

New Zealand's plan to contain rising costs



New Zealand has achieved some success in containing costs and improving effectiveness within its healthcare system, finds Dean Westcott.

■ In previous issues we have reported back on the lessons learned from ACCA's recent study tour to New Zealand. A common theme was the fact that despite outwardly appearing to differ, its healthcare system faces many similar issues to other countries.

A challenge facing all health care systems is that of delivering cost effectiveness and value for money when the potential cost of healthcare as a percentage of GDP will continue to increase unless we change the way healthcare is delivered.

Our study tour found that New Zealand is enjoying some success in containing costs and improving effectiveness, and this article focuses on three features that contribute to this.

Accident Compensation Corporation

Since it abandoned a tort-based system for medical negligence in 1974, compensation for medical negligence in New Zealand is provided by a Government scheme run by the Accident Compensation Corporation, a state owned entity. Claims arising from treatment injuries are covered under a 'no fault' compensation system, whereby patients agree to give up the right to sue for damages arising out of any personal injury. The scheme covers not only medical incidents, but also accidents at home, the workplace and road traffic accidents.

The cost of medical care is covered as well as compensation for more serious events (up to 80% of previous salary levels for as long as is needed). The scheme is funded by a series of levies on employers, fuel duty, car tax and in part income tax.

So what are the benefits of the scheme? First, it is widely acknowledged as being fast (most cases are settled within months and many within weeks) and provides an equitable approach using a simple claims process applying consistent eligibility criteria.

In terms of costs, legal and administrative expenses average around 12% of the value of claims compared with an average of around 55% in the US.

Another benefit is that clinicians enjoy significantly lower premiums for medical indemnity cover regardless of the speciality

practised. Whilst acknowledged as still capable of improvement, the Accident Compensation Scheme has many benefits compared with an increasingly litigious tort-based environment facing ever increasing costs, and is worthy of close examination by other countries.

Pharmaceutical Management Agency (PHARMAC)

PHARMAC is a crown entity established in New Zealand in 1993 to ensure the availability of pharmaceuticals that deliver the best health outcomes that are reasonably achievable within the funding available. On the face of it, PHARMAC may be compared with the National Institute for Clinical Excellence (NICE), but there are some key differences.

PHARMAC does not buy or sell drugs and nor does it register drugs or decide which drugs can be registered in New Zealand. However, it does manage the New Zealand pharmaceutical schedule that lists all subsidised medicines along with any restrictions on eligibility for subsidy. It also has the responsibility for managing the budget for pharmaceutical spending which is fixed and is set as part of the vote for healthcare expenditure.

PHARMAC manages the budget by negotiating prices with the pharmaceutical industry and controls entry for certain therapies. Based on recent history, PHARMAC has been successful in controlling drug costs. Against a backdrop of drug prices rising between 8%–10% per annum, New Zealand has managed to contain costs within a budget that has been rising by just 3% per annum.

Not surprisingly, New Zealand has one of lowest levels of pharmaceutical spending of all the developed OECD countries. So how is this achieved? Essentially by two methods:

- encouraging generic drug entry and use where cheaper
- creating competition between similar therapies.

PHARMAC operates a system whereby it tenders for the purchase of off-patent or generic medicines and once the tender is awarded – typically for a three year period

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– all similar medicines are deleted from its approved list. PHARMAC introduced this process in 1996 and currently sources some 40% of its medicines through open tender thus leading to significant purchasing efficiencies, sometimes as much as 90% of previous prices paid.

For 2006 it is estimated that the community drug bill would have been NZ\$1.03bn higher than it was had it not been for PHARMAC's activities. It is fair to say that this commercial approach is not popular within the pharmaceutical industry, and one of PHARMAC's key challenges is to maintain public confidence in the face of concerted industry lobbying.

Success in managing costs does not mean that New Zealanders have less access to therapies available in other countries, indeed the number of drugs available in New Zealand is about the same as in the US.

All of the drugs that PHARMAC is asked to fund by the industry are subject to a cost utility analysis, CUA, which is just one part of a wider set of decision criteria to decide whether a drug should be added to the list. The CUA essentially looks at the efficiency of the treatment and places a value on the health gain. It does not necessarily address need, nor does it distinguish between those who are sickest and give them priority.

Despite its success PHARMAC is not immune from the pressures of patient and industry lobby groups to fund an ever increasing range of drug therapies. Yet if we return to its legislative objective – namely to 'secure pharmaceuticals to achieve the

best health outcomes that are reasonably achievable from within the amount of funding provided' – on this basis it is difficult to conclude that PHARMAC is not achieving.

elective prioritisation

As in the UK, New Zealand has waiting lists. Until 2000 there was a major concern that patients were uncertain as to whether they would receive treatment, that access to services was inconsistent and that responses were based on waiting times rather than need.

These problems led to the Government publishing a strategy to deal with the issues and saw not only increased investment and improved performance management, but also the introduction of a nationally consistent clinical assessment process that gives patients access to specialist services based on need rather than waiting time.

Patients are assessed by clinicians using a scoring mechanism, which determines clinical need by the application of a scoring threshold. If the score reaches or exceeds the threshold the patient is put on the waiting list where a maximum wait is applicable (currently six months although frequently this is much lower). Patients who do not meet the threshold target scores are referred back to their GP for management.

One of the most striking differences between the NHS and New Zealand's system is that the need to ration services within the funding available is transparent and accepted by both the population and clinicians. The system is largely seen as successful. Waiting times have fallen significantly and people now know whether or not they will receive treatment and that they will receive treatment in a timely manner. But under a nationally applied clinical assessment process, they also know that they are being treated equitably in a system where finite resources are directed to those with the greatest clinical need. ■

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