry of Health, 2007f). The first and foremost-identified inequality is the inequality of health outcomes based on ethnicity. New Zealand experiences significant and enduring health disparities related to both ethnicity and deprivation. The important ethnic minorities in New Zealand for whom significant disparities have been demonstrated are Māori and Pacific people. For convenience, non-Māori non-Pacific population, which is mainly of European descent, but also includes Asian and other ethnicities, is referred to as “other New Zealanders”.

Decreasing long standing inequalities in health status, especially those of Māori and Pacific people, has been one of the goals in every elected government in New Zealand (Creech, 1999, p. 4). The government outlined specific goals and objectives to address these disparities (King, 2000, pp. 13-16). New Zealand commitment to tackle

inequalities in health has been stressed over and over again in various policy documents. The Annual Report of Ministry of Health even has a special section to track progress on reducing inequalities in health.

New Zealand's priority objectives to reduce inequalities have been identified as (Annette King, 2001, p. 3):

- Ensure accessible and appropriate services for people from lower socioeconomic groups
- Ensure accessible and appropriate services for Māori
- Ensure accessible and appropriate services for Pacific peoples.

A strong information base backs these objectives. Several decades of census ethnicity data and a small area socioeconomic deprivation index that includes a unique identifier are available to support studies in health inequality. The deprivation index, for instance, is a measurement of a small area deprivation. NZDep2001 (Ministry of Health, 2002a) combines variables from the 2001 census, reflecting eight domains of deprivation, for example income, unemployment, home ownership and car ownership. Each variable was calculated as the proportion of people with the specified deprivation characteristic in each small area, comprising at least one mesh-block. Mesh-block is the smallest geographical units defined by Statistics New Zealand, containing a median of 90 people (60 people in rural area and 110 in urban area) (Statistic New Zealand, 2007a). Each proportion is age standardized and, where necessary, adjusted for household composition.

In general, the Māori and Pacific people population are over represented in areas of high socio-economic deprivation due to social and economic policies that resulted in very uneven distribution of social and material resources across different ethnic group (Crengle, Crampton, & Woodward, 2004, p. 286). Both Māori and Pacific people are more likely to live in deprived communities, with over 50% of each ethnicity living in areas in the most deprived three NZDep2001 deciles (Maori Health, 2007b).

As ethnicity and socioeconomic deprivation are entwined, and furthermore with greater proportions of minority ethnicities living in deprived areas, it is difficult to

separate the relative effects of ethnicity and deprivation. The size of the health effects associated with deprivation and ethnicity are large enough not to be ignored. The avoidable mortality rate for Māori is 2.5 times the other New Zealander's rate, while Pacific people have an avoidable mortality rate that is 1.9 times that of other New Zealanders (National Health Committee, 2000, p. 10). With this in mind, the next step to answer the research inquiry is to analyze whether differential in access to healthcare is recognized as one of the contributing factors of ethnic inequality in health.

The socioeconomic and ethnic health disparities described above exist in other countries also. However, New Zealand is unusual because it has a predominantly publicly funded health system with both significant co-payments for primary care visits and a strong gatekeeper role for general practitioners (GPs). This nonconforming fact suggests that people are delaying access to primary care due to financial barriers and exacerbate the health impact of socioeconomic inequalities.

A survey found that a higher proportion of Māori were high users of services (.i.e. over six visits to a GPs in the preceding twelve months) than other New Zealanders, and yet they also have a higher rate of unmet needs i.e. not visiting a GP when they feel that they should (Crengle et al., 2004, p. 288). In fact, an analysis of Māori health service utilization asserted the limited uptake of primary care service and that the underutilization on health service relative to Māori population each year was \$550-\$650 million (Health Funding Authority, 2000, p. 11). A similar finding of Pacific people utilization rate also showed that a substantial number of people with greater health needs are not making full use of Pacific health services or any other healthcare services (Tofi, 1996, p. 62).

There are various reasons for low utilization of services. One that is relevant to this research is the existence of cost barriers, in particular in regard to mainstream services (Caccioppoli & Cullen, 2005, p. 138).

## **4.2. Strategies to reduce inequality of access to healthcare**

The following section analyzes and discusses the next research inquiry, which is how the governments intended to reduce inequalities of access to healthcare. It will analyze how equity policies have been endorsed by governments through different periods since. It will discuss the appropriation of these strategies as well as the likelihood of success.

For a second time we need to emphasize the delimitations of the research as set in chapter 1, which are:

- By 'inequality of access to healthcare', the researcher refers to inability of people to access healthcare due to cost barriers.
- By 'equity policy', the researcher focuses on the availability of subsidies, benefits, and other provisions that were designed based on the equity principle to enable people from lower socioeconomic status, especially Māori and Pacific people, to access healthcare.
- By 'equity', the researcher refers to different treatment of people in order to reduce the consequences of inherent differences.
- By 'access', the researcher refers to *opportunity to seek access*. Thus providing equal opportunity refers to removing cost barriers. Depending on the context, a proxy indicator for the so-called 'opportunity' will be used, for instance utilization rate of services, enrolment status, and card uptake.
- By 'healthcare', the researcher limits herself to primary healthcare, in particular the general practitioner (GP).
- By 'health status', the researcher limits herself to the avoidable mortality rate, as it is the most basic indicator of health outcomes.

### 4.2.1 Generic Strategy

There are generally two distinct approaches to tackle inequality of access to healthcare related to the financial barriers of access. One is universal free provision, and the other is targeted benefits/subsidies.

Chapter 3 had demonstrated how the national health system evolved and the State became a universal free healthcare provider. Since early 1840s, government already holds a strong commitment toward the poor. State hospital, for instance, was restricted to the lowest stratum of society, known as 'paupers'(Dow, 1999, p. 23). For Māori, earmarked financing for health in Civil List budget had begun since early 1850s through Constitution Act 1852 (Dow, 1999, p. 16), as well as Native Reserve funding for Māori in specific location (Dow, 1999, p. 60). Māori Council was set up in 1900 and one of their responsibility was to collect data on their general health and mortality information (Dow, 1999, p. 99). However, accurate data about admission patterns and illness trends were quite hard to obtain and thus Māori attitude toward institutional care and access to services remained a problematical issue. Lack of research on Māori health in the early 1900s had resulted in difficulty in examining the discrepancy between Māori health and other New Zealanders health at that time.

Despite this, government remained committed to provide a relatively equal access to health services. The strategy itself could be regarded as a generic strategy, as it was provided to all New Zealanders regardless their ethnicity. The Social Security Act 1938 marked the introduction of a comprehensive health system that mandated the provision of free care for all (Department of Health, 1974, p. 43). Aside from free access to public hospital, the first Labour government also provided subsidy of GP visits (Dew & Kirkman, 2007b, p. 217). In addition to that, there were several other provisions to ensure relatively equal access to healthcare. All of these policies demonstrated the application of a fundamental social democracy principle in which the State is seen as the instrument to achieve greater socialism and reduce inequalities (Cheyne et al., 2005, p. 73).

Easton (1980, pp. 136-137) summarized the prominent government's role in providing additional benefits throughout 1930s to 1980s as below:

Year	State Medical Benefits
1939	Treatment in State Mental Hospitals Maternity Benefits In-patient benefits
1941	Out-patient benefits Pharmaceutical benefits General Medical Services (GMS) which is a part payment towards consultation X-Ray diagnostic services
1942	Physiotherapy benefits
1944	District Nursing services Domestic assistance
1946	Laboratory Diagnostic services
1947	Dental benefits for children Artificial aids (e.g. contact lenses, artificial limbs, wheelchairs, etc)
1969	Specialist Consultation benefits Higher GMS for social security beneficiaries Rural practice bonus
1974	Free treatment for all accident induced injuries and occupational disease Higher GMS for children Practice nurses Higher private hospital benefit for non surgical hospital
1978	Contraception and pregnancy test

Unfortunately, as chapter 3 illustrated, in the 1970s and 1980s there was a view that public expenditure on welfare was too high and that society should take greater responsibility. Although 'appropriate' level of funding might be difficult to define, the health funding debates in the 1980s and 1990s were largely centered on the level and

share of public funding. Key issues in this period, not only in New Zealand but also elsewhere, were concerns over the nature of funding and purchasing arrangement as well as the share and interface between public and private spending (Scott, 2005, p. 164) .

Beginning in the mid 1980s New Zealand governments required most people to meet some or all of the costs of their own primary healthcare, and have chosen to target benefits to low-income patients, rather than offer universal free services paid for through taxation or through statutory insurance (Hindle & Perkins, 2000, p. 94). It was a move to reduce the State level of roles and responsibilities in the welfare state. As chapter 3 suggested, the Neo-Liberalism reforms during the 1980s and 1990s reflected this view (Cheyne et al., 2005, p. 216).

New Zealand moved to a different equity policy approach by means of adopting a more targeted benefit approach. Subsidies were extended throughout the 1990s to improve access to primary healthcare and pharmaceuticals for low-income patients and children, via concession cards (Ashton, 1999, p. 135). Thus, New Zealand health policy could be regarded as selectivist, pro-natalist and anti-poverty oriented, as demonstrated by policies such as free or subsidized primary care offered for maternity services, children and people on low incomes. With the exception of children under six, the government subsidy covered less than half the cost of a visit with a GP (National Health Committee, 2000, p. 21). These tighter benefit targeting was a way to allow government to reallocate resources to other commitment in health, for instance to shift priority from hospital care to community care (Cheyne et al., 2005, p. 219).

The *Community Services Card* (CSC) was introduced in February 1992 to provide healthcare subsidies to people on low to middle incomes, and thus replaced GMS (Dew & Kirkman, 2007b, p. 220). The eligibility includes people on income-tested welfare benefits, and families who earn below a certain threshold. In 2001 the income limits started from \$18,586 for a single person sharing accommodation and the income limit increase depending on the size of the family. Over 40% of the New Zealand population holds concession cards, but varying estimates suggest that perhaps another one-quarter of eligible people do not. Further, people whose incomes are just

above the eligibility threshold for concession cards (another 5–10% of the population) face financial barriers in accessing primary care. In 1999, 43% of other New Zealanders, 64% of Māori and 68% of Pacific people were estimated to hold CSC (Ministry of Health 1999).

The *High Use Health Card* offers the same subsidies as the Community Services Card, for people with greater health needs for general practitioner services (Ministry of Health, 2007b). The card is issued specific to a person and s/he must have visited their general practitioner more than 12 times in the previous 12 months for an ongoing condition, irrespective of an individual's income (Ministry of Health, 1999a, p. 23).

The *Free Child Health Scheme*, introduced by the coalition government in 1996, subsidizes general practitioner consultations for children under six. The subsidy of \$32.50 was intended to cover most of the consultation fee (Ministry of Health, 1999a, p. 24). Since the amount has not changed since its introduction, general practitioners might find it increasingly difficult to maintain the service without co-payment (National Health Committee, 2000, p. 21). Children between six and eighteen years also have their general practitioner visits subsidized, and children whose parents have a concession card attract a higher level of subsidy (Ministry of Health, 1999a, p. 24). General practitioners can claim on consultations with cardholders, which reduce the co-payment made by a patient.

The government subsidies in 2001 were as follows (Ministry of Health, 1999a, p. 25):

- \$32.50 per visit for all children under six years
- \$15 per visit for children aged 6–18 years (families without a concession card)
- \$20 per visit for children aged 6–18 years (family with a concession card)
- \$15 per visit for adults (over 18 years) with a concession card.

Pharmaceuticals are free for inpatients, and people pay a maximum co-payment of \$15 per item on the Pharmaceutical Schedule from community-based pharmacies (Ministry of Health, 1999a, p. 25). Co-payments are reduced for people with concession cards to \$3, while pharmaceuticals are free for children less than six years (Ministry of Health, 1999a, p. 25). The *Pharmaceutical Subsidy Card* (Ministry of Health, 2007c) entitles the holder and their family to prescription charges of only \$2

per item for the rest of the year after the first 20 pharmaceutical items (Ministry of Health, 1999a, p. 25). The government set a standard charge of \$15 for prescribed drugs, while children under six being exempt (Ministry of Health, 1999a, p. 25). If the holder of a Pharmaceutical Subsidy Card also holds a Community Services Card then they pay no prescription fee at all after the first 20 prescriptions (Ministry of Health, 1999a, p. 25).

To summarize, this section has illustrated how the New Zealand government identified inequalities in health and inequalities in access to healthcare. To address this issue, New Zealand had tried different approaches, namely universalistic provision approach during the 1930s to mid 1980s, and then switched to target benefits approach in the 1990s. Result had demonstrated some limited success, yet it was not satisfactory.

#### **4.2.2 Developing Primary Health Organizations**

As King stated, primary healthcare is regarded to play a central role in tackling inequalities in health (2001, p. vii), not only because it served as the first level entry into the health system, but moreover because it is universally accessible. Primary Health Organization (PHO) is regarded as the local structure to meet the needs of a defined group of people. PHOs are organizations that GPs collectively set up as an infrastructure for their provider side in contracting. There are four types of PHOs, i.e. Independent Practitioners Associations (IPAs), loose network, community-owned organizations (usually non-profit), and smaller contracting practice (usually GP-owned) (Controller and Auditor General, 2002, pp. 131-132).

Although at first Primary Healthcare Strategy was perceived as a way for government to move back to universalism (Ashton, 1999, p. 147), through recent development it proved that it is more than that. It is a representation of the tension between social democratic population-based approach versus neo-liberal individualist approach (Cheyne et al., 2005, p. 226).

Primary Healthcare Strategy is not a new thing in New Zealand. It was well understood that the New Zealand primary healthcare policy for a long time has been influenced by a desire to achieve the following objectives: (1) to create a national health insurance arrangement involving the provision of GP services at zero or very low user charges on a universal basis, (2) to create an arrangement where an increased proportion of GPs is induced to locate in rural areas, (3) to increase the proportion of primary health care services going to low-income patients, (4) to improve the effectiveness of GP care in promoting health, and (5) to lower the total cost of care provided by GPs (Brown & Crampton, 1998, p. 88). However, Brown and Crampton (1998, p. 97) stated that previous policies were only partially successful in meeting these objectives. During the 1980s and 1990s there was growing bipartisan political consensus that universal government funded and organized health systems need to be equitable and efficient, and during those period more emphasis was placed on efficiency objectives (Brown & Crampton, 1998, p. 97).

The new Primary Health Care Strategy released in 2001, in contrast, places more emphasis on equity. As King asserted, the Primary Health Care Strategy priority objectives to reduce inequalities are to ensure accessible and appropriate services for people from lower socioeconomic status, for Māori and for Pacific people (2001, p. 3). She further mentioned that this priority was based on the New Zealand Health Strategy principles (2001, p. 2) which are:

- Good health and wellbeing for all New Zealanders throughout their lives
- An improvement of health status for *those currently disadvantaged* (emphasis added)
- A timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, *regardless of ability to pay* (emphasis added)

Universalism is based on the premise of 'same service to all' equivalent to 'equal services to all'. This might not be the case, as it denies the fact that there are some people who have obstacles in accessing the service (Reid, Robson, & Jones, 2000, p.

46). In other words, it might legitimate the non-recognition of ethnic disparities. A mix with targeted approach might be the next best thing.

Primary Healthcare Strategy is a unique key lever strategy to reduce inequalities of access because it is specifically designed not only to ensure accessibility for people from lower socioeconomic status, but also to provide equitable opportunity for Māori and Pacific people through its funding policies. The funding policy of PHOs reveals a distinctive feature of primary health strategy being a combination of both universalistic approach and targeted approach.

There are many ways to fund a health care service. In New Zealand, the main ways of funding primary healthcare are:

(1) **Fee-for-service** : a provider is paid a fee for each particular service they provide (WHO study group, 1993, p. 37), e.g. for a GP visit, for an immunization, for a cervical smear test, etc. Service might be defined quite broadly (e.g. for a GP visit) with few services and fees specified, or there might be well defined services (e.g. for a flu immunization) with many services and fees specified. Thus, the total revenue received by the provider depended on the number of services delivered, i.e. the more services delivered the more revenue the provider earns.

Fee-for-services has been the traditional way in which the government funded GPs, midwives, pharmacies and laboratories in New Zealand. In addition, user part charges and private payments for primary care are also paid on a fee-for-service basis. However, Bohmer (1998, p. 19) warned that fee-for-service appeared to reduce accessibility when a co-payment mechanism was involved.

(2) **Fee-per-case** : a provider is paid a fee for a particular case (WHO study group, 1993, p. 37), for example for each admission to hospital. Compared to fee-for-service arrangement, this method of funding provided an incentive to keep the volume and cost of individual services down. Thus, the total revenue received by the provider depended on the number of cases treated, i.e. the more cases treated the more revenue the provider earns.

(3) **Budget holding** : a provider is paid a budget for particular period (e.g. a year) (WHO study group, 1993, p. 37). The budget may be based on historical cost or on expected expenditure, or be based on a capitation approach. The budget may cover a narrow (e.g. GP care only) or a broad range of services (e.g. all primary care and hospital-based services). Bohmer (1998, pp. 36-37) suggested that providers would be under more financial risk as they would not receive more funding even though they delivered more services. Increases in the budget are usually negotiated with purchasers or insurers and budget may not automatically change as the population size and composition changes.

(4) **Capitation** : a provider is paid a 'per head' amount for a period of time (e.g. a month or a year) to provide care for the people who enrolled or registered with them (WHO study group, 1993, p. 37). The breadth of services covered may be quite narrow (e.g. GP services only) or extensive (e.g. all types of care, including hospital and long stay care). Capitation payments may be adjusted when a population or an individual has greater need (e.g. poorer health status) or when there is higher cost due to special circumstances (e.g. rural populations. Thus, the total revenue received by the provider depended on the number of people who enroll or register, and on the population's characteristics or other special circumstances. In comparison to the other funding mechanisms, capitation payment might have the greatest potential to reduce the cost to health service users as well as to control the cost of services (for more theoretical effects of fee-for-service, capitation and budget-holding, see Cumming, 1999, pp. 64-67).

The government had decided to introduce universal access to low cost services in phases by targeting the most needy populations first. These populations are defined as including Māori, Pacific people, or residents of the most deprived areas i.e. NZDep deciles 9/10 (Ministry of Health, 2004d). PHOs whose enrolled population is regarded as high need population are funded under the 'access' capitation formula, which includes levels of funding to enable low cost access for all enrolled persons regardless of their individual income level, deprivation level or ethnic characteristics (Ministry of Health, 2002b). Providers serving less needy populations were encouraged to form PHOs as well although their capitation funding is based on historical levels of fee for service subsidy. The funding formula for this group is called the 'interim', as it is an

interim formula until all PHOs is funded with one formula, i.e. 'access' formula (Ministry of Health, 2002b).

On average, an 'access' PHO receives 60% more government income than PHO under the 'interim' formula (Hefford, Crampton, & Foley, 2005, p. 14). The direct impact on this subsidy is reduce in co-payments from \$40 (PHO with 'interim' funding) to \$15 (PHO with 'access' funding) per visit for previously unsubsidized adults, and from \$25 (PHO with 'interim' funding) to \$15 (PHO with 'access' funding) for previously subsidized adults (Hefford et al., 2005, p. 14). It is possible that the 'access' formula created major incentives for the initial development of PHOs with sufficient deprived, Māori or Pacific people enrollees to qualify for the higher subsidies.

A further funding stream aimed at deprived populations is referred to as 'services to improve access' payment (Ministry of Health, 2007d). The structure is as follow: A premium of 20% of the base capitation rate is calculated for every individual living in a most deprived quintile census area, and a further 20% premium is added for every self-identified Māori or Pacific people enrollee, and the amounts are cumulative (Ministry of Health, 2007d). Both 'access' and 'interim' funded PHOs receive this funding.

The different between 'services to improve access' funding from 'access formula' funding is that it is available to all PHOs, in amounts determined by the number of qualifying individuals on their register (Ministry of Health, 2007d). Hence, it is equitably allocated across the deprived population. Furthermore, it is intended to pay for supplementary non-medical services not uniformly provided by primary healthcare services, for example mobile nursing, and thus reduce transportation cost for users (Ministry of Health, 2007d). In other words, it provides resources to support PHOs working with those groups with high health needs and/or poor access.

The 'very low cost' funding was also introduced in 2006, and act as payment for PHOs that charge nothing for children under six, a maximum of \$10 for children aged 6-17 and a maximum of \$15 for adults (above 18) (Ministry of Health, 2007e).

The other new funding stream for PHO services is for health promotion services, a needs-adjusted using the same weights described above for Services to Improve access (Ministry of Health, 2007a). The funding enables PHOs to engage in population-based health promotion services, including those addressing structural determinants of health through community and in local policy action.

The Ministry of Health, set minimum requirements for PHO to be eligible to receive the new capitation funding, and one of these requirements explicitly stated that “PHOs will be required to work with those groups in their populations (for example, Māori, Pacific and lower income groups) that have poor health or are missing out on services to address their needs” (2001, p. 4). It is clear from this statement that PHO is regarded as a vehicle to address inequality in health.

Growth in total PHO enrolment is potentially showing positive result. For example, enrolment in ‘access’ PHOs was almost double the initial projections and this reflected interest and willingness on the part of providers to offer reduced costs services (Hefford et al., 2005, p. 15). There were also policy changes that contributed to the rapid growth of PHOs, that Hefford et al identified (2005, p. 15) : (1) allowing all providers in whole districts to receive ‘access’ level funding if the population characteristics of the district meet access thresholds; and (2) allowing ‘access formula’ funding to apply at a practice level.

Hefford et al (2005, p. 15) further illustrated that as at October 2004, 78% of New Zealanders (3.7 million) were enrolled with PHOs, and most of them were enrolled with ‘access’ PHOs or ‘access-funded’ practices. As ‘access’ PHOs have relatively low levels of total enrolment (averaging just under 20,000 in comparison to the overall average of 40,000) they are tend to be more community-focused (Hefford et al., 2005, p. 15).

A community-focused PHO is crucial and in line with the World Health Organization concepts of primary healthcare. The World Health Organization sees primary healthcare as the most local part of a comprehensive health system, and recognizes that the public should participate individually and collectively in the planning and implementation of healthcare, and thus regards primary healthcare as vital in

achieving Health for All (Starfield, 1992). Studies in Europe and the UK suggested that public demand for a more community-oriented approach to primary care delivery is recognized as a major structural and organizational challenge to health service delivery (Saltman & Figueras, 1997, p. 58).

Crampton (1999, p. 4) summarized from previous studies that community participation in primary care occurs across a range of activities including receiving benefits of a program, participating in program implementation, monitoring and evaluation, and contributing to program planning and management. He also found that potential benefits of community participation in primary healthcare include improved effectiveness and efficiency, better coverage and greater equality of resource allocation, and greater self-reliance (Crampton, 1999, p. 4). Thus, while there is limited evidence linking community participation in primary healthcare with improved health outcomes, he suggested that the potential for it to do so by means of the benefits is significant (Crampton, 1999, p. 4). The next section depicts how third sector primary care has an important role of addressing inequalities of access in New Zealand.

#### **4.2.3 Developing the Third-Sector**

Community participation, community development and the Primary Healthcare concept are essential to understanding the development of third sector primary care in New Zealand. The community development approach evolved out of social reform movements in the 1960s and was embodied in Health For All 2000 in 1977, the Alma Ata Declaration, the Lalonde Report and later the Ottawa Charter (Crampton, Dowell, & Woodward, 2001, pp. 1492-1493). Traditionally, community trusts provide or contract for healthcare facilities and services for people in their local community and have been encouraged by the funding authorities to develop integrated health services. In order to receive government funding, a community trust must show that it represents and serves its community.

Crampton (1999; Crampton et al., 2001) had provided a comprehensive review over the political economy background of the third sector based on several studies. From

the politic viewpoint, he mentioned that a healthy voluntary sector is characteristic of democracies in which third sector organizations cater for diversity in a way that would not otherwise be achievable (Crampton, 1999, p. 6). From the economic viewpoint, Weisbrod (as cited in Kendall & Knap, 1996, p. 12) developed the demand-side theory that the third sector responded to demands for public goods or quasi-public goods and services supplied by neither the market nor the state due to its nature of being non-excludable and non-rival. While Crampton (1999, p. 10) stated that Hansmann presented the contract failure theory which suggested that third sector organizations arise where ordinary contractual mechanisms do not provide consumers with adequate means to evaluate accurately the quantity or quality of the service a firm produces for them.

Two broad sets of circumstances for the development of third sector had been identified, which are in the context of countries with inadequately developed healthcare systems where social mobilization and access to basic services are key motivating factors; and in the context of industrialized countries in which the public provision of primary medical care is diminished or where there is no universal financial cover for primary medical care (Crampton et al., 2001, p. 1494). Arguably the development of third sector in New Zealand reflected the latter.

The third sector had an accepted and widespread role in the provision of a range of services including well-child care, family planning services and particularly disability support services, and evidence of acknowledgements of their importance can be found in a variety of sources. The 1974 White Paper, *A Health Service for New Zealand*, noted that “Voluntary organizations in New Zealand have generally arisen to meet a need or plug a gap in the network of State provided health services” (Minister of Health, 1974, p. 88). The *Report of the Committee to Review Primary Medical Services* admitted that third sector development was also drawn to their attention (Committee to Review Primary Medical Services, 1982, p. 5). The Report of the Royal Commission on Social Policy further endorsed the role of the third sector in provision of health services (Royal Commission on Social Policy, 1988, p. 751).

Government support for third sector organizations in primary healthcare was explicit for the first time in 1991 through *The Green and White Paper* (Upton, 1991, p. 35).

The policy guidelines for regional purchasing authorities reflected the above support for new approaches, particularly in the context of Māori health (Shipley, 1995, p. 29). During the health reforms of the 1990s, the government identified Māori wanting greater autonomy and flexibility in the delivery of healthcare, thus a lot of emphasis on Māori health gains, Māori participation in planning and implementation of health service policy, and Māori provider development was being placed in government objectives throughout the 1992 to 1997 reforms (Crampton et al., 2001, p. 1497).

Crampton (1999, p. 16) noted that the third sector primary healthcare in New Zealand was developed as a response not only to financial barriers to access healthcare for low income population, but also as a response to a desire of *iwi* and consumer groups to exercise more control over primary healthcare services. This was an important feature of the development of third sector primary healthcare in the 1990s as it reflected the very notion of Third Way in health sector. A study focused on Health Care Aotearoa (HCA) is the best example to illustrate this.

HCA is a national network of non-profit primary care providers established in 1994 (Crampton et al., 2001, p. 1496) that adopted population approaches to the provision of primary care services in four areas. The first area is targeting of high needs population which are based on the ethnicity, deprivation and CSC holding status of patients (Crampton, 1999, pp. 25-26). The second area is geographical location of services: The geographic location of HCA services was governed by the needs of the communities served (Crampton et al., 2001, p. 1498). Consequently, the majority of HCA organizations were located in poor urban areas, or in remote rural areas with predominantly Māori population (Crampton et al., 2001, p. 1498). The third area is population-based funding (Crampton, 1999, p. 26). The most common model for funding HCA organizations was block funding by the government purchasing agencies, generally via a capitation funding formula which is a form of population-based funding where income is determined by the size of the patient register, with weighting for factors such as age, sex, CSC status, and average number of consultations (Crampton et al., 2001, p. 1498). The last area is denominator management which refers to the consideration of the practice population, or sub-groups, in the planning and evaluation of health interventions (Crampton, 1999, p. 26).

So far we have looked at generic strategies that New Zealand adopted to address the inequality of access to healthcare. The strategies consist of: (1) provision to the population through universal free access scheme plus additional benefits (1938-1984) which then changed to merely targeted benefits scheme (since 1984), (2) funding policies to the provider, as evidenced by various equity funding policies to PHOs, and (3) partnership with the third sector to serve the disadvantaged and marginalized population. The abovementioned strategies deal directly to reduce cost barriers to access primary healthcare. Aside from those strategies, there are other strategies that specifically designed to improve primary healthcare accessibility for Māori and Pacific people, as described below.

#### **4.2.4 Specific Strategy**

The next section analyzes and discusses some specific strategies to improve accessibility to healthcare for Māori and Pacific people. The strategy is taking a twofold approach that supports both the development of Māori and Pacific people provider services and the enhancement of mainstream services. This research focuses on the former, as the latter is more aimed to reduce non-financial barriers of access.

##### **4.2.4.1 Developing Māori health provider**

Māori healthcare is a high priority area for New Zealand, in response to demands for political self-determination by Māori, and given concerns about the poorer health status of Māori compared to other New Zealanders (Ellison-Loschmann & Pearce, 2006, p. 616). Key issues include focusing health policy on making mainstream health services more responsive and whether Māori should be supported in running their own health system.

A single health system provides services to both Māori and other New Zealanders, known as the mainstream services. In other words, there is no parallel health system for Māori and other New Zealanders. Thus, there is no preferential access to services

or Māori control over their own separate healthcare system. Consequently, (1) funding for Māori health providers is sourced through the government budget Vote: Health; (2) Māori providers have similar contracts to other New Zealanders services; and(3) Māori are able to make use either mainstream or Māori health services, while on the other hand people of any ethnic group are able to attend Māori health provider services.

During the 1990s, the New Zealand government used *Whaia te Ora mo te Iwi* document as the basis of Māori health policy, and stated two specific foci for Māori health which are Māori health provider development and the provision of comprehensive Māori health services (National Health Committee, 2002, p. 10). Maori health policy objectives of RHA and the Public Health Commission were stated in *Whaia te Ora mo te Iwi* , namely (Te Puni Kokiri, 1993, p. 14):

- 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; and
- the development of culturally appropriate practices and procedures.

As this research focuses on the cost barriers to access, we will not discuss the development of culturally appropriate practices and procedures. Having said that, we acknowledge that it is highly important to provide such practices and procedures, however it should be discussed extensively in other research.

*Te Puni Kokiri* (Ministry of Māori Development) that was established in 1992 and Māori Health Directorate that was established in 2000 advised the government on how to improve Māori health outcomes (Maori Health, 2007a; Te Puni Kokiri, 2007). In 2002, *Māori Health Strategy* was released and discuss several policy areas as follows: funding health services that respond to the needs of *hapu* (sub-tribe), *iwi* (tribe) and Māori; monitoring Māori health outcomes; and reviewing the responsiveness of the Ministry of Health to Māori (Minister of Health and Associate Minister of Health, 2002).

The restructuring of the New Zealand health system and the new purchasing arrangements in 1993 opened up more opportunities to Māori healthcare providers (Ashton, 2000, p. 118). Māori community trusts were encouraged to provide services, to contract with other providers, and to develop alliances with local health and social service providers (Cunningham & Kiro, 2000, p. 76). Māori provider services have specifically identified access issues as a key factor and have used a range of strategies to address these issues, including extensive mobile services and outreach clinics, free or low cost health care, employment of primarily Māori staff who are more likely to have access to Maori consumers in their communities and active inclusion of the community in the planning and delivery of services (Ellison-Loschmann & Pearce, 2006, p. 615).

The 1993 health reform had enabled Māori to access mainstream funding for the delivery of primary healthcare to Māori by Māori. As a result, the number of independent Māori health service providers increased significantly. Many *iwi* (tribe) and urban-based health organizations manage a range of health and disability services for enrolled populations, typically offering public health services, screening, primary care, well-child services and home support (Te Puni Kokiri, 1994, pp. 7-17). There were four funding assistances under Māori Provider Development Scheme (MPDS) to boost the development of Māori health services provider, and this scheme helped increased the number of Māori health providers from 23 in 1993 to over 240 in 1998 (Ministry of Health, 1999a, p. 34).

However, the bulk of funding for Māori health remains concentrated in mainstream services, thus it is not clear to which extent priorities for resource allocation take account of Māori needs and perspectives. For example, a closer look at Vote:Health 2000/2001 revealed that direct expenditure for Māori health services was \$181.6 million (an increase of \$54.8 million from the previous year's expenditure). In addition, \$10 million was budgeted and expanded for the Māori Provider Development Scheme that allocated on an annual basis, for provider and workforce development. The direct expenditure for Māori health services is grouped into two categories namely services provided by Māori health providers (\$136 million), and Māori initiatives delivered by mainstream providers (\$46 million).

To address the financial barriers to access relating to co-payment for GP and prescriptions, the Māori health providers markedly cheaper co-payment (for those with or without CSC) while working with local pharmacies in making drugs free for CSC-holders and reduced for non-CSC holders (Crengle, 2000, p. 51). They also use mobile clinics and satellite clinics to improve access and reduce cost of patient's transport (Crengle, 2000, p. 51).

An important feature of the national PHO contract contains provisions to report priority health gain in regard to Māori Health Action Plans (MHAP) which include (Ministry of Health, 2004c, p. 2):

- the ethnicity of enrolled service users
- service utilization
- health promotion activities for high needs groups
- services to increase access for high-needs groups

This policy is important to incorporate primary healthcare strategy into Māori health strategy, and thus directly link PHOs to the effort of reducing inequalities of access for Māori.

With the Crown's growing commitment to the Treaty of Waitangi, any discussion of Māori health policy now acknowledges biculturalism and the special relationship under the Treaty between the Crown and Māori (Cunningham & Kiro, 2000, p. 67). The development of Māori health services during the 1990s was based upon the principles that health inequalities must be reduced and that the special needs of Māori should be met (Maori Health, 2007a). These strategies have included allocating more health funds to areas with a large Māori population, strengthening Māori healthcare provider organizations, improving skills in the Māori healthcare workforce, gathering better data on Māori health status, and making mainstream health services more responsive.

Emphasis on Māori involvement in health has been stated in the Māori Health Strategy Discussion Document *He Korowai Oranga*, that advocated the concept of *Whanau Ora* (Ministry of Health, 2002d, p. 3). Four pathways have been identified to implement this concept: Pathway One, the development of *whanau*, *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 (Ministry of Health, 2002d, p. 4). The document urges greater partnership, participation and health protection according to the principle of Treaty of Waitangi (Moon, 2007, p. 91). Again, we found the notion of community development and community participation in this policy.

A new government set out partnership with Māori in the New Zealand Public Health and Disability Act 2000 and in the District Health Board accountability documents. These provisions require that District Health Boards (Ministry of Health, 2006):

- 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.

These developments reflect the government commitment to achieve greater participation by Māori people at all levels of the health and disability sector. However, an unresolved issue persists on the extent to which Māori wish to control their own healthcare, through *kaupapa* services (by Māori for Māori), through community services, and primary healthcare (Cunningham & Kiro, 2000, p. 77).

#### 4.2.4.2 Developing Pacific peoples health providers

The people from the Pacific Islands make considerable use of mainstream health services, mostly in secondary care, for preventable diseases and emergency care (Ministry of Health, 1997, p. 7). Therefore, more priority is being directed at improving access to primary care for the Pacific population (Minister of Health, 2002, p. 12). One of the working principles for Pacific health strategy is the equity principle as it is desirable for the Pacific people to achieve greater equity in the

allocation of resources as measured by health outcomes and health status (Ministry of Health, 1997, p. 11). Another priority area for Pacific health is developing Pacific providers to enable 'by Pacific for Pacific' (Minister of Health, 2002, p. 15).

Although a large number of Pacific people came to New Zealand during the 1950s and 1960s, Pacific health providers were only growing in the late 1980s and later on in the 1990s (Ministry of Health, 2003, pp. 11-13), for example with the establishment of Pasifika Healthcare in 1989 (Ministry of Health, 2003, p. 15), Healthstar Pacific in 1994 (Ministry of Health, 2003, p. 22), and many others in the late 1990s. It seemed that in the 1990s, Pacific people started to move from being spectators to being involved citizens in advocating better health, at the same time as various Neo-Liberal and Third Way reforms of the health system were introduced in New Zealand.

In 1998, Pacific Provider Development Fund (PPDF) was established by Ministry of Health (Ministry of Health, 2003, p. 9), to enhance management skills and health services skills of Pacific people in order to participate in the development of the health and disability sector. This resulted in the development of 30 Pacific owned health providers in 2000 (Minister of Health, 2002, p. 15). Annually, \$25 million is spent by Pacific health provider (Ministry of Health, 2003, p. 49). Specific services for Pacific people totaled \$21.3 million in the 2000/2001 financial year, including services delivered by Pacific providers and those delivered by mainstream providers. This was a significant increase from the first targeted funding of \$2.6 million that the Pacific Health received in 1993 (Ministry of Health, 2003, p. 8). In addition, the PPDF Scheme administered \$1.5 million in 2000/2001.

In 2004, 96% of Pacific people were registered with a PHO and indicated a further potential improvement (Ministry of Health, 2005, p. 13). Yet, the report also indicated that Pacific people were more likely not to see a doctor even when they perceived a need to (Ministry of Health, 2005, p. 17). Cost barrier is mostly the reason for this unmet need (Davis, Suaalii-Sauni, Lay-Yee, & Pearson, 2005, p. 4). Consequently, Pacific people have higher rate of avoidable mortality than all New Zealand benchmark at about 50% excess risk (Ministry of Health, 2005, p. 3).

### **4.3 Discussion**

This section discusses the above findings to answer the research inquiry on the whether the abovementioned strategies are appropriate to reduce inequalities of access to healthcare, as well as likelihood of success of these strategies.

Universalism and selectivity are the traditional principles of social allocations. Universalism refers to benefits available to an entire population as a basic right, while selectivity refers to benefits available on the basis of need, determined by a test of income (Gilbert & Terrell, 2005, p. 97). The universalist aims for social cohesiveness, while the selectivist aims for targeting the most dire straits.

Howden-Chapman (2005, p. 63) firmly suggested that universal provision provided more complete coverage of population and reduced relative inequalities. She (2005, p. 56) revealed a small progress in absolute mortality rate for Māori that had declined by 28% in 1980s compared to mid 1970s. Report had demonstrated that between the 1940s and 1960s the differences in mortality rates between Māori and other New Zealanders decreased significantly (Dew & Kirkman, 2007a, p. 245). It could be the result of high investment in health by governments during that period.

Arguably, universal provision was regarded as ineffective because the middle to high-income individuals and families benefited as much as the poor, better known as 'middle-class capture' (Boston & St John, 1999, p. 98) . It is also a known fact that the non-poor tend to make greater use of health services and thus public expenditure suffered for the benefit of the better off rather than the poor (Le Grand, 1982, p. 3). Thus, health reforms were expected to produce better equity policies.

In reality, health reforms in the 1980s and 1990s did not necessarily yield net benefits to society. The neo-liberal effort to introduce competition, for instance, did not produce the desirable impact. Competition in New Zealand quasi-market, in particular managed competition might be no more than rhetoric. It was manipulated to justify

privatization, budget cuts, user fees, two-tier access and rationalization of services, as chapter 3 demonstrated.

Total expenditure in real or nominal terms is a crude but readily available measure of health policy analysis. Its value however is muddied by the fact that the total health budget usually increases in real terms regardless of the organizational structure. Moreover, changes in real health expenditure by the public sector have to be considered alongside increases in out-of-pocket payments by households and increases in the proportion of the population with private health insurance. Private out-of-pocket expenditure, private health insurance and contributions from charities accounted for 12% of total health expenditure in 1979/80 and 23% in 1994/95, indicating an average annual increase of 15.5%. (Ministry of Health, 1996, vol. 2).

As chapter 3 suggested, there was an overwhelming evidence that private expenditure had increased at a much higher rate than public expenditure, and this trend indicated that the government was controlling public expenditure largely by cost shifting (Cheyne et al., 2005, p. 221). A study in Sweden had found that co-payments discourage visits for low-income people, irrespective of how medically necessary the visit was thought to be (Burstorm, 2002). There was extensive evidence that this was also the case in New Zealand (J. Barnett & Coyle, 1998; Dixon, Watt, & Thompson, 1994; Waldegrave, King, & Stuart, 1999). For instance, a study suggested that level of utilization fell by 15% shortly after the introduction of the new subsidy and charging regime in GPs (Davis, Gribben, Yee, & McAvoy, 1994). New Zealand government also had reviewed the user-charges regime to see when charges were useful and where they were not in order to manage access for targeted groups (Treasury, 1999, p. 26).

Another critique suggested that the cut-off point for subsidized healthcare is so low that those families located in lower income level above this point were severely penalized (Social Policy Unit, 1991, p. 13). A survey had found that adults with below-average income were more likely to report having gone without needed care because of the cost while similarly Māori adults were twice as likely as non-Māori to have gone without needed care in the past year for the same reason (Ministry of Health, 1999c, p. 206). In other words, this tendency was partly reflecting income differences.

The likelihood of holding health insurance is higher among employed people, but Māori are less likely than non-Māori to have private insurance (Caccioppoli & Cullen, 2005, p. 139). In the absence of health insurance coverage, access to timely medical care has to be paid for privately, but many Māori lack the means to do so (Blumberg, 2006, p. 50). A later assessment in 1984 and 1991 showed that Māori still have poor health status in comparison to other New Zealanders (Watene-Haydon et al., 1995, p. 17), suggesting that inequality in health persist in this period.

Furthermore, New Zealand has a lower ratio of medical practitioners for its population than many other OECD countries. Health Funding Authority data showed considerable variation in the distribution of general practitioners and in the use of general practitioner services, with rural areas, poorer towns and poorer areas in cities generally under-served. Research in Auckland in the mid-1990s showed that primary care expenditure in disadvantaged parts of the city was 30% below that expected in Health Funding Authority calculations, while wealthier areas were 40% above (Malcolm, Wright, & Barnet, 1999). The HFA calculation included general practitioner subsidies, pharmaceuticals and laboratory tests and was based on the local population size. This study showed that people living in disadvantaged areas were not making full use of the health services available to them, and that this under-use of primary care is almost certainly related to poorer health and to greater use of hospitals by these populations.

Since Māori tend to live in areas of higher deprivation, the inverse care law operates. While Māori certainly have greater health needs, the research on their use of health services, however, is equivocal: some studies show lower use of health services and others show higher use, suggesting different groups of high and low service users. For example, the 1996/1997 Health Survey found that Māori and people on low incomes, visited their primary care provider more often than the rest of the population, but also reported higher unmet needs (did not see a GP when they thought they should) from this group due to cost barriers, especially Pacific people (Ministry of Health, 1999c, pp. 3, 201-203, 206).

Although the mortality rate from all major causes had continued to decrease, the mortality rate for Māori, still exceeded those of other New Zealanders (Watene-Haydon et al., 1995, pp. 80-82). Similarly, the Pacific people was also not getting appropriate access to care (Southwick, 2005, p. 108), most probably due to the fact that they are even in a more deprived decile (Ministry of Health, 2002c, p. 10). The fact remains that Pacific people are experiencing poorer health than other New Zealanders (Ministry of Health, 1999b).

As at July 1, 1997 about 30% of New Zealand population were CSC holders (Crampton, 2000, p. 212). A study suggested that CSC-holding has been shown to be associated with increased utilization of primary care (Gribben, 1992). However, Crampton (2000, p. 212) suggested that a significant minority of those eligible for a CSC have not received it, because of administrative, cultural or other barriers. As a result, the usefulness of CSC ownership as a means of targeting those most in need was limited (Cheyne et al., 2005, p. 220).

As cited by Crampton (2000, p. 212), Parks found that 28% of non-CSC holders interviewed were eligible for a CSC but did not have one. Other New Zealanders were significantly more likely to have one, while Pacific people were significantly less likely to have a CSC. Similarly, Crampton (2000, p. 212) cited that Gribben research estimated the CSC uptake rate among those eligible was only 77%.

We found that targeted benefits, when it is on top of universal provision, might have advantages to tackle ethnicity disparities; but when it is a stand-alone scheme, might have limitations. Howden-Chapman's analysis (2005, p. 63) demonstrated that health services were less available to low-income families compared to the rest of the population, even with CSCs.

That being said, the 1990s also marked by increased in Māori health providers and community-focused services (Cheyne et al., 2005, p. 222). Although there was no parallel improvement in Māori health status, Durie (2000, p. 9) praised government's recognition of Māori health as a priority health gain area, higher health awareness among Māori and greater participation in health decision. With Māori health providers grew significantly and more Māori entered medicine or associated health

professional training, these might result in *kaupapa* Māori in the near future (Cooper, 2000, p. 106).

A study suggested tracking the progress of enrolment status of Māori whether at mainstream PHOs or Māori provider. For instance, data suggested that Māori enrolment at 34 PHOs established as at the end of June 2003 was 46%, while 16 out of 34 PHOs were designated Māori PHOs (NZIER, 2003, p. 8). A high proportion of Māori members is associated but not exclusive to, being a Māori PHO. Similar reports should be made available to track progress of Pacific people enrolment at mainstream PHOs and Pacific PHOs.

The reform in 2000 marked of the return to the social democrat way, although it is now more of a 'new' social democrat, or the Third Way (Cheyne et al., 2005, p. 74). The government withdrew from the original 1938 universalism provision, and yet it did not reverse to the full-blown market-driven healthcare of the 1990s. Rather, the current strategy was a mix of private, community-based and public sector with a more cooperative framework and partnership (Cheyne et al., 2005, p. 223). This was done through the establishment of a more equity funding policies for primary healthcare and the development of third sector.

Firstly, we need to consider whether the primary healthcare policy delivers improved access to healthcare and, secondly, whether improved access to care will deliver health outcome benefits for Māori and Pacific people, especially those living in deprived areas.

In 1996/97 survey, Māori people had a higher proportion of frequent GPs visit compared to other ethnicity, while the Pacific people had similar proportion of frequent visit to GPs as other New Zealanders despite having higher health needs (Ministry of Health, 1999c, p. 202). The survey also demonstrated that people from the most deprived areas were significantly more likely to be frequent users of GP services (Ministry of Health, 1999c, p. 203). However, it also demonstrated that 18.6% of Māori and 17.5% of Pacific people did not visit a GP although they have need to do so, which was more than 1.5 times the rate of unmet need by other New Zealanders (Ministry of Health, 1999c, p. 206). In general, unmet need for GP

services increased with level of deprivation, especially in urban areas, and tended to have cost barrier as reason for not visiting GP (Ministry of Health, 2007g, p. 50).

A study of Pacific patterns in primary healthcare utilization suggested that in some respects Pacific patients used primary health care services in a way very similar to other New Zealanders, but in other respects they seemed disadvantaged (Davis et al., 2005, p. xiii). The survey analyzed data from independent/private GPs, community-governed PHOs and Māori provider and concluded that third sector providers were important for Pacific people (Davis et al., 2005, p. 93). The survey also suggested that the primary health care system is working positively for Pacific patients as the predominance of Pacific patients at clinics that are community-governed, and the higher level of service they receive there, indicated aspects of the system that appear to be operating as intended (Davis et al., 2005, p. 95).

A study suggested that there are evidences of improved access for disadvantaged and marginalized population by introducing equity principle in PHOs funding policy. Firstly, almost 10% of the New Zealand population who had not previously been subsidized is now subsidized for the cost of primary care visits (Hefford et al., 2005, p. 16). Among them are the vulnerable Māori and Pacific people ethnic groups, and around 52,000 are not Māori or Pacific people, but live in the most deprived areas (Hefford et al., 2005, p. 16). Specifically, 34% of the Pacific people enrolled in 'low cost access' PHOs did not previously receive subsidized care (Hefford et al., 2005, p. 16). Further, although 60% of 'access' PHO enrollees were already subsidized under the previous policy, the subsidy amount is now 25 to 66% greater (Hefford et al., 2005, p. 16).

Secondly, the per person payment to PHOs on behalf of Māori and Pacific people enrollees is more than 70% greater than the per person amount for other ethnicities (Hefford et al., 2005, p. 16). This was a result from the combined effect of having a greater proportion of the Māori and Pacific people populations enrolled in 'access' PHOs, the younger age profile of the Māori and Pacific people population and the need weightings used in the funding for 'services to improve access' and health promotion (Hefford et al., 2005, p. 16).

Notwithstanding the above, the funding policy has some negative impacts to equity as well. For instance, almost 41% of the recipients of the 'access' formula are not in the high priority target groups, i.e. they are not Māori, or Pacific people, nor do they live in the areas containing the most deprived 20% of the population, hence the amount spent on providing them with low cost access is unlikely to reduce health disparities (Hefford et al., 2005, p. 17). This implied an allocative efficiency issue i.e. the funding being used to subsidize these groups could have been allocated to extend subsidies for high priority groups (Hefford et al., 2005, p. 17).

Another potential risk is the trade offs between the amount of the available subsidies, and the number of individuals who qualify for subsidies. It was argued that emphasis on universal entitlement carried the risk of using new funding to extend subsidies to further less needy individuals rather than to raise subsidy levels for the most highly deprived populations (Hefford et al., 2005, p. 17).

There are other tradeoffs that might occur as well. Co-payments by those with Community Service Cards could have been lowered, though this would not affect the significant number of people who are eligible but do not have these cards (Hefford et al., 2005, p. 18). The universal higher subsidy for children under six could have been made available for all children and adolescents. This would particularly benefit the Pacific people and Māori population who have a much lower median age than other ethnicities, however it would also benefit children of high income families, thus not addressing the financial barriers for adults with high health needs and low incomes (Hefford et al., 2005, p. 18). We could conclude here that the tension between the goals of universal low cost access and very low cost access for the most deprived populations is most unlikely to be resolved in near future.

The requirement that PHOs provide comprehensive medical care has the effect of targeting the strategy at providers with a certain critical mass of enrollees and extensive human resources (Hefford et al., 2005, p. 20). Thus, Māori and Pacific provider which often provide limited services might not be eligible to access PHO funding for their populations. One possible result is that Māori organizations might need to align with other entities to create PHOs or to subcontract a PHO (NZIER,

2003, p. 14). On the other hand, there is pressure for IPAs to form such alliances, since they must meet requirement to work with groups that have poor health and involvement of *iwi* in governing processes (Hefford et al., 2005, p. 20).

It is clear that the strategy of developing PHO is not enough to solve the inequalities of access problem. There are, in fact, risks that the inherent tradeoffs, in particular its funding policy, could have disadvantaged equity. Next we need to discuss whether the development of third sector in providing services to the disadvantaged and marginalized population would have impact on reducing inequalities of access.

As mentioned in the previous section, HCA registered practice populations are categorized in terms of ethnicity, deprivation and CSC-holding. The ethnicity profile of the registered practice populations was highly atypical for New Zealand, with 21.8% European, 36% Māori, 22.7% Pacific Island and 12% other (Crampton, 1999, p. 29). Overall, registered patients tended to live in highly deprived areas, with 64.9% of patients lived in areas defined as being amongst the 30% most deprived areas in New Zealand (Crampton et al., 2001, p. 1497). The recorded CSC holding rate amongst HCA organizations varied between 43 and 75% (Crampton et al., 2001, p. 1497). By and large, the population served by HCA organizations represented the characteristic of low-income groups. Crampton et al. (2001, p. 1498) argued that the overall CSC holding rates were higher than that recorded in other primary care studies and that deprivation distributions were highly skewed. This data implied that HCA has great potential to play major role in providing services for the disadvantaged and marginalized population, although further research might be needed to prove this argument.

#### **4.4 Summary**

This chapter demonstrates that New Zealand government has always acknowledged inequality in health, in particular that of ethnic health disparities. This chapter also demonstrated that policies aiming at improving equal access to healthcare had gone from universal provision to targeted benefits and/or subsidy. The Community Service Card policy is one of the targeted benefit policies that still adopted throughout

different health systems and different ideologies behind those health systems. In later year, New Zealand also utilizing PHOs funding policies to address issue of access, as well as encouraging the Third Sector to contribute to population health.

PHOs funding policy is an example of a mix between universalistic approach and targeted benefit approach. For many New Zealanders, in particular Māori, Pacific people and the lower income population, there are now lower fees to access primary healthcare, and there are indications that access to services has improved. Nonetheless, there are also risks and tradeoffs involved. Consequently, the primary healthcare strategy needs to be implemented with close monitoring. With equitable funding policies for PHOs, plus additional funding scheme such as MPDS, it is expected that the number of Māori providers offering a range of primary care services will grow, as will similarly Pacific provider numbers through PPDF scheme. However, it is important to understand that funding mechanism by itself could not improve health outcomes.

New Zealand evidence demonstrates that third sector organizations play an important role in providing primary care services to disadvantaged and marginalized populations. HCA organizations were generally located in low-income areas that had high need for primary care services, and user charges were low. Financial barriers to access were thereby minimized. However, there is very little published New Zealand evidence related to the effect of third sector primary care on health status of populations.

The final chapter will elaborate further summary of the findings as well as point to some conclusions.

## CHAPTER 5 Summary and Conclusion

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The primary concept of justice from an egalitarian and liberal point of view is that individuals are of equal worth and should be treated equally. These views are concerned with whether there is an assured equal opportunity for every individual to obtain care, regardless of personal characteristic such as age, gender, race, income or whether one lives in the city or rural area. On the other hand, governments aimed at minimizing, or if possible, eliminating the health status differentials or variations. Accordingly, studies in health equity usually concern themselves with health disparities and the fairness and effectiveness of policies and procedures for addressing these disparities. The ultimate test of the equity in health policy is the extent to which disparities or inequalities in health persist among subgroups of the population, in particular those of disadvantaged and marginalized subgroups.

### **5.1 Summary**

#### **5.1.1 Summary of research process**

The purpose of the research is to provide an insight into New Zealand's health system in relation to different policies and strategies addressing the inequality to access of healthcare for Māori and Pacific Island people. In investigating this issue, the research compares the Social Democracy, the Neo-Liberal and the Third Way perspectives as the framework of analysis. The main difference between the above mentioned perspectives is their view of the responsibility and role of government in ensuring equity.

This research employs a system level analysis that focuses on the availability, organization and financing of healthcare as aggregate and structural property. Primary and secondary data sources were used for analysis. As a descriptive study, this

research focuses primarily on profiling and reflecting data that are collected to identify symptoms of an issue of inequality in health in New Zealand, and to some extent making summative evaluation of the equity policies that were designed to address the issue. The research explores the appropriateness of strategies and what impact they have on reducing inequalities.

### **5.1.2 Summary of findings**

For many decades, New Zealand had attempted a universal provision driven by an ambition to achieve Social Democracy goals. The objective of Social Democratic policies was to expand social rights to the entire population as a way to protecting the citizens throughout their lifecycle. The Social Security Act 1938 mandated an open-ended commitment to universal access to healthcare. The provision of free in-patient care was followed by universal subsidies for General Practice (GP) and other medical services. Health spending was mounting and yet access to primary care was restricted. Subsequently, the health status did not show an equal outcome between subgroups of population.

In the 1980s perceived growing problems in financing and delivery of healthcare had urged a need to reform the health system. Public demand for healthcare is potentially insatiable and government health expenditure had risen tremendously. The extensive development of the welfare state in the Social Democratic regime required large taxes, a strong State and a high, if not full employment rate. As was also the case for many countries, New Zealand then shifted policies from those which would spread resources very thinly to those which target available resources at the most needy. In the previous model, healthcare was seen as positive rights in which the State has an obligation to provide resources so that the people could meet their health needs. In the latter model, healthcare was seen as negative rights in which healthcare function in the free market outside the public sector.

This was in line with Neo-Liberalism perspectives of the welfare state. The welfare state responsibilities were assigned to the private sector while public expenditure tended to be concentrated to the needy, with 'need' defined according to political-

administrative criteria. The New Zealand government promoted privatization of healthcare which in turn created an urgent need to ensure that the disadvantaged and marginalized population was not totally neglected. Targeting was perceived to be a powerful way of ensuring the efficiency of social expenditure.

Consequently, the issue of defining the target group and choosing the type of targeting became important. New Zealand's case provides example of a mix between targeting by income, by age, and by need. The target benefits in New Zealand are subsidized primary care services based on age (all children under 18 and senior above 65), income (through *Community Services Card*), beneficiary status, and medical need (through *High Use Health Card*). The government subsidy covered less than half the cost of a visit with a GP, except for children under six who receive a full subsidy.

The New Zealand health system, with fee-for-service primary care and GPs acting as gatekeepers to secondary services, seems to be more accessible to those with higher incomes. Higher rates of co-morbidities, multiple disabilities, more complex health needs, and lower incomes, make access to optimal healthcare a particularly important issue when considering health status differentials between Māori, Pacific people and other New Zealanders. Clearly, targeted benefits are not enough.

Ever since the launch of the Alma Ata Declaration, and more recently *Health For All*, primary healthcare has been promoted as a powerful means of addressing health inequalities. The New Zealand primary health care strategy is a bold attempt to redesign the financing and delivery of primary care services, consistent with the principles of the Alma Ata Declaration.

The government decided that PHOs serving people from most deprived areas are funded under the 'access' capitation formula, which includes levels of funding to enable low cost access of the enrollee regardless of their individual income level, deprivation level or ethnic characteristics. In addition, there are specific targeted benefits on top of this funding formula. A premium of 20% of the base capitation rate is calculated for every enrollee living in a most deprived quintile census area, and a further 20% premium is added for every self-identified Māori or Pacific people enrollee.

Some experts argued that there are a number of countervailing factors that may curb the effect of primary healthcare strategy on reducing inequality. These factors are the fact that many middle class people also benefit from the strategy, the question of whether co-payments are low enough to improve access for the poor, the question of whether PHOs use the funds intended to reduce disparities appropriately, the inexperience of 'mainstream' PHOs in designing and delivering services for high need enrollees and notably the small size and limited infrastructure of PHOs, especially the 'access' PHOs.

It is indicated by previous researches that lowering the cost of care is likely to lead to increased use of services. This has been demonstrated where studies have consistently shown that low income families go without needed care due to financial barriers. Many experts asserted that access to care is an important component in the elimination of socioeconomic disparities in health. However, there are a number of reasons why equity policy may reduce financial barriers to care for disadvantaged and marginalized populations, but fail to improve inequalities overall.

One reason is that a policy may improve health outcomes for all groups, meaning that the comparatively well off outcomes were also improved, resulted in persisting health inequalities. Middle class capture is another reason. It might be the case that the greatest subsidy and health benefits are captured by the more middle class populations.

Meanwhile, in the late 1990s the Third Way made its way into the health sector. The claim was that while the Neo-Liberals were keen to shrink the State, the Social Democrats constantly wanted to expand it. The Third Way is a way to reconstruct this extreme. The stress is upon re-establishing the link between "rights" and "responsibility" with recognition that some responsibility does not entail rights. The welfare state concept was transformed to the welfare society.

The State was expected to act in partnership with agencies in civil society to foster community development that might involve an extension of market economy. The third sector is perceived to be a way to end welfare dependency and actually

contribute to serving the disadvantaged and marginalized population. One of the best examples of the third sector serving disadvantaged and marginalized population in New Zealand is Healthcare Aotearoa (HCA).

The development of third sector primary care in New Zealand has been the result of perceived failures in government policies for funding primary care, namely lack of universal funding and provision of primary care. Third sector primary care services have been viewed by government, Māori groups and communities as worthwhile alternatives to public sector primary care arrangements. The concern, however, lies on to what extent the third sector should be regarded as a partial alternative to universal funding and provision of primary care services. It may be a convenient alternative to reduce State involvement in funding and provision of healthcare, but may not be desirable from the point of view of equality and the diminishing welfare state.

## ***5.2 Conclusion***

To answer the research questions, the New Zealand government has identified inequalities of access to health leading to inequality of health outcomes for disadvantaged and marginalized populations, namely the Māori and Pacific population, especially those living in most deprived areas, and has committed to reduce these inequalities. The commitment was reflected not only in the various approaches to equity policies throughout the years, but also in the effort of collecting data for monitoring and tracking progress of these inequalities. The commitment also incorporated attempts to better define 'ethnicity' in statistic and census process, as well as recognizing Māori concept of health and the Treaty of Waitangi principles.

The most important causes of the evolution of the funding and organization of healthcare are political. Efforts toward reducing inequalities need to trace back to the public policies carried out by the State's governing party. The values and ideologies of the ruling party play a major role in designing and implementing equity strategies. New Zealand is yet another example of how the government view of equity and equality from different perspectives lead to different strategies and policies in tackling

them, ranging from universal provision, targeted benefits and a mix of both. It also provides an example of different degrees that the State views responsibility in providing the services, ranging from mainly public to private, and a mix of public and third sector. It was clear that how the government intended to solve the issues of inequality of access to healthcare largely depended on what were the values and ideologies of the ruling party.

Health reforms during the 1980s and 1990s had shifted substantial cost of healthcare from government to individuals, and thus moved the New Zealand health system from universal access to access according to ability to pay. It seemed that the focus of reforms had been on greater economic efficiency, while the call for individual and community responsibility had been of secondary concern. The result was that for marginalized and disadvantaged population health reforms had produced a less equitable and less accessible health system.

Notably, it is not possible for a health system alone to achieve equal health status for all. Firstly, there are other socioeconomic determinants to health status, and the health system alone can not address every dimension. Secondly, social gradient exists, as many health sociologists might agree. No matter how prosperous a population is, those lower down in the socioeconomic hierarchy are likely to have worse health outcomes than those above them. However, it is certainly possible for a health system to pursue policies aimed at using more resources for those who most need them, give high priority to improving health of subgroups with worst health status, meet healthcare needs of different social groups, and strive for equity of access to treatment and preventive measures. These are contributions the health system can make towards closing the gap of inequality in health.

However, assumptions that improved access to care will automatically lead to improved health outcomes should be treated with caution. While the evidence for the impact of ethnicity and deprivation on health outcomes is fairly clear, the evidence for the impact of access to primary healthcare on health inequality is inconclusive. It is equally important to underline that variation in health status is not a result of ethnicity *per se*, but rather a result of differences in socio-economic status. Thus, ethnic and

socio-economic inequalities need to be monitored comprehensively and regularly using disparity factors while also considering contextual variables.

Primary healthcare strategy and funding mechanism have promising potential to address inequality of access to healthcare. The phasing strategy from targeted benefits back to universal provision was a wise decision and the government should proceed with caution to avoid the return of the middle class capture syndrome. Partnership with the third sector in providing services for the marginalized and disadvantaged population also seemed to have positive results. The third sector primary care has been largely successful in achieving its main aim of providing care to marginalized and disadvantaged populations, and in doing so helping to achieve key government health objectives. Still, there is a risk of third sector being less under the control of government and may behave more and more like organizations in the private sector. This risk calls for greater governance and stewardship function of the government.

Considerable effort is now required to measure cost, quality and effectiveness, and perhaps including health outcomes of services provided by primary care organizations serving disadvantaged and marginalized populations. These measurements will enable comprehensive evaluation which provides the opportunity to build future primary care policy on models that have been demonstrably successful in achieving health policy objectives.

New Zealand has undergone a series of health reforms. Nevertheless, the people and the health professionals need to have a sense of security and stability of the healthcare sector. Ultimately, it is time to find balance, rather than tension, between universalism and targeted benefits, between individual and collective responsibility, between principles of need and principles of justice.

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